Indian Health Service's Implementation of the Indian Self-Determination Process

National Indian Health Board and American Indian Technical Services.

JL. Whitecrow

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Indian Health Service's Implementation of the Indian Self-Determination Process

National Indian Health Board, Denver, CO

Prepared for
Indian Health Service, Rockville, MD

Apr 84
The project was designed to define "maximum participation" and "successful outcomes" of Indian Self-Determination (ISD) process as authorized in P.L. 93-638; described example successful implementation; describe how successful outcomes are achieved; and assess the quality and types of technical assistance provided to tribes and tribal organizations. Site visits were conducted to seven IHS Areas, and four tribal organizations were contacted in each Area. The contractor concluded that ISD process is generally working well, but that improvements are needed in facilitating the planning phase when tribes consider whether to contract, and in some aspects of contract monitoring and T.A.
EVALUATION REPORT

The Indian Health Service's Implementation of The Indian Self-Determination Process

Prepared by:

National Indian Health Board
&
American Indian Technical Services

April 1984
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DISCLAIMER

This Report was prepared for the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (DHHS) under Contract No. 240-83-0080. The National Indian Health Board (NIHB) believes that the opinions expressed in this Report represent an accurate, fair, and objective view of the implementation of the Indian Self-Determination Process by the Indian Health Service.

However, the findings, conclusions and recommendations contained within the Report are the sole responsibility of NIHB and the Report principal authors. Therefore, the Report does not necessarily represent the views, policies, or positions of the Indian Health Service, the Health Resources and Services Administration, or any other Agency of the Department of Health and Human Services.
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INTRODUCTION

The Indian Self-Determination and Education Assistance Act (P.L. 93-638) was the first major Indian policy legislation since the Indian Reorganization Act of 1934 (P.L. 73-383). The critical importance of the Act lies in its specific recognition of the right of Indian people to direct their own destiny, while at the same time preserving their rights and trustee status with the Federal government.

After a careful review of the Federal government's historical and special legal relationship with and resulting responsibilities to American Indian and Alaska Native people, the United States Congress found that:

- The prolonged federal domination of Indian service programs has served to retard rather than enhance the progress of native people and their communities by depriving them of the full opportunity to develop leadership skills crucial to the realization of self-government.

- Federal domination has also denied Indian people as well as Alaska Natives an effective voice in the planning and implementation of programs for the benefit of Native people which are responsive to the true needs of Indian communities.

- True self-determination in any society of people is dependent upon an educational process which will ensure the development of qualified people to fulfill leadership roles.

In enacting P.L. 93-638, the Congress declared its commitment to the maintenance of the Federal Government's unique and continuing relationship with and responsibility to Native peoples through the establishment of a meaningful Indian self-determination policy. This policy permits the transfer of Federal authority over programs and services to Indians for effective and meaningful participation by Indians in the planning, conduct, administration and control of those programs and services.

In the Act, the Indian Health Service is directed to contract with tribes or tribal organizations and in the few instances where contracts are rejected, the Indian Health Service must offer convincing evidence for rejection and must provide assistance to the tribes in removing, where possible, the grounds for declining the contract. The Act and Regulations provide for four major tools which may be used by the tribes:
- grants to strengthen tribal governance, planning for contract arrangements, for monitoring Indian Health Service programs.

- contracting for Indian Health Service programs, all or any part.

- planning, designing, monitoring and influencing any programs the Indian Health Service continues to operate, excluding any trust resource program.

- employing or directing Federal personnel to help tribes carry out their programs.

Nine years have elapsed since the Act was signed into law in 1975. This Evaluation was solicited by the Health Resources and Services Administration (HRSA) to review the Indian Health Service's (IHS) involvement in Indian self-determination activities. This report reflects the results of the evaluation and provides recommendations regarding refinement of the Indian Self-Determination (ISD) Process.

SUMMARY OF THE METHODOLOGY

The evaluation was performed by the National Indian Health Board and American Indian Technical Services of Denver, Colorado under a contract (No. 240-83-0080) with HRSA between October 1983 and April 1984. The evaluation considers the IHS ISD Process up to the point of contract award. It does not consider aspects of post contract award administration. The evaluation involved four principal tasks:

- Define "maximum participation" and "successful outcomes" of the Indian Self-Determination Process as authorized in the Indian Self-Determination and Education Assistance Act (P.L. 93-638).

- Describe examples of successful outcomes in the implementation of Indian Self-Determination.

- Describe how successful outcomes are achieved.

- Assess the types and quality of technical assistance provided by IHS to tribes and tribal organizations.

The evaluation methodology consisted of an interactive process under which the study team performed a series of tasks: the development of data through telephone and on-site discussions, quantitative and qualitative analysis of the data, and the development and refinement of various products and reports. Specific topical issues were developed for both the telephone and on-site discussions. In addition, an evaluation measurement tool was developed for use in conjunction with the on-site visits.
Respondent groups for the telephone discussions included IHS personnel and voluntary tribal participants from both contracting and non-contracting tribes. Eleven Area/Program Offices (APOs) were included in the telephone discussions. As a result of these discussions, five APOs (including one test site) were selected for on-site discussions, in keeping with the assessment of the Study Team that these would be conducive to the type of investigation defined under the evaluation. Four tribes within each selected APO jurisdiction were also visited. An attempt was made to obtain representation from both non-contracting and limited contracting tribes as well as from contracting tribes.

SUMMARY OF FINDINGS

The findings discussed here relate to IHS implementation of the ISD Process. Included in this discussion is information regarding the specific issues that inhibit or constrain the success of the process. Because of the study purposes, APOs with extensive experience in contracting under P.L. 93-638 were the focus of the evaluation. Thus, the findings describe the processes that lead to maximum participation and successful outcomes of the ISD process. We note, however, that the telephone discussions revealed that the ISD Process may not be working as successfully in some other APOs, and this may require additional evaluation to obtain a complete picture of IHS implementation of the ISD process.

IHS and Tribal Understanding of the ISD Process.

- The ISD Process has been implemented successfully by the Indian Health Service. Some APOs have implemented the process better than others, but the goals contained therein have been satisfactorily achieved.

- The ISD Process is viewed as establishing a response framework for tribal intentions under P.L. 93-638. The procedures were found to be adequate for this purpose. APOs have refined and/or deviated from the process only on rare occasions and for the purposes of addressing local needs.

- Both IHS and the tribes in the evaluation are familiar with P.L. 93-638 and the available options to tribes under the law. These options are understood better by the tribes that are contracting than by those with limited contracting experience.

- Tribes are more familiar with the law and regulations than with the Indian Self-Determination Memoranda (ISDMs). They tend to relate to the philosophical underpinnings and the intent of Congress. In this regard, contracting is the option with which they are more familiar. There were only a few instances where planning for the utilization of IHS resources was discussed as an option.
- Most IHS personnel see the process as a tool by which Indian self-determination can be achieved. For the most part, the process was defined on the basis of ISDM guidelines and staff relationships in the process.

- Planning which is inherent in the process is identified as an area of weakness by IHS and tribes alike, and this weakness has hindered tribes from developing innovative approaches.

- Staff shortages have been cited in some APOs as reasons for not being able to fully attend to tribal intentions under P.L. 93-638.

The 638 Contracting Process.

- The 60-day mandated timeline for the APO Director's decision to award or deny a contract generally is being met. There are variations in how this is applied, and some confusion in interpretation.

- Some contracting tribes are dissatisfied with the use of threshold issues to hold up the contracting process. This is attributed to the ambiguous use of the term which interacts with other issues related to federal procurement laws and regulations. Both tribes and APOs seemed to feel that clarification of threshold issues is needed.

- Reasons given by tribes for not wanting to contract include the administrative burdens that must be assumed in contracting and the fact that indirect costs are not adequately covered. Tribes who were generally satisfied with IHS delivery of services also expressed that they are less interested in contracting these services.

Successful Outcomes and Determinants.

- Success under the law is defined by both IHS personnel and tribes as obtaining a contract for a program, facility or service and its successful operation.

- Exemplary programs are characterized as those that provide better health care opportunities than had been previously provided by IHS or that meet tribal needs. The manner in which this is achieved includes the assumption of small IHS responsibilities, the full takeover of IHS facilities and services, and the establishment of services where none existed before. The approach of "piece-mealing" programs to tribes is seen by some APOs and tribes as logical because it allows for capacity-building.
- In some areas, IHS personnel have been criticized by tribes as not committed to Indian self-determination. This carries through to the manner in which IHS responds to tribal initiatives to contract.

- Tribes under the jurisdiction of some APOs indicate a limited contact level with IHS personnel and considered this lack of communication as a problem.

Technical Assistance:

- Technical assistance provided by APOs begins when a tribal notice of intent to contract is submitted to the Area Director. This generally involves informing the tribe of contracting requirements and the provision of contracting information so that the tribe can prepare a proposal.

- The data suggest that tribes who have been through the process do not request much assistance in developing contract proposals.

- There is agreement by tribes and the IHS alike that technical assistance offered is not sufficient subsequent to contract award. The orientation of technical assistance has been toward achieving success in contracting -- i.e., what the APO requires in a proposal, what deadlines are, and the timetable for review.

- Some tribes feel that IHS technical assistance is reactive and is provided only after a tribe experiences a problem.

- There is a concern that IHS staff are not well prepared to assist tribes in contracting. The point was made on many occasions that gaps exist in the technical assistance provided which hinders tribes from implementing accountability measures developing health delivery systems, and/or taking over the control of an IHS facility.

- Some IHS personnel see that interactive technical assistance along with the dissemination of information is important in the ISD process.

- Technical assistance approaches do not go beyond the requirements of the ISD process except in certain APOs like Nashville where a systems approach is utilized in connection with contracting and tribal capacity-building.

- A number of tribes voiced the opinion that IHS medical and professional staff are uncommitted to assisting tribes to contract. They perceive this lack of commitment as stemming from greater interest on the part of these professionals in providing direct services.
CONCLUSIONS AND RECOMMENDATIONS

The Indian Self-Determination Process.

Our conclusions are that the ISD Process is generally well understood by APOs and tribes. It should also be noted that the Bureau of Indian Affairs (BIA) and the Administration for Native Americans (ANA) have similar self-determination goals and that cooperative efforts may be possible with respect to the capacity building requirements of the law. Specific areas where improvements can be made at both the Headquarters and APO levels are outlined below.

1. Headquarters staff must continue to affirm the commitment of IHS to the goals and principles of the ISD process.

2. The role of planning must be reemphasized in the ISD process. Moreover, the ISD process must be broadened to include non-contracting activities, so that tribal health priorities are included in service unit plans.

3. Headquarters must assume the responsibility for monitoring the implementation of the process by the APOs.

4. The mission of the Indian Resource Liaison Staff (IRLS) must be publicized so that tribes understand its arbitration and conflict resolution roles.

5. IHS staff must be aware of a shift in agency mission from service delivery to program administration.

6. IRLS staff should review the procedures and experiences of other federal agencies involved in Indian self-determination activities.

Communications between APOs and Tribal Organizations.

Communication is a primary need of the tribes for continued and/or further involvement in contracting. Yet, this is an area identified by the tribes as an area of need. There are several issues in this regard, including the responsibilities of the Contract Proposal Liaison Officer (CPLO) and the Leadership Team members for monitoring, regular and routine contacts, and in mailing information packages as a requirement of the ISD Process. We believe that the communication aspect extends beyond this and relates to the image of the IHS in fostering Indian self-determination. Recommendations are as follows:

7. Communication between APO staff and tribes must be improved.

8. APO staff responsibilities for ISD process must be clarified and understood by the tribes.
9. Tribal requests for information or assistance must be handled more effectively.

10. APO staff must be careful to project an image of support for the ISD process.

The 638 Contracting Process.

Almost all tribes contacted related difficulties in the contracting process. While some of these are unavoidable parts of the procurement process, there are areas where improvements could be made. Specifically, clarification should be provided on the Secretary's discretion to waive certain procurement requirements, and eliminate some steps in the process that require signatory approval. Second, the information which tribes must have to contract -- i.e., program descriptions and budget information could be expedited to avoid further delays. There is also a belief from this evaluation that contract renewals should not be subjected to the full requirements under the ISD Process. Other specific recommendations are:

11. Contracts for tribal assumptions of existing IHS programs should not be encumbered by the parameters of previous operations.

12. Certain aspects of the 638 contracting process need further clarification and better definition. These include:

- specification of program and service standards,
- definition of threshold and declination issues,
- clarification of the 60-day mandated time requirement for proposal action.

13. APOs need to strengthen response mechanisms to tribal expressions to contract under P.L. 93-638.

Technical Assistance.

At present, the vast majority of technical assistance provided pertains to the 638 contracting process and the mechanics of obtaining a contract. While this is generally good, it does not meet the tribal capacity building requirements to meet the administrative and service provision needs defined under the law. The following recommendations are suggested for improving this aspect of the ISD process:

14. The scope of technical assistance should be expanded to include health care planning, infrastructure, capacity building, contract administration, and health care service delivery.

15. IHS must improve its capability to deliver TA in areas outside of the 638 contracting process. Specific improvements are:
• adding or shifting personnel in consideration of their capabilities to perform these functions within the APO;
• sharing staff with required specialties among APUs;
• developing staff capabilities at the headquarters level which could be utilized by APOs in responding to tribal requests;
• contracting at the national or regional level for the provision of TA; or
• providing tribes with funding to secure the needed expertise.

16. TA must be provided on a timely basis.

Future Evaluation Requirements.

Although a high level of success in ISD implementation is reported on the sites visited, there are some doubts as to overall success. Further sporadic problems occur even in the most successful locations. We believe that the evaluation measurement tool provides a good basis for further evaluation work. In addition, there are other areas where additional assessment is needed beyond the point of contracting. The findings, conclusions and recommendations listed above are believed to be sound in the context of this evaluation's purposes and for the sites visited in depth. We also believe that this evaluation has identified other areas for future evaluation.
CHAPTER 1
INTRODUCTION

1.1 PURPOSE AND SCOPE OF THE EVALUATION

This report presents the findings of six months of field research and technical reviews of the Indian Health Service's implementation of P.L. 93-638, the Indian Self-Determination and Education Assistance Act of 1975. The evaluation was performed by the National Indian Health Board (NIHB) and American Indian Technical Services (AITIS), both of Denver, Colorado, between October 1983 and April 1984. The report was prepared under Contract No. 240-83-0080 with the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (DHHS).

The evaluation addresses the policies, actions and outcomes associated with the Indian Self-Determination Process (ISD Process), the mechanism defined by the Indian Health Service (IHS) for achieving the purposes of P.L. 93-638. The methodology, data, findings, conclusions and recommendations are presented in following chapters of this report.

The purposes, requirements, and scope of work for the evaluation are contained in the HRSA Request for Proposal (RFP No. 240-IHS-18(3) DE), and the subsequent contract between HRSA and NIHB. Briefly, HRSA asked that a contractor evaluate IHS implementation of the ISD Process through four basic tasks:

1. Define "maximum participation" and "successful outcomes" of the Indian Self-Determination Process as authorized in the Indian Self-Determination and Education Assistance Act (P.L. 93-638);

2. Describe examples of successful outcomes in the implementation of Indian Self-Determination;

3. Describe how successful outcomes are achieved; and

4. Assess the types and quality of technical assistance provided by IHS to tribes and tribal organizations.

Fourteen tasks were defined in the contract scope of work. Planning and performing these tasks required much interaction between the NIHB/AITS Evaluation Study Team and IHS personnel, including both Headquarters and Area/Program Office (APO) levels of the Indian Health Service. In addition, discussions with voluntary tribal participants provided substantial input and guidance to the development of the evaluation tasks. The tasks fall under the following categories:
design and refinement of evaluation issues;

telephone and site discussions with IHS personnel and voluntary tribal participants;

quantitative and qualitative analysis of evaluation data; and

preparation of the evaluation report.

The evaluation was performed by senior staff members of NIHB and AITS, integrated into an overall Evaluation Study Team consisting of four principal members. In addition, two research analysts were involved in conducting some of the telephone and on-site discussions. Performance of the evaluation was monitored by the IHS Project Officer, a senior member of the Indian Resource Liaison Staff (IRLS) in the Indian Health Service.

1.2 EVALUATION SETTING AND ENVIRONMENT

The enactment of P.L. 93-638 -- the Indian Self-Determination and Education Assistance Act of 1975 -- is pivotal in terms of the development of philosophy and policy applied to the overall Federal-Indian relationship. The Act represents the achievement of an important milestone in Indian affairs in that it: (1) reiterates the policy statements and commitments framed in President Nixon's Message on Indian Self-Determination delivered to the Congress on July 8, 1970; and (2) provides a framework for accountability and relevance to Indian tribes in the design and conduct of Federal Indian programs. The two Federal agencies with primary responsibility for Indian affairs, the Departments of Interior and Health, Education and Welfare (subsequently, Health and Human Services), are directed to implement the provisions of the Act. For the purposes of this report further discussions with regard to P.L. 93-638 focus on the provision of health programs and services by the Indian Health Service.

1.2.1 Historical Setting for the Indian Health Service

The provision of health care for Indian people is part of a long established Federal-Indian relationship and is rooted historically in treaties, legislative acts, and executive orders that extend back to the formative years of the Nation. These actions of the federal government have been documented in Federal Indian Law (Cohen 1972), and referenced in various other administrative and legislative investigations and reports. Among these, the Report on Indian Health (1976), prepared by Task Force Six of the American Indian Policy Review Commission (AIPRC), documents the special problems and needs for improving the health status of Indian people in the United States.

Basically, the earliest transactions between the United States and the tribes involved securing land for occupancy and expansion, maintaining peace, and establishing trade within newly acquired ter-
ritories. Later actions by the United States were primarily for isolating and confining tribes within specific reservation boundaries. The practice of making treaties with Indian tribes continued until 1871, when a phrase in the Appropriations Act terminated the process. Following that date, the United States continued its relationship with the tribes through executive orders and legislative acts (Washburn 1973: 1-3).

These treaties, executive orders, and acts generally recognized tribal rights to specific lands and their rights of self-government. In addition, these documents contain assurances for certain benefits and services, i.e., protection, merchandise, annuities, education, etc. While a number of treaties did not include a provision for health care, health care was considered necessary in order to carry out other provisions of the treaties and to maintain friendly relations with the tribes (AIPRC, Task Force Six 1976: 28). Thus, Federal agencies with initial responsibility for Indian affairs had some role in the health maintenance of Indian people.

A number of studies have described New World Indian populations before and following white contact. Generally, there is agreement that indigenous tribal peoples were once more numerous, and were isolated from the diseases common in Europe, Asia and Africa (AIPRC, Task Force Six 1976: 27). However, contact with European and African groups was devastating to the tribes. In The Columbian Exchange, Crosby (1972) relates that:

Migration of man and his maladies is the chief cause of epidemics... Medical historians guess that few of the first rank killers among the diseases are native to the Americas... These killers came to the New World with the explorers and the conquistadors.

The fatal diseases of the Old World killed more effectively in the New, and the comparatively benign diseases of the Old World turned killer in the New. There is little exaggeration in the statement of a German missionary in 1699 that "the Indians die so easily that the bare look and smell of a Spaniard causes them to give up the ghost" (1972: 37).

The ravages of such epidemics were widespread, and caused the gradual decimation of the New World tribal populations. S.F. Cook (1955, reprinted in Walker 1972: 172-192) reports aboriginal population losses in California and Oregon; and, Maximilian reflects on the destruction of the Mandan villages on the Missouri in the early 1800s. Coupled with the introduction of firearms and the reservation system, newly introduced illnesses were directly attributable to the European successes in the New World. By the time the United States succeeded in controlling major eastern territories of this continent, the tribes were physically less able to resist additional westward expansion. (Crosby 1972: 35-63).

As tribal dependence on the federal government increased, the health needs of Indian people became more prevalent. In the initial
years, care provided by the federal agencies was minimal and involved dispensing vaccines "... more for the protection of military personnel and the white population than for the Indians themselves" (AIPRC, Task Force Six 1976: 28). In addition, reservation life along with inadequate diets and unsanitary conditions, led to further Indian health problems.

The Snyder Act of 1921 "... for the benefit, care, and assistance of the Indians throughout the United States" (Snyder Act, 25 U.S.C. 13) authorized the Indian Bureau to provide Indian health care. Following this enactment, the U.S. Congress authorized the first congressional review into the conditions of American Indians in the United States. In 1928, the Report prepared by Lewis Meriam of the Brookings Institution, was submitted to Congress. Entitled Problems of Indian Administration, the Report extensively defined issues pertaining to the Federal government's negligence and inconsistent policies relating to Indians. In addition, Meriam recommended a course of action which would correct inconsistent policies and improve the conditions of Indians in the United States. The areas proposed for correction included tribal self-government, education, health, and reservation development (Meriam 1928).

Throughout this period, Indian health needs continued to rise far beyond the capabilities of the Indian Bureau. Health problems became so acute that in 1926, Interior Secretary Work turned to the Public Health Service for assistance. The Public Health Service continued to provide health care services through the 1940s, although the Division of Indian Health within the Indian Bureau maintained primary responsibility.

Under Commissioner of Indian Affairs John Collier (1933-1945), the Indian Bureau's initiatives focused on the improvement of reservation conditions in several ways. In 1934, the Indian Bureau sent representatives to consult with the tribes on their specific problems with the Indian Reorganization bill -- an action which was in itself revolutionary since previously tribes had seldom been consulted on Federal actions or legislative proposals (Collier 1947: 264). The bill was enacted later in 1934 (Indian Reorganization Act, 48 Stat. 984, June 18, 1934), with six primary parts: (1) the recognition of the right of tribes to govern their own affairs; (2) the creation of an Indian civil service for training and administration of the Indian Bureau; (3) cessation of Indian land allotments; (4) establishment of a revolving credit fund for agriculture and industry; (5) the provision of civil and criminal law enforcement under a system of tribal courts; and (6) the consolidation of fractionated allotted lands. The Johnson-O'Malley Act, also passed in 1934, enabled states and other political subdivisions to provide for the health, education, and welfare of Indian people through a system of contracts and grants-in-aid (Collier 1947: 265-266).

Besides the enactment of specific Indian legislation, other programs were brought to Indian reservations. The Civilian Conservation Corps (CCC) had an Indian Division which was instrumental in providing both jobs for Indians and numerous improvements and con-
struction of reservation facilities and roads. In addition, the CCC work led to improvements to range and agricultural systems as well as the provision of forest work that made it possible to develop timber resources (Roberts and Egan-McKenna 1983). The expansion of education and health facilities was also a major effort of the Indian Bureau under Collier.

From the late 1940s through the late 1950s, the Indian world was shocked by a sharp reversal in Federal-Indian policy which emanated from the Congress. As early as 1944, the Congress expressed its concern to "find a solution to the Indian problem" (Sen. Rpt. No. 91-501, 1969). This viewpoint ran parallel to the broader view of the 80th Congress for reducing the war debt by making government provided services self-sustaining through reimbursable programs (Sen. Rpt. No. 91-501, 1969). Since the programs under the Bureau of Indian Affairs were incapable of attaining this goal, Commissioner William Zimmerman was asked to formulate a plan for the withdrawal of Federal services to Indian tribes.

The Zimmerman plan was straightforward and expedient, and took into account: (1) the degree of tribal acculturation, (2) tribal economic resources and conditions; (3) tribal willingness to be relieved of Federal control; and (4) the willingness of States to assume responsibility for Indian affairs (Sen. Rpt. No. 91-501, 1969). Funding reductions followed the Zimmerman Plan and, in 1952, Congress enacted P.L. 83-280 authorizing the extension of State jurisdiction over Indian reservations. This was followed by the adoption of H. Con. Res. 108, which expressed the intent of Congress to favor the termination of Federal-tribal relationships (AIPRC, Final Report 1977: 151). With "termination" principles entrenched as federal Indian policy in the 1950s and early 1960s, a number of tribes, rancherias, and communities lost their Federal recognition and experienced both the withdrawal of Federal services and transfer of jurisdiction to States.

While termination permeated Federal-Indian policy during the 1950s, a substantial number of questions were raised concerning Indian health. Specifically, the issue of placement of responsibility for Indian health, either under the Bureau of Indian Affairs (BIA) or under the Department of Health, Education and Welfare, was debated. A bill was finally introduced for the transfer of the Division of Indian Health to HEW based upon the premises of the House Committee on Appropriations that: (1) Indian illness was extensive; and (2) the availability of facilities and services remained inadequate to meet existent needs. The transfer occurred in 1955 with the agency being redesignated as the Indian Health Service under the Public Health Service of HEW (AIPRC, Task Force Six 1976: 32). Since then, this agency has remained the primary agency for the provision of Indian health care.
Only through a concerted national tribal effort was the termination policy reversed. There was lingering tribal concern, however, that termination would be revived and throughout the 1960s the tribes persistently sought a national policy which would officially end the termination efforts (Tyler 1964: 22).

A concurrent philosophy began to evolve that Indian tribes and people should have the right to exercise direct control over their lives, lands and resources. Based on the OEO experience begun in 1964, experiments in contracting for programs once under the BIA were conducted at Zuni Pueblo in New Mexico and at the Salt River Pima-Maricopa Indian Community near Scottsdale, Arizona. Further, the BIA transferred Rough Rock School in Arizona to an Indian-controlled school board and contracted with them for the operation of a "Demonstration School." (AIPRC, Task Force Five Report 1976: 257). As tribes achieved success in contracting, the spark of self-determination began to smoulder. Fanned by young Indian activists and proponents within the Federal structure in the late 1960s, the concept ignited into the policy framed by President Nixon in his Indian Self-Determination Address of July 8, 1970. Stressing that the past Federal policies were failures in improving the economic base and quality of Indian life, Nixon espoused a philosophy of tribal self-determination. This was reflected in the Message:

Both as a matter of justice and as a matter of enlightened social policy, we must begin to act on the basis of what the Indians themselves have long been telling us: The time has come to break decisively with the past and create the conditions for a new era in which the Indian future is determined by Indian acts and Indian decisions (President's Message, June 8, 1970).

As a gesture of the good will of the Federal government, the sacred Blue Lake in New Mexico was restored to the control of the Taos Pueblo. President Nixon framed the policy of Indian self-determination in defining the Federal role of "... improving the conditions of Indian life ... (through) a new and balanced relationship between the United States government and the first Americans" (Ibid.: 16). His Message asked that the Congress begin to frame legislation which would enhance this self-determination process. This was finally accomplished on January 4, 1975, when the Indian Self-Determination and Education Assistance Act, P.L. 93-638, was signed into law by President Gerald Ford. Responsibility for implementing the process was placed in the hands of the Secretaries of the Interior and Health, Education and Welfare.

The backdrop within which the Indian Self-Determination Act was adopted can be termed a reversal of the assimilationist and terminationist movements of the 1940s and 1950s. The contracting experiences of the 1960s and 1970s conducted by various branches of the BIA had been possible under the authority of the Buy Indian Act (25 U.S.C. 47), but this Act proved to be inflexible for tribal self-determination purposes. Thus, grassroots tribal organizations such as the
Coalition of Indian Controlled School Boards (CICSB), the All-Indian Pueblo Council (AIPC), the National Indian Health Board (NIHB) and other tribal/organizations began to seek a legislative direction that would give more flexibility and wider latitude to the IHS and BIA in contracting services under their authority.

The legislative movement for an Indian self-determination policy began with the Senate's introduction of S. 1017 in 1973. However, the bill as first introduced had the single purpose of reforming the Johnson-O'Malley Act. The Indian community's response to the proposal was that they did not need yet another educational program, but stronger contracting authority that would enable tribes to contract for BIA and IHS programs as well as educational programs. As a result of extensive hearings, the scope of S. 1017 expanded to include all facets of services and programs of the BIA and IHS programs. Thus, the final version of the bill had two titles: Title I contained the self-determination and contracting provisions; and Title II provided for the reform, through self-determination, of BIA educational services. As such, the bill was reported out of joint committee in late 1974 and P.L. 93-698 was signed into law on January 4, 1975.

1.2.3 Provisions of P.L. 93-638

As noted above, P.L. 93-638 contains two titles: Title I is entitled the "Indian Self-Determination Act" (25 U.S.C. 450) and Title II is "The Indian Education Assistance Act" (25 U.S.C. 455). For the purposes of the evaluation, further references to the Law will center on Title I, particularly those sections that relate to the Secretary of Health, Education and Welfare (subsequently Health and Human Services).

P.L. 93-638 is intended to reverse longstanding Federal dominance over Indian affairs. The law reaffirms the commitment of the Federal government to maintain its relationship with American Indian tribes; and acknowledges an obligation to respond to tribal expressions for self-determination by providing opportunities for "maximum Indian participation" in programs under the direction of the Indian Health Service. This is more clearly stated in the purposes of P.L. 93-638, which are:

1. "To provide maximum Indian participation in the Government and education of the Indian people;"

2. "To provide for the full participation of Indian tribes in the programs and services conducted by the Federal government for Indians and to encourage the development of human resources of the Indian people;" and

3. "To support the right of Indian people to control their own educational activities, and for other purposes."

"Maximum tribal participation" as called for in the Nixon Address was proposed through legislation to establish a unique con-
tracting mechanism for programs formerly administered by the Federal government including any program or service provided by either the IHS or BIA, including the administration of Indian hospitals or clinics. Moreover, the President recommended that certain assurances be contained in the legislation for accountability, maintenance of the federal trust responsibility, and other measures to ensure the sovereign immunity from suit enjoyed by the tribes. The right to retrocede any program for any reason was also recommended with the proviso that such an action would not jeopardize any other contract or grant operated by a tribe.

In response to the Nixon Address, Congress framed P.L. 93-638 to be almost identical to the recommendations contained therein. Contracting eligibility under Title I includes any "tribe, band, nation or other organized group or community, including any Alaska Native village or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act." Tribal organizations are defined as the recognized governing bodies of any Indian tribe, or "any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of Indians in all phases of its activities" (25 U.S.C. 450(b)(c)).

Within Title I, eligible Indian tribes may contract for any program or service operated by the government. Moreover, Section 103(a) directs the Secretary of HEW (subsequently DHHS) to contract with any Indian tribe which requests to "carry out any or all of his functions, authorities and responsibilities under the Act of August 5, 1954 (68 Stat. 674). The Secretary may decline to contract if he finds that:

1. The services to be rendered to the Indian beneficiaries of the particular program or function to be contracted will not be satisfactory;

2. Adequate protection of trust resources is not assured; or

3. The proposed project or function to be contracted cannot be properly completed or maintained.

This section also establishes the manner in which contracting with tribes will occur and places specific measures of accountability into the contracting process. Specifically, tribes must demonstrate capability to contract on the basis of adequate equipment, bookkeeping and accounting procedures, substantive knowledge of the program to be contracted for, community support for the contract, adequately trained personnel, or other necessary components for contract performance. In the event of a declination of a contract proposal, the tribe is entitled to a written statement giving the reasons for the declination and a hearing for the purpose of appealing the decision.
Although the Secretary may decline to contract with a tribe, the Indian Health Service must provide whatever assistance is practicable to ensure the tribe's right of self-determination. Section 104(b) provides for grants to enable tribal organizations to develop their capabilities (in terms of facilities construction and organization) to carry out programs contracted for under Section 103.

The remaining sections under Title I provide for the utilization of Federal commissioned Corps personnel in meeting tribal contract requirements (Section 105), the provisions by which contracts are to administered (Section 106), the promulgation of rules and regulations as well as the timetable for accomplishing this requirement (Section 107), reporting requirements of contracting tribes (Section 108), and the conditions under which the Indian Health Service is required to "reassume" a program (Section 109). Of particular note is that the Secretary is required to rescind a contract upon tribal request, and reassume a program within ten days if the life or safety of Indian beneficiaries is threatened. Finally, the remaining Section 110 under Title I assures the sovereign immunity of contracting tribes and the trust responsibilities of the Federal government for Indian people.

1.2.4 Indian Health Service Involvement with P.L. 93-638

Following the enactment of P.L. 93-638, IHS planning for implementation was first to treat Indian self-determination activities within the basic management modality of that agency. Basically, implementation procedures would be highly decentralized to ensure relevance to tribal needs in the process. However, before the IHS could address the contracting provisions of the Act, it was necessary to strengthen appropriate parts of the IHS structure. Steps taken included:

1. Establishing measures for accommodating the various differences in the 638 contracting process and other Federal contracting laws and regulations;

2. Developing IHS staff capabilities and capacities;

3. Adjusting the workloads of IHS staff; and


In reflecting on the success of IHS implementation of P.L. 93-638, Dr. Emery Johnson stated in 1977 that the previous year IHS had implemented 41 contracts totalling $6,192,677 and processed 92 grant applications resulting in 32 awards at $2,509,240. These grants were primarily in the areas of planning and development to prepare for the tribal assumption of Indian health systems. Dr. Johnson also maintained that the level of improved health status and quality of care were the true measures of the success of P.L. 93-638 implementation (Sen. Hearings 1977).
During the Senate Hearings, Dr. Johnson also identified certain problems associated with the implementation of the Act. First, contracting was an expansion in function for the IHS and the agency faced problems of developing the administrative processes to conduct and manage this function. The IHS had also assumed the position that tribes must initiate the contracting process. Tribal acceptance was also an initial problem since the new law held the fear of termination for some tribes. Thus, IHS was committed to using the contracting mechanism with which the tribes felt most comfortable. Uncertainties relating to Indian preference and assignments under the Intergovernmental Personnel Act (IPA), as well as resolving questions of what constitutes a tribe needed to be resolved (Sen. Hearings 1977).

The Senate Hearings conducted on the implementation of the P.L. 93-638 process and the GAO Reports of 1978 and 1981 have traced the implementation of the law within the BIA and IHS. These reports have generally been critical of implementation, and have alleged that both Agencies have met the intent of P.L. 93-638 in a weak manner. One of the implementation problems has been that both agencies initially developed policies that their staff would respond to tribal action but would not encourage or facilitate tribal action. The rationale used in this regard was that "... encouraging tribes to contract would be contrary to the concept of self-determination." The implementation problems cited in this regard have been the level of understanding to make internal decisions related to contracting and inadequate funding levels to support tribal assumptions (GAO Report 1978: 23).

As tribes began to exercise their options under the ISD Process, other issues emerged. The 1981 GAO Report focused primarily on accountability and contract compliance issues, but pointed out that problems may also be rooted in the procedural aspects of the affected agencies (GAO Report 1981: ii-vi). Among these are the absence of clearly defined accountability measures, the lack of evaluation guidelines for the overall 638 contract management process, and deficiencies in tribal financial/budgetary control. Associated with these were the unauthorized use of expired appropriations, funding increases with little evidence of a concomitant service increase, and the use of technical assistance funds for purposes other than improving tribal management capabilities.

A major policy change within IHS came in 1981 with the development and implementation of an "Indian Self-Determination Process." At that time, Indian Health Service policies for P.L. 93-638 became embodied in Indian Self-Determination Memoranda (ISDM). These provide instructions and clarifications on technical and/or administrative procedures associated with implementation of the ISD process. ISDMs are issued:
To ensure compliance of the Indian Health Service (IHS) contracting process with the Indian Self-Determination Act (P.L. 93-638) and the regulations issued thereunder and to simplify the process to the extent that the law and regulations permit (IHS, ISDM No. 81-1, January 30, 1981, page 1).

In addition, IHS utilizes serial forms known as "Indian Self-Determination Advisories" (ISDAs), which serve to provide clarifications on technical and/or administrative procedures associated with the various related aspects of the ISD Process. ISDM No. 81-1 provides a sample 638 Cost Reimburseable Contract with applicable provisions from Title 42 of the Code of Regulations. ISDM No. 81-2 identifies an IHS team approach and states that the Team members must include a representative from the Area/Program Director's office. The memorandum also defines the right of tribes to contract and the operating within which the IHS must function relative to tribal contracting proposals.

ISDM No. 81-3 of April 17, 1981, defines five integral development stages of the ISD process:

Stage 1: Preparation
Stage 2: Preproposal Development
Stage 3: Proposal Assessment
Stage 4: Contract Award
Stage 5: Contract Administration

The steps required by the process emphasize the interactions that are necessary between IHS and a contracting tribe, once a tribal determination to begin a contracting process has been made. IHS is required to provide technical assistance to a tribe throughout the ISD Process in order to bring about a successful outcome of the overall contracting effort. However, a tribe, after reviewing all of the related facets of contracting, may choose not to contract. Rather, it may desire, instead, to specify the manner in which a service is provided and/or the content level of a specific program. Within available resources, IHS is mandated to comply.

Included in the 638 process is the right of a tribe to retrocede a program. Retrocession may take place when -- for whatever reasons -- a Tribe finds that its ability to provide effectively the services under contract is impaired. In this type of situation, retrocession represents an assurance that an adequate level of service will be maintained. It is not, however, to be considered a negative reflection on a tribe's management ability.
ISDM No. 81-4 defines minimum health program and professional services to ensure compliance with the provisions of the Indian Self-Determination Act. The Memorandum references the Indian Health Manual in identifying the 18 major medical (health) and professional activities of the IHS for which the IHS has established minimum health programs and professional standards. ISDM 81-4 further instructs that

... Where the Manual does not identify IHS established standards for an activity, the standards established by the appropriate national standard setting or accrediting body shall be applicable to that activity (ISDM 81-4, May 29, 1981, page 2.)

Since major medical (health) and professional activities are contractible under P.L. 93-638, an evaluation must be made of contractor demonstrated capacity to meet established IHS standards. However, ISDM-81-4 advises that some consideration must be given to the level of performance currently in effect in a given location with respect to the established standards. In locations where the level of performance is less than specified in the standards, ISDM 81-4 states that

In evaluating a 638 contract proposal, and in negotiating a 638 contract, the IHS shall not require the proposed contractor to maintain a higher level of performance for the health services to be contracted than is reasonably attainable under prevailing conditions of funding, staff and facilities at the location concerned. (ISDM No. 81-4, May 29, 1981)

However, it should be noted that the standards themselves, whether applied by the IHS or the contractor, remain as established, regardless of the current level of performance.

If one measures 638 contracting performance from the date of the GAO Report on Indian Self-Determination Act implementation (1978), there has been significant progress in performance. Table 1.1, below, summarizes IHS contract data for Fiscal Years 1981, 1982, and 1983. In 1978, the total number of contracts within the IHS were 15, compared to an estimated 365 contracts for FY 1983. During FY 1982, IHS 638 contracts represented about $89.3 million, more than doubling the total 1978 appropriation under P.L. 93-638 for both the BIA and IHS.
Table 1.1

INDIAN HEALTH SERVICE 638 CONTRACT AMOUNTS FOR FISCAL YEARS 1981-1983

<table>
<thead>
<tr>
<th>FY</th>
<th>TOTAL IHS CONTRACTS ($ in Millions)</th>
<th>TOTAL IHS 638 CONTRACTS ($ in Millions)</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>'81</td>
<td>$169,942</td>
<td>$ 79,203</td>
<td>47</td>
</tr>
<tr>
<td>'82</td>
<td>$175,878</td>
<td>$ 92,438</td>
<td>53</td>
</tr>
<tr>
<td>'83</td>
<td>$190,508</td>
<td>$119,116</td>
<td>62</td>
</tr>
</tbody>
</table>

2.1 SUMMARY OF THE EVALUATION APPROACH

2.1.1 Introduction

The general purpose of this evaluation was to assess the ISD Process as implemented by APO staff of the Indian Health Service in terms of "maximum participation" and "successful outcomes." As noted above, the ISD Process is defined in a series of policy memoranda issued under the general title "Indian Self-Determination Memoranda" (ISDMs), which address the administrative and contracting aspects of P.L. 93-638. Of primary importance is ISDM No. 81-3 (April 17, 1981), which defines the various stages and steps essential in responding to tribal self-determination articulations. The evaluation addressed the first four stages of the ISD process, up to the point of contract award. The role of APO staff and their involvement with tribes once a contract is signed and the delivery of health care services begins is beyond the scope of the present study.

The evaluation also attempted to review the health care services planning functions independent of the contracting provisions of P.L. 93-638. However, the steps defined in ISDM 81-3 apply solely to the contracting process, and thus provide a benchmark for evaluating only that aspect. At the same time, it is essential to note that contracting is only one means of expressing Indian self-determination, and that the process should include a planning function which may or may not involve contracting.

The evaluation process involved the performance of 14 tasks enumerated and explained in the NIHB/AITS Proposal of August 26, 1983. The tasks included the development and refinement of evaluation topics from the RFP, the conduct of telephone and on-site discussions with IHS personnel and voluntary tribal participants, the development and application of an evaluation measurement tool in conjunction with the site visit discussions, and analysis of evaluation data.

2.1.2 General Approach

Because this was the first formal evaluation to be conducted of the IHS ISD Process, it was designed to have a flexible and responsive methodology in keeping with its exploratory nature. Information was collected from both IHS staff and voluntary tribal participants through informal discussions, both by telephone and in person, rather than through highly structured and rigid interview schedules or questionnaires.

In developing the research approach, several specific requirements and constraints were taken into account. As in any policy study, we expected that additional issues of importance to the re-
search would emerge as the evaluation proceeded. The methodology had to address questions important to IHS, and research techniques were selected based on their appropriateness for probing these questions directly. We fully expected to learn new things about the ISD Process in performing this study and to incorporate these insights into our analysis and reporting in order to provide the maximum amount of information on the process.

The data of primary relevance to a study of this nature are likely to be highly qualitative and to show a degree of variability among sites. We were concerned with the process of self-determination, how IHS administers its self-determination responsibilities under P.L. 93-638, and the procedures by which tribes successfully exercise this right. This led to our decision that a qualitative approach would be most effective for data collection, interpretation, and analysis in this evaluation. Not only has this method been used extensively and successfully by members of the project team in past projects, but it facilitates the utilization of existing secondary data and the analysis of both qualitative and quantitative data in an intensive, integrated and rigorous fashion. This approach assures that the individuality of each site is recognized, yet allows data to be systematically examined across cases. An additional advantage of this approach is that findings of possible significance can be delineated and circumscribed in a "package" that is usually small enough to prevent subtle differences from being lost.

The identification of study topics proceeded in an interactive manner, beginning with analysis of the content of ISDMs and the information requirements of IHS for the evaluation. These initial topics were the basis of a series of telephone discussions conducted with representatives of APOs and tribes in 11 of the 12 IHS jurisdictions. Results of the telephone discussions allowed the evaluation staff to select four areas for site visits and to refine the site discussion topics. These site discussion topics were field tested in a preliminary visit to the Oklahoma City APO and several tribes in that area, resulting in some minor procedural revisions and adjustments (These changes were so slight that it was determined that the data collected during the Oklahoma City site visit could be incorporated into the body of the main study without substantial concern for methodological problems.). Finally, the Oklahoma City visit provided input to the development of the measurement tool, a device to be used by evaluation staff for the systematic and quantitative recording of their impressions, and to field staff training procedures, designed to ensure that good field practices would be followed and that all necessary information would be obtained from the APO and tribal informants.

Data from the investigations are first presented in narrative form as a summary of telephone discussions and a description of each of the five visitation sites. The general outline of these discussions, contained in Chapter 3, are consistent for all sites; however, there are variations in the detailed content that reflect differences in local conditions. Quantitative data from the measurement tool is also presented in tabular form along with some summary descriptive
statistics. No attempt has been made to perform any sort of statistical analysis (significance testing) on these results given the extremely small sample size. The qualitative and quantitative data both were used in preparing the findings summarized in Chapter 4, and the conclusions and recommendations presented in Chapter 5. The balance of this Chapter 2 presents additional detail concerning the methodology employed throughout the course of the evaluation.

2.2 DATA COLLECTION METHODOLOGY

2.2.1 Development of Benchmark Definitions

Indian self-determination is a concept that has evolved to express a universal desire to maintain and optimize tribal sovereignty and self-government. The process involved in achieving self-determination includes control over the obvious elements of tribal land and natural resources taking into consideration the social, cultural and economic environment within Indian reservations. Thus, the Indian self-determination process -- as distinct from the 638 Process which is specific to IHS and matters of health care -- is composed of tribal cultural, political, and community actions which lead to tribal self-governance and self-sufficiency. While the IHS ISD Process is grounded in the ideals of tribal sovereignty and control, it is also a legislatively mandated policy. As such, P.L. 93-638 requires federal interaction whenever a tribe requests to takeover and/or redefine certain BIA/IHS functions. Within the IHS such a request initiates the 638 process referred to as the ISD Process, as defined in ISDM No. 81-3. Tribal decisions are key in the process, regardless of the "ultimate" tribal choice to contract or not.

As a first task of the evaluation, benchmark or "working definitions" were developed for the key terms of self-determination -- maximum participation and successful outcomes. These definitions appear below and were used in the course of performing the research.

MAXIMUM PARTICIPATION is a level of interaction between the IHS and Indian tribes and Alaska Native villages sufficient to:

1. lead to an informed decision to contract (or not) based on tribal needs and/or desires;

2. enable tribes to work with IHS in planning for the delivery of Indian health care services/programs based on tribal needs and available IHS resources; and

3. ensure the effective delivery of Indian health services/programs.

Maximum participation is accomplished through a program of technical assistance and information provided by the IHS through its Area/Program Offices to any tribe or Alaska Native village that expresses an interest in greater involvement in the delivery of IHS programs and services. Under the Indian self-determination concept, contrac-
ting is not the only option available to the tribes. Rather, the intent of tribal participation is to achieve an understanding of the available options so that "informed decisions" are reached with respect to planning and/or contracting for the delivery of services/programs that meet tribal needs.

SUCCESSFUL OUTCOMES of the ISD Process are achieved when an Indian tribe or Alaska Native village has reached an informed decision in concert with the IHS on the effective delivery of Indian health programs/services. Full understanding of the available options and the exercising of these options -- either through 638 contracting or participation in the IHS planning process -- are important indicators of successful outcomes.

2.2.2 Development and Refinement of Discussion Topics

Along with the task of developing benchmark definitions, a corollary task of the evaluation involved the development and refinement of discussion topics relating to the ISD Process. These needed to be well defined since the approach for the evaluation relied on non-structured discussions as the principal means of securing information. That is, these topics represented the variables for which data were collected. Deriving a slate of topics for the telephone discussions involved reviewing the steps under ISDM 81-3 and other related ISDM materials. This review also enabled Study Team members to gain an in-depth understanding of the requirements of the ISD Process. Topics were tailored to both IHS personnel and voluntary tribal participants.

The results of the telephone discussions are summarized in Section 3.1. Analysis of the discussions enabled the identification and/or extension of key issues for the subsequent on-site visits. This revised topics list enabled the Evaluation Team to focus in principal issues within the site visits and thus to explore the concepts of maximum participation and successful outcomes in detail. Telephone discussion and site visit topics are presented in Appendices B and E, respectively.

2.2.3 Determining Respondent Groups

It was decided early in the evaluation to involve 11 of the 12 Area or Program offices of the Indian Health Service in the evaluation. The Navajo Area Office was excluded from the evaluation based on the premise that the population and land base of the Navajo Nation is not characteristic of sites that would be found within other IHS jurisdictions.

The methodology for the study required the selection of individual respondents for two purposes: conducting the telephone discussions with IHS personnel and with voluntary tribal participants in the APO jurisdictions; and for performing on-site visits to four
IHS APOs and approximately 16 tribes within those jurisdictions. Complete lists of the individuals contacted during all phases of data collection are included in Appendix C (telephone contacts) and Appendix D (site visits).

For the telephone discussions at IHS Headquarters level it was determined that the most appropriate individuals to be contacted regarding their understanding of the ISO Process were the Director, members of the Indian Resource Liaison Staff (IRLS), and contracting personnel. Appropriate IHS discussants at the APOs were determined to be the Contract Proposal Liaison Officer (CPLO) and members of the 638 Leadership Teams. APO directories were used to identify the appropriate persons to be contacted, and a preliminary contact list was submitted to the Project Officer for review. This review resulted in a slight expansion of the list of individuals to be contacted, revisions based on recent personnel changes, and the identification of CPLOs. The final contact list was then submitted to the Project Officer for concurrence and approval. In all, a total of 69 IHS staff members were identified and discussions were completed with 57 of these: 7 at Headquarters and 50 in 11 of the APOs.

The evaluation required that discussions be conducted both with tribes that are contracting with IHS under the provisions of P.L. 93-638 and with tribes that are not. A further requirement was that tribal participation in the evaluation had to be voluntary. This stipulation applied both to the telephone and on-site contacts. The immediate problem for the evaluation methodology revolved around two questions:

1. What selection process should be applied in determining tribes for telephone contacts and site visits?
2. What persons within the tribes selected could provide the information needed for the evaluation?

Adequately addressing these concerns was viewed as essential to the development of a reliable data collection approach. Specifically, the selection had to stand a methodological rigor: tribes selected had to be adequately representative of the required cases; would preferably meet certain geographic distribution criteria; and yet would respect the right of tribes to refuse to participate without jeopardizing the data collection effort.

Certain assumptions were then applied in designing the selection process for both telephone contacts and site visits. First, the inclusion of 11 APO jurisdictions within the telephone contact data collection phase ensured that needs for a representation of both contracting and non-contracting tribes and a wide geographic distribution in the inquiry would be addressed. In determining the selection process for site visits, it was believed that the telephone discussions would serve to identify areas where 638 contracting is not currently extensive or appears problematic. The level of 638 contracting taking place within an area and the willingness of tribes
to participate in a site visit were primary factors of consideration. Given the evaluation purposes of examining "maximum participation" and "successful outcomes," and the identification of examples of these, areas which appeared to be heavily involved in contracting under P.L. 93-638 were seen as most relevant for site visits. Finally, it was decided that contacting six tribes within each area for the telephone discussions would provide a buffer (two refusals per site) against refusals of either telephone discussions or site visits. In fact, this buffer was more than sufficient, since no tribes contacted refused to participate in telephone discussions, and by the time the visitation sites were determined, it was known that tribes within the site were willing to participate in a visit.

Selecting the actual tribes to be contacted proceeded upon two distinct lines for contracting and non-contracting tribes. For contracting tribes, IHS was able to make available a fairly recent (within the past contracting period) list of contractors. The lists were aggregated by APO jurisdiction and by the types of programs under contract. Thus, we were able to draw a representative sample from these data, stratified on the basis of APO. As noted above, some oversampling was performed to accommodate any problems in making actual contacts such as tribes that did not want to participate, or whose personnel were unavailable. The sample derived for each APO was then reviewed with the appropriate CPLO to see whether the selections were representative of the tribes that had gone through the ISD Process. For the most part, the CPLOs agreed with the choices and in only a few instances was an alternative choice recommended. Such recommendations were followed where tribes had not in fact gone through the process or where tribes were only operating programs which are considered to fall outside of the ISD Process—specifically, CHR which has always been a tribally-operated program; alcoholism programs previously funded by NIAAA; or contracts that were simply conversions of previously existing Buy Indian Act contracts.

Selecting non-contracting tribes was somewhat more difficult since we did not have a record of non-contracting tribes. We therefore relied on the CPLOs for each APO as the best source of information for this information. However, for several APOs, CPLOs reported that virtually all tribes (in some cases, excluding only one tribe or a recently Federally-recognized group) had some experience with contracting under the ISD Process. Thus, we broadened the assumption for these cases to include tribes who had recently decided not to expand the number of contracts they operate under P.L. 93-638, information that was easily obtained from CPLOs. We were then able to complete the selection process on this basis. A total of 105 tribal contacts were identified and discussions were completed with 98 of these individuals.

2.2.4 Telephone Discussions

Telephone discussions were conducted with IHS personnel and tribal volunteers during December 1983 and January 1984. All senior NIHB and AITS staff involved in the evaluation effort participated in
making calls so that this experience would assist them in later site visits. The substantive findings of the telephone discussions are summarized in Chapter 3.

2.2.5 Site Visits

The site visits were a major element of the evaluation, permitting the Study Team to probe in depth a variety of issues pertaining to maximum participation and successful outcomes. The APOs and associated tribes or tribal organizations selected for on-site visits included the following:

- **Alaska Area Office**
  - Aleutian Pribilof Island Association
  - Yukon Kuskokwim Native Association
  - Tanana Chiefs Health Authority
  - Cook Inlet Native Association, Inc.

- **Bemidji Program Office**
  - Leech Lake Reservation
  - Red Lake
  - White Earth Chippewa
  - Stockbridge-Munsee Band of Mohicans

- **California Program Office**
  - Tule River Tribal Council
  - Southern Indian Health Board
  - Susanville Rancheria
  - Central Valley Indian Health

- **Nashville Program Office**
  - Coushatta Tribe of Louisiana
  - Mississippi Band of Choctaws
  - Seneca Nation

Site evaluation procedures were developed and tested during December 1983 in the Oklahoma City Area Office and with three tribes in that site (Creek Nation, Chickasaw Nation, and Comanche Tribe). Because of the success of this field test, the data collected in the Oklahoma City site has been incorporated into the main body of the evaluation. The field procedures included a set of guidelines to govern site etiquette and interview procedures, as well as the topics to be covered in discussions. As noted above, an initial set of Site Discussion Topics guided the Oklahoma City review and provided the basis for the refinement of topics and protocols for the remaining sites. The protocols, which are included in Appendix E, basically included the following elements:

1. Information regarding the first line of contact at the APC and participating tribal offices.
2. Procedures for the conduct of an entrance meeting: the purposes of the visit, who should be involved, the length of time that the meeting should be and the limits of the information that could be provided.

3. Procedures for the conduct of discussions: utilization and expansion of discussion topics, probing techniques, recording notes and responses, and setting limits for each discussion.

4. Information to ask for or accept as support for key discussion points.

5. Instructions for the close-out of site files.

Each member of the Study Team received copies of the discussion topics and site visit protocols prior to the actual site visits. In addition, an in-depth training session of team members was performed prior to travel.

At a minimum, discussions were held with the following personnel at each site:

1. Area/Program Office:
   - Director;
   - Leadership Team and/or Proposal Assessment Team members;
   - CPLO for each of the tribes visited; and
   - Project officers for each of the contracting tribes being visited.

2. Tribe:
   - Tribal Chairman;
   - Health Director;
   - Director of IHS or contracted Service Unit;
   - Other tribal members with present or prior involvement in the planning and contracting process under 638.

When possible, APO visits in each region were performed before tribal visits as a matter of protocol. However, all visits were preceded by telephone discussions with key individuals of each of the APOs and tribes to be visited. Therefore, field staff were somewhat familiar with the individuals and issues in each site before they arrived. This advance information allowed a much more efficient use of time on site.

APO visits began with a meeting of the two NIHB/AITS field staff members and the office director (or his designate), together with members of the APO's P.L. 93-638 Leadership Team, members of prior Proposal Assessment Panels, Project Officers for each of the tribes involved (which may involve from one to four individuals, depending on how responsibilities are assigned) and the Contracting Officer(s) for the tribes. This session did not require more than one hour. Following this group meeting, the field staff members met separately with the CPLO for approximately 1.5 to 2 hours to discuss in more
detail his/her experience regarding IHS Process implementation and specific tribal contracts. After this meeting, individual meetings of a similar nature were held with the remaining members of the Leadership Team and appropriate Project Officers.

Tribal site visits likewise began with a session including the two field staff members and the Tribal Chairman or his designate. In some cases, this role was filled by the tribe's Health Director. This was followed by a group discussion including the Chairman, the Health Director, and other tribal members who had experience with contracting under P.L. 93-638. The group discussion was followed by individual discussions with group members who appeared to have more information to provide or who appeared to be reticent to participate in the group session. These follow-ups generally included one field staff member and one tribal person, although this varied slightly. Where applicable, a visit to the service unit director was also conducted prior to leaving the site.

The structure of the discussions at both the APO and tribe followed generally the same pattern. Initial meetings with the Director/Chairman began with a presentation by the field staff on the purposes of the evaluation study and what information we were seeking, also providing an opportunity for questions to be asked. We then covered the topics appropriate to that individual. Similarly, the group discussions commenced with the same presentation concerning the evaluation before getting into the substantive discussions. Individual follow-up discussions did not require this introduction because these discussants had heard the presentation in the group session.

2.2.6 Evaluation Measurement Tool

A "measurement tool" was designed for use in the evaluation of the ISD Process within the Indian Health Service. This tool was designed to be used by the NIHS/AITS evaluation staff who performed extensive on-site investigations of the ISD Process in a number of APOs and participating tribes. The tool is a device to focus the perceptions and judgments of these professionals onto a common set of issues and descriptions. It was not designed to be used as an interview guide or questionnaire administered in the field, or to collect quantitative data. Rather, the qualitative data collected by field staff using a variety of methods was initially recorded in narrative form through site visit notes. The measurement tool is a technique for distilling these impressions of diverse sites to a limited set of concerns to facilitate overall analysis and reporting of the evaluation data and conclusions.
A complete copy of the measurement tool as it was used in the field is contained in Appendix F. The sections of the tool are:

I. Contracting Process Checklist;
II. Impressions of Area/Program Office ISD Process;
III. Impression of tribal contracting ISD Process; and
IV. Summary of participation and outcomes.

The first section is a method for recording APO compliance with the procedures of the P.L. 93-638 contracting process as defined in ISDM 81-3. Responses to the items in this section are either "yes" or "no." The remaining three sections call for responses to be made on a seven point rating scale for each item. In this scale, a value of 7 indicates a highly positive rating while a 1 is extremely negative. A rating of 4 would, therefore, be a midpoint. In all cases, narrative descriptions of what situation would constitute a rating have been included in the body of the measurement tool to serve as anchors for the evaluators' judgements. These descriptors have been formulated for the odd-numbered points of the rating scale (1, 3, 5 and 7), with the evaluators allowed to use even-numbered values to indicate that a site falls between two of the narrative items.

The measurement tool was filled out by field staff after completion of a site visit to a tribe or APO. Two staff members performed each of these visits. The staff members initially completed the tool individually by entering their observations and ratings along with supporting evidence and comments as necessary. The two staff members then met to prepare a single set of ratings for the site based on a reconciliation of their independent impressions. This composite result is reported in this study and later discussions; however, the original individual forms have been retained in the Project File for reference. In the event that the two staff members had substantially different perceptions about an item, a senior staff member of NIHB or AITS was consulted by the Field Team to act as a mediator to effect a compromise.

Specific sections of the Tool were implemented as follows. The Contracting Checklist (Part I) includes those steps which are essential parts of the Contracting Process as defined in ISDM 81-3. Certain steps which pertain only to internal communication with IHS have been omitted for simplicity. Also, the Contract Administration stage of the process as described in the ISDM is not being considered as part of the scope of the present evaluation effort. Evaluation Staff obtained information regarding compliance with the Checklist from appropriate and knowledgeable Area/Program Office (APO), tribal staff, or written documentation (e.g., contract files).

Part II of the Evaluation Measurement Tool, Impressions of the Area/Program Office, was completed by field staff to reflect their perceptions regarding the Indian Self-Determination Process as implemented by APO staff as well as selected issues related to the
effectiveness and quality of their functions. This section was completed for APO site visits only. Comments and supporting evidence were written in the available space or on the reverse of the document. Evaluators selected the appropriate rating value (from 1 to 7) and entered it in the space provided, using the descriptors of key scale points to guide selection of a rating value.

Part III of the Evaluation Measurement Tool, Impressions of the Tribal 638 Process, was completed by field staff to reflect their impressions of the ISD Process as it has been followed in the specific case of a single tribe. This section was completed for tribal site visits only. As before, comments and supporting evidence were written in the available space or on the reverse of the document. The evaluators selected the appropriate rating value (1 to 7) and entered it in the space provided, using the descriptors of key scale points to guide selection of a rating value.

The final section of the Measurement Tool, Part IV, Summary of Participation and Outcomes, provided an opportunity to summarize the degree of participation of tribes in the P.L. 93-638 contracting process and the success of this process in facilitating Indian Self-Determination. Ratings were provided for each item twice: once for the APO or for the specific tribe which was the subject of the site visit, and once for the perception of the field staff member completing the form. The former ratings reflected the perceptions of tribal or APO officials as they were expressed to the evaluator; the latter ones were the independent perceptions of the evaluator. The two ratings did not always agree. This form was completed for both types of sites (Tribes and APOs). Procedures for assigning ratings were the same as explained above. "No opinion" was also a valid option for any of these questions.
3.1 TELEPHONE DISCUSSIONS

The first major component of the data collection effort for the Evaluation consisted of telephone discussions with IHS Personnel within the Headquarters and 11 Area/Program Offices, and with a number of Voluntary Tribal Participants in these IHS jurisdictions. Table 3.1 summarizes the number and completion rates for each of these discussant groups.

Table 3.1

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<th>IHS Office</th>
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<td><strong>TOTALS:</strong></td>
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In the subsections below, highlights of these discussions are presented, and the technical issues identified for refinement and clarification during later Site Visits are summarized.

3.1.1 Summary of Discussions

Understanding and Definitions of ISD Process

Generally, there is agreement among IHS personnel and contracting tribes with the philosophical purposes of P.L. 93-638 to enable American Indian tribes to take over and control programs provided by the Indian Health Service, and a belief that P.L. 93-638 gives the tribes a level of primary control over Indian affairs without the fear of termination. Some non-contracting tribes, however, expressed fears that ISD and termination may be synonymous. IHS personnel see the "process" as expressed in the ISDM/ISDA series as a "tool" by which Indian self-determination can be achieved; the locus of decision-making resides with tribes; and regular advisory and technical assistance by IHS are to be provided at tribal request. IHS personnel believe that their responses to tribal requests should be organized around expressed tribal needs and desires as mandated under the law, published Rules and Regulations, and the ISDM/ISDA series.

IHS personnel tend to perceive the steps in the process according to the nature of their involvement largely dictated by their specific staff roles. In many cases, the actual steps in the process were enumerated from the preapplication information phase through contract award or declination. APO personnel were often eager to point out "refinements or deviations" in applying the process within their area. Several APOs focused upon different ways of processing new ISD contracts and contract renewals. Essentially, the differences relate to efforts to "streamline" the process somewhat, thereby eliminating the need to repeat items where information was already intact. In the case of the Nashville Program Office, where a "systems approach" to the planning and delivery of health care is utilized, refinements of the process are associated with the needs of recently federally recognized tribes for health care services in areas which had not previously had IHS programs.

Tribes described the process in terms different from those of IHS personnel. Basically, in only a minority of cases did either tribal leaders or health directors/administrators define the process in terms of the five integral stages. Rather, they tended to focus on the philosophical underpinnings and intent of Congress with respect to P.L. 93-638, and on discussing their successes and failures in contracting for services and/or programs. Discussions with non-contracting tribes revealed that some tribal leaders seem unfamiliar with various aspects of the law and are, therefore, wary of involvement. In addition, some leaders of non-contracting tribes perceive the delivery of health care and services as a "trust responsibility" of the government, and therefore feel that it is not appropriate for
tribes to assume such functions. Finally, smaller tribes noted that they lack both the management/administrative infrastructure and facilities to contract for the delivery of health care.

Maximum Participation. There were several gradations in IHS personnel's perceptions of maximum participation. In several instances, maximum participation was defined as total takeover by a tribe of its health care programs/facilities and their operation. Others defined it in terms of tribal and IHS involvement where both parties are participating to the extent they desire in order to ensure adequate delivery of health services. IHS personnel perceive maximum participation as including both interactive technical assistance to a tribe and dissemination of information. This leads to further tribal involvement in planning and health delivery through the ISD contracting process.

In the majority of cases, tribes defined maximum participation as tribal involvement to the maximum extent of its capabilities, with a realization that this may vary over time and among tribes. Maximum participation was seen as stymied on the one hand by lack of knowledge or commitment on the part of some tribes, and on the other by IHS defensiveness of "its territory." Failure to achieve maximum participation was also seen as resulting from budgetary restrictions imposed by the Indian Health Service that have caused major revamping of tribally-designed programs between proposal submission and contract award.

Successful Outcomes. Interestingly, both IHS personnel and tribal participants viewed a successful outcome as a tribe's being awarded a contract under P.L. 93-638. Some qualified this by stating that a successful outcome meant not only the award, but successful operation by the tribe of an ISD contract. In some cases, a successful outcome was seen as the tribe's operating the program not only as well as IHS but better than IHS in terms of the level of health care provided to tribal members and the appropriateness of care to tribal members' needs.

Success was seen as measurable by the degree of satisfaction experienced by tribal members and in all cases "meeting tribally defined needs" emerged as a contributing factor of successful outcomes. In no case was input into the planning process alone defined by a tribe as a successful outcome, although some IHS personnel voiced this opinion.

Tribal discussants were asked to respond to readings of the working definitions of "maximum participation" and "successful outcomes." Tribal discussants who voiced basic satisfaction with the ISD Process tended to agree with the working definitions supplied. Both dissatisfied and non-contracting tribes, however, described the definitions as "idealized" or "sounding good" but having little to do with the actual process as they had experienced it or perceived it. With respect to maximum participation, the specific criticisms offered on each of the three elements of the definitions were as follows:
1. (a) There is not sufficient interaction to lead to "information decisions"; and
   (b) Tribal needs and desires are not given enough consideration.

2. Tribal needs are not being met, and IHS resources are inadequate for meeting them.

3. IHS resources are not clearly understood.

4. Too often, the effective delivery of Indian health services and programs is not achieved.

Many considered the definition of maximum participation to be exceedingly long and unnecessarily complex. Dissatisfied tribal discussants generally considered successful outcomes as not occurring within the limits of the working definition because they do not believe that informed decisions are made in concert with IHS, but rather are made by IHS and then imposed upon the tribes both through contract provisions and budgetary controls. A large number of those interviewed expressed surprise that there are other options available besides contracting. In general, there was a consensus that there is little tribal participation in the IHS planning process, and no expressions of how participation in the planning process can be achieved.

Perceptions of IHS Implementation

Technical Assistance. IHS personnel believe they have a clear understanding of the technical assistance function emanating from the ISDM Series. For the most part, technical assistance emerged in the IHS discussions as a major mechanism of assisting tribes to achieve their self-determination objectives. While the IHS is obligated to assist the tribe in realizing its intent to contract, IHS personnel believe there are multiple facets to structuring a technical assistance approach. These relate primarily to the technical nature of the program/services under consideration for contracting, as well as to the budgetary and financial issues that are associated with assuming a program. Thus, the provision of technical assistance is complex, requiring the involvement of both IHS technical project personnel and persons from contracting, finance, personnel, and other IRS functional areas.

The approaches described by the IHS discussants varied on the basis of how complex the contracting issue is and whether the tribe has previously been through the process. A primary emphasis was to ensure the tribe has adequate information to proceed on its own in preparing a proposal. Wherever tribes need additional assistance in this regard, IHS personnel expressed their availability to provide it. The initial technical assistance orientation generally is held to define the steps in the process in meetings with the tribe, followed by episodes where technical assistance is provided to enable the tribe to develop and/or enhance in-house capabilities for undertaking
a contract under P.L. 93-638. The resolution of threshold issues is also seen as an important facet in the satisfactory completion of this objective. Some IHS personnel believe that the ambiguities surrounding "threshold issues" make these difficult to resolve. That is, because there are no clear definitions for these, almost any unresolved issue may be considered a threshold issue that stands as a barrier to contracting under P.L. 93-638. In almost all instances, the dissemination of information on contracting and/or the process defined under the ISDM/ISDA series were linked to the technical assistance role of Area/Program Office personnel.

Tribes who have expressed basic satisfaction with the IHS implementation of the ISD Process generally reported that they receive technical assistance whenever they need it in areas which they themselves or their Project Officers have identified. Tribal discussants noted that Indian Health Service personnel generally provide good orientation sessions in the preapplication stage of contracting. However, uniformity of satisfaction with technical assistance breaks down beyond this stage. Some tribal discussants commented that their Project Officers and/or Service Unit Directors were highly involved in the provision of technical assistance, but noted that many Project Officers have been assigned too many tribes and/or programs to monitor, which tends to dilute effectiveness over time.

Tribal discussants were eager to offer suggestions for improving the technical assistance element of the ISD Process. Some tribes cited the need for more assistance in defining their goals and objectives and in developing a scope of work for their programs; others believe they need more help in understanding the IHS budgeting process and how it affects them directly. In addition, more technical assistance in understanding contracting procedures was cited as a need by several tribal discussants.

Recently recognized and newly participating tribes commented that they need more followup by IHS personnel, noting that they were being asked to absorb a lot of new information and concepts in a relatively short period of time. Dissatisfied tribes expressed the opinion that IHS personnel tend to provide technical assistance in a reactive mode—i.e., "after we get into trouble," or "when there is a problem," IHS responds with the needed technical assistance. Such dissatisfaction applied to the contract administration phase of the ISD Process, which as stated above, is not a focus of this evaluation.

A final criticism of IHS technical assistance was that it is offered "in generic terms" rather than through specific information provided to tribes concerning the types of technical assistance available. In short, more definition of and planning for the delivery of technical assistance were suggested as means of improving this element of the ISD Process.

Characteristics of Exemplary Programs or Successful Outcomes.
Both IHS and tribal discussants basically conveyed the view that self-determination "activities" center on contracting. Discussants
pointed out that tribal contracting varies by the nature and size of the contract, which are in turn bound by certain parameters.

Certain factors as defined by both IHS and tribal discussants appear to influence tribal decisions to contract. These include:

1. satisfaction with the IHS provision of services;
2. the availability of funds for certain programs/services; and
3. the administrative burden created by the contract and the tribe's ability to absorb the burden (by virtue of administrative capability and tribal infrastructure).

In addition, where IHS has had no or limited service capacity, there has been a tendency on the part of tribes to increase available services through the ISD contracting process. This is particularly true in the Nashville Program Office area where a number of tribes have only recently achieved federal recognition and in Alaska where geography influences and in some instances limits the delivery of tribal health care and services.

Exemplary projects were basically identified as those that provide better health care opportunities than had been previously provided by the IHS. There were also expressions that exemplary situations were those where a tribe, through "piecemeal" contracting and continued capacity-building, has been to build an effective health care delivery system through additional, paced, contract development. In almost all instances where definitions were offered, the term specifically was applied to services provided under a tribal health contract and the adequacy of services provided to meet health needs of tribal members.

3.1.2 Technical Issues Identified for Refinement

Indirect Costs. Both IHS personnel and tribal discussants noted that in indirect costs have strained the budgets available to tribes for their ISD contracts. IHS personnel commented that this problem has placed them in a difficult position with respect to negotiating ISD contracts with the tribes, since indirect costs need to be worked into the original IHS budget allocations for the program/service, thereby reducing the amount available for salaries and direct services. The tribal discussants pointed out that this seems to imply a lowering of standards on the part of IHS with respect to tribal programs, since salary levels imposed for staff positions are lower than what IHS would itself allocate. A corollary problem to this is that this lowering of salary levels makes it difficult for some tribes to attract and retain well qualified staff. Also, it was pointed out that tribal indirect costs had to be taken from available program funds without consideration for other "hidden costs" which are borne by the tribes but not by the Indian Health Service in the operation of a program. Such indirect costs may include costs of facilities.
operation, maintenance and repair, as well as malpractice insurance or the cost of attending meetings with IHS which are not specifically included in the contract scope of work.

Equity Funds. While the award of Equity Funds has assisted a number of small and/or disadvantaged tribes in improving the local delivery of health care services and programs to tribal members, both IHS personnel and tribal discussants cited that the budgeting complexities and timelines associated with the allocation and receipt of such funds causes them to be less effective than they could be. By the time IHS Area/Program personnel learn what funds are actually available for allocation to tribes within their jurisdiction, it is late in the fiscal year -- too late, many argue, to enable the development of a tribal proposal for the delivery of a particular service or upgrade of an existing service. One stop-gap solution to this problem has been to allocate these funds to existing ISD contracts of the recipient tribes. However, no "carry-over" provision such as applies to ISD contract funds exists for Equity Funds. Accordingly, whatever Equity Funds are not expended by the end of the fiscal year are lost to the tribes and revert to the government. A number of tribes have felt that since such funds were placed into existing ISD contracts, the carry-over provisions associated with ISD contracts should be applied. Much confusion and some hard feelings have resulted from this in a few instances.

Ambiguity of Threshold Issues. A problem perceived by both IHS and tribal personnel is the concept and application of the term "threshold issues." Theoretically, the term is defined as a problem identified during the process of proposal review which must be overcome but should not be considered a barrier in the contracting process. As applied, however, any element of a proposal or step in the ISD process that is considered unclear is identified as a threshold issue requiring some form of remediation -- either by the potential tribal contractor or by IHS administrative staff. From the IHS perspective, the problem is not in the threshold issue concept itself but in the ambiguity of the term, which from an operational standpoint is largely undefined. A close parallel is the needed determinations that must be made with respect to technical program requirements or contract management pro forma. It appears that there is general tribal understanding for the term, but a feeling that threshold issues are used unnecessarily by IHS staff. Tribal discussants felt that this bears directly on whether mandated timelines can be met and may influence the "starting and stopping of the clock" with respect to processing tribal proposals, since resolution of threshold issues must occur before proceeding to subsequent stages or finality in the contracting process. Finally, there is seemingly no concern for the administrative burden imposed in resolving threshold issues.

Contract Negotiations. A number of contracting tribes commented on the cumbersome nature of the ISD contracting process as applied by IHS. Several cited instances where contract negotiations were conducted in an atmosphere of indecisiveness and squabbling among the various members of their Leadership Teams. Others complained that
the timeline between filing a letter of intent to contract and actual contract award is too great, and stated that streamlining of the process and/or associated approvals would be of great assistance to them. Finally, the terms and conditions imposed upon tribes as well as the extensive reporting requirements demanded as part of contract administration were considered burdensome by many IHS personnel as well as the participating tribes. It was mentioned that IHS requirements on tribal contractors are sometimes beyond what can be legitimately demanded from a non-Indian contractor. In addition, it was noted that some contract terms and conditions were originally developed for use with defense contractors and are thus inappropriate to non-defense contractors of any type. Finally, it was suggested that there needs to be a mechanism for incorporating into tribal contracts any relaxations that occur in Federal regulations of government contracts.

Multi-Tribal Service Units. Multi-tribal service units pose a number of problems both for IHS personnel and the tribes to be served. In the first place, many such units are spread over extensive geographic areas, particularly in California and the Pacific Northwest. Thus, tribal members may have to drive 60-120 miles to the nearest IHS clinic or hospital for treatment. Second, tribal takeover of services or programs within a multi-tribal service unit is exceedingly difficult to achieve, since concurring resolutions must be obtained from all tribes within the service unit area. A number of tribes suggested that the procedures requiring concurring resolutions be modified to differentiate between contracts involving direct health care services and contracts for ancillary services -- such as grounds maintenance or housekeeping services. Additional comments were that Indians residing outside an IHS service unit area could still obtain services as needed while visiting within the area, without requiring that a concurring resolution from their own tribe be on file. Finally, tribal discussants commented that where consortiums of geographically adjacent tribes could be assembled, contracting for local service delivery was easier to achieve.

The Technical Issues defined in the Telephone Discussions as needing additional clarification or refinement were incorporated into the Final Revised Site Discussion Topics to be utilized by Field Staff with both IHS and Tribal participants. These are presented within the presentation of Site Visit Discussions in Section 3.2 below.
3.2 SITE VISIT DISCUSSIONS

An initial site visit was conducted in December 1983, involving the Oklahoma City Area Office and three tribes under the jurisdiction of that office. As discussed in Chapter 2, the Oklahoma City Area served as a test site for field testing the evaluation discussion topics, protocols, and measurement tool. However, given the minor changes involved in the design for the site visits following this initial visit, data for Oklahoma City Area have been included within this evaluation report. Four additional areas were the subject of field visits in February and early March 1984. Including the Oklahoma City Area visit, this phase of the evaluation involved a total of five IHS APOs, one IHS Field Office; discussions with four representatives of Alaska Native Health organizations in Juneau, Alaska; and visits to 14 tribes. These site visits, including descriptions of the relevant IHS jurisdictions and participating tribes are summarized below.

3.2.1 Oklahoma City Area

Description of the Program Area

The Oklahoma City Area Office is responsible for the provision of Indian health care in Texas, Oklahoma, Kansas and Iowa. It provides administrative, fiscal, and medical technical assistance to the hospitals, clinics and programs in its jurisdiction. Within Oklahoma, the Area Office serves 36 eastern and western Oklahoma tribes. The Indian Health Service provides a wide range of health care services both on a direct basis and through contracts under the Buy Indian Act and P.L. 93-638.

The variation in approaches to health care delivery is in part a result of the geography, political organization, and sizes of the tribes within the state. Most of the tribes were relocated to Oklahoma when that region was established as an Indian territory in the late 1800s. Land allotments dissected Indian ownership and many of the allotted tracts passed to non-Indians through land sales and other exchanges. There are no reservations within the state, per se, although the boundaries of treaty lands still exist and the areas contained therein have "Indian country" status. Thus, the Indian population is distributed over a broad area and scattered in many small Oklahoma towns which in some cases coincide with original tribal assignments. However, the tribes have retained their status as Indian tribes which has enabled them to obtain Federal benefits and services. It is also on this basis that tribes have established organizational structures for conducting tribal business affairs.

Contracting under P.L. 93-638 is not extensively used for the takeover of IHS hospitals and clinics except in a few instances. Rather, 638 contracts are used by the tribes to provide limited health services such as community health programs. The Creek Nation Hospital in Okema was the first full service facility to be developed under P.L. 93-638. This is a facility which has previously been
closed and was reopened on the basis of a congressional appropriation for which the tribe had successfully lobbied. Subsequent to this, the Chickasaw Nation has contracted a number of ancillary services under P.L. 93-638 including housekeeping, grounds maintenance, and some accounting functions of the Indian Health Service hospital at Ada.

There are a number of reasons why some tribes do not contract extensively for the takeover of IHS facilities. First, many of the existing facilities are multi-tribal service units and the organizational requirements for demonstrating the necessary tribal and community support are difficult to develop. Second, there is expressed general tribal satisfaction with the IHS facilities that provide Indian health care services, and some tribes have placed contracting for IHS services below tribal economic development priorities. Finally, a number of smaller Oklahoma tribes simply feel they cannot bear the added burden and responsibilities of assuming a major IHS operation.

The tribes visited within the jurisdiction of the Oklahoma City Area Office are described below.

Chickasaw Nation is located in southeast Oklahoma with the tribal headquarters located near Ada. The traditional reservation boundary lines include approximately 7,140 square miles distributed over nine full counties and parts of two others. Traditional boundaries also constitute the service area for providing Indian health services. The Indian population for the service area is estimated at 19,461, of which 12,340 are members of the Chickasaw Nation.

The IHS maintains a health referral center which serves the Chickasaw Nation as well as Indians from the Lawton, Shawnee, and Talihina Service areas. The Chickasaw Nation contracts with the IHS under P.L. 93-638 for non-health related services -- grounds maintenance, housekeeping services, and tribal management services. The Nation also contracts for a CHR program to provide health outreach services, and a Community Health Nurse at the outpatient facility in Tishomingo.

Creek Nation is located in eastcentral Oklahoma and has its headquarters at Okmulgee. The traditional reservation boundary lines lie in an eight-county area embracing 4,685 square miles. As with most Indian lands in Oklahoma, only a small portion are retained in Indian ownership, due primarily to the consequences of Indian allotment policies. The eight-county area does establish the service area for the Creek Nation Community Hospital with the health centers (clinics) at Evaula, Okemah, Sapulpa, and Okmulgee serving the Indian population in their respective counties. An estimated 22,9/2 Indian persons constitute the Indian population for the area.

The hospital and health centers referenced above have been contracted under P.L. 93-638 by the Creek Nation. The tribe began to contract in 1975 through the Community Health Representative program, and then added the health centers and hospital in 1980. The hospital was reopened on the basis of an appropriation by the U.S. Congress.
The hospital provides primary and emergency health care, dental services, health education, and community outreach services. The facilities at Okemah, Evaula, and Sapulpa are accredited by the Joint Accrediting Agency for Hospitals.

The Comanche Tribe is located in the general location of Lawton, Oklahoma, which is approximately 88 miles southwest of Oklahoma City. The general membership consists of 8,053 Comanche tribal members with an estimated 4,000 residing within the lands of the former reservation. The tribe adopted a constitution in 1967 which established a 7-member Business Committee, a system of subcommittees, and a tribal business manager. However, the Constitution went through a revision which became effective in 1981, with the Chairman made the primary individual charged with transacting business for the Tribe.

There is an IHS-operated outpatient clinic in Lawton, which is the primary health facility for seven tribes in the area. Of these, the Comanche, Kiowa, and Apache Tribes are the majority of the service population. The Comanche Tribe operates a Community Health Representative Program under P.L. 93-638. At the moment, this program is the only IHS-funded project the tribe has chosen to operate. The tribe expressed several reasons for not expanding its contract base with the IHS. The primary reason appears to be general satisfaction with the IHS operation of health service units. In addition, the tribe has elected to give economic development a higher priority for the present.

Impressions of ISO Implementation

1) ISO Process as a Whole: IHS personnel within the Oklahoma City APO readily provided information on the implementation of the ISO Process. Basically, there is general familiarity with P.L. 93-638 and the stages and steps under ISDM 81-3. Moreover, they have met the organizational requirements by establishing a Leadership Team and identifying a CPLO on a permanent basis. It was reported that there is little tribal interest in contracting other than for the renewal of existing programs. Only several of these represent major assumptions of Secretarial programs; the operation of hospitals and clinics or the provision of major health care.

The discussants (both IHS and tribal) reflected a favorable understanding of the law and the implementation aspects under the ISO Process. General satisfaction with these was expressed by both groups, but there is some dissatisfaction and a number of questions expressed in terms of actual program implementation by the APO. These concerns are defined in further detail below. Tribes that have submitted proposals for assuming major IHS functions see certain stages as time-consuming or problematic. This is so where program descriptions of a contractible service have not been prepared. Still other tribes who have existing contracts cannot see the need for repeating each step in the process on their contract renewals.
The APO sees problems in the accountability aspects pertaining to contracts under P.L. 93-638, which prevent tribes from fully exercising their options in the spirit of Indian self-determination. Comments surrounding the topic generally related to the systems (i.e., fiscal, personnel, administrative, etc.) that have to be in place to comply with federal procurement laws and regulations as well as the requirements of Section 106 of P.L. 93-638. The problems cited relate to tribal compliance and the possible necessity of regulation changes and waivers. It was also suggested that a new contracting format, a hybrid between a contract and grant, may need to be devised to overcome this particular problem.

2) Preparation Stage: As specified in the ISD Process, the APO has organized a Leadership Team and designated a CPLO. Functional statements of responsibility for each member of the team have been developed, which explicitly state their roles in the process. These statements give direct responsibility to the Area Director for the implementation of regulations. IHS staff roles are defined specifically by the job that the team member holds in the APO. IHS personnel believe that this approach makes it clear to the tribes who is responsible for each specific task or step in the ISD Process.

There are some misgivings by the contracting tribes about the Area Leadership Team composition. This includes their concerns about the Team's understanding of P.L. 93-638 and the contracting process. They also feel that the Team should be more sensitive to tribal planning issues and to the need for developing tribal capacity to contract. Tribes feel that IHS tries to block contracting by overlapping service areas and, in effect, creating multi-tribal situations. This leads to the necessity of securing resolutions of support from all tribes in the service area which can then become a threshold issue.

There were tribal concerns that the APO is not responsive to tribal expressions of self-determination. This is reflected in the manner that IHS personnel are mobilized to respond to requests under P.L. 93-638. Moreover, they see the APO as being indifferent and impersonal to tribal intentions. Although this was noted, IHS has prepared contracting manuals and information checklists for tribes on the ISD Process. They have indicated that these materials are provided to all tribes that are contracting, or may want more information on what contracting involves.

3) Preproposal Stage: According to APO staff, major planning activities relating to contracting are concentrated in this stage. This is the time when the options and materials are presented to an interested tribe. This usually occurs in the preproposal conference, although a tribe may request any member of followup meeting it feels necessary for preparing a contract proposal.

After the preproposal conference, the APO prepares "Program Descriptions" on the program, service, or unit of health care the tribe wants to contract. The APO staff have indicated that this generally takes time since a specific program/service statement has to be developed. This increases with the complexity of program if the services to be provided increase.
The APO has related some uncertainty as to whether 638 contracts are to be fixed price or cost reimbursable. Their implication here is on the length of time needed to prepare one contract form or the other, with a heavier burden placed on cost reimbursement contracts. Another reported problem is the lack of discretion to use grant or contracting authority for 638 projects. In the absence of clearer direction, the interpretation that the APO uses is that all services are contractible and that tribal management and/or capacity building activities fall under Section 104 as grants. They have expressed concern about the inflexibility this presents in getting awards out to tribes.

Other issues raised by APO staff were the administrative and accountability measures associated with contracting. It was related in the discussions that the Secretary has the discretion to waive any federal procurement regulation that is necessary to implement the purposes of P.L. 93-638. Staff see a number of problems in the areas of accounting, IPAs, and property transfers. There is some uncertainty as to how these are to be treated, and staff consider this as an obstacle to contracting.

The APO position described above is criticized by the tribes as a contrivance on the part of the APO to delay the contracting process. This is seen as a non-commitment by IHS to use the 638 contracting modality. In fact, tribal experiences have been that the APO raises as problems matters that are easily resolved through the IRLS. The tribal question raised here is why should they have to resort to the Headquarters level for resolution of problems when APO personnel should be assisting them.

To the tribes, technical assistance from the APO is problematic. In fact, they have experienced numerous instances where information was not forthcoming, and other instances when it was inaccurate. This became a particular concern in one instance when APO staff were told to inform a tribe that it could expend carryover funds, but the following day found that the funds had been reallocated to other service units. IHS staff expressed concern over their ability to develop and maintain credibility with the tribes in these circumstances. The tribes see such instances as examples of APO inconsistencies. Moreover, contracting tribes are not overly impressed with APO competence as a result, and often do not seek technical assistance for this reason. Especially for technical assistance post-contract award and in the development and/or refinement of health delivery systems, tribes do not rely on APO capability.

4) Proposal Assessment Stage: The responsibility for proposal review is vested in the Leadership Team which functions as the proposal assessment panel. The panel has responsibility for assessing the merits of a proposal and identifying any potential threshold issues. The APO believes that this serves to circumvent problems and helps in determining technical assistance needs. On the other hand, tribes believe this gives IHS more latitude in blocking the contracting process since any issue, real or perceived, can become a threshold issue.
Another concern expressed by the tribes was the use of the cost analysis for determining the relevance of budgets in the latter stages of the ISD Process. Since the analysis is done in HRSA, they are not entirely sure how comparability in costs are derived. Yet, the APO is compelled to use HRSA analysis for budget preparation and subsequent negotiations. They see substantial gross inequity in this process.

There was some indication that Project Officers play an insignificant role in the review process. Since they are also the people that have the best general knowledge of tribal projects, it would seem that they could provide valuable input.

5) Decision Stage: If tribes provide the necessary information, the Oklahoma City APO can usually meet its required responsibilities under the ISD Process. As far as meeting the timetable of 60 days, there were no clear indications. The major issue that surfaced related to the burden placed on tribes in preparing acceptable proposal documentation. It was stated that IHS has actually written some tribal proposals, leaving tribes with only the responsibility for obtaining the required resolutions. However, tribes have not always been able to provide these on a timely manner.

Site-Specific Recommendations

The Oklahoma City APO has met pro forma requirements as outlined in the ISDM series but has not increased its outreach efforts in letting tribes know about P.L. 93-638. Better mechanisms are needed to publicize the Indian self-determination message to all tribes under the jurisdiction of the Oklahoma City Area Office.

Clarification needs to be provided on some of the issues raised by the APO with respect to the contracting process. The main concern here is with the image the Area Office has developed with tribes in its past implementation of P.L. 93-638. It appears that both the tribes and the IHS in this area need a better understanding of the available options.
3.2.2 Alaska Area

Description of the Program Area

The Indian Health Service has provided health care for Alaska Natives since the transfer of these responsibilities to DHEW in 1955. The Alaska Area Office is located in Anchorage and serves all Indians and Alaska Natives as defined under the Alaska Native Claims Settlement Act (85 Stat. 688, 1977). The Alaska APO jurisdiction includes the broad geographic extent of the State of Alaska within which Aleuts, Eskimos, and Indian tribes comprise the service population of IHS. The native population is distributed over the entire state, which covers close to 600,000 square miles and a range of geographic and cultural differences.

There are a number of factors that have led to the present policies for contracting with Alaska Native regional corporations. Contracting for health care delivery within the Alaska Area has long been viewed as necessary because of the geographic and cultural diversity referenced above. However, contracting under P.L. 93-638 is an outgrowth of the special status given to area, regional and village structures under the ANSCA legislation. In this regard, the law established regional and village corporations to conduct the affairs delineated under the Act, including the distribution of assets from land settlements as well as other affairs of regional government. As such, Alaska Natives have been able to develop well organized governmental infrastructures, primarily through the resources provided through ANSCA. The corporations have subsequently assumed an expanded role in governmental and business management, especially with respect to oil and gas development.

When P.L. 93-638 was enacted, the corporations and the Indian Health Service saw the law as an appropriate vehicle for improving health care within the sociocultural and geographic limits previously discussed. Thus, the Alaska APO approached contracting on a broad scale. The organizational design involved the establishment of regional health boards sanctioned by the corporations. Subsequently, the IHS contracted with approximately 18 regional health boards and associations for the provision of a wide range of health services and programs. These health boards serve as umbrella providers for many of the towns and villages in rural Alaska as well as the Alaska Native populations in the principal cities of the state. These contracts include the full takeover of IHS hospitals and clinics, the development and expansion of corporate health facilities, and cooperative efforts with church affiliated health systems. In addition, some contracts have been let for the provision of partial services, including the operation of alcoholism and CHR/CHS programs.

The health care delivery mechanisms that have developed under the regional structure are best described as "village systems." The village systems operate under the umbrella of the regional corporations for administrative support and health care within a major service unit or clinic. The CHS/CHR programs are decentralized to the
villages so that direct on-site emergency and community health education can be provided. Local paraprofessionals trained by the IHS are an important link with the primary service unit. This serves two primary purposes: (1) it enables professional medical personnel to attend to more pressing medical needs; and (2) it removes cultural and linguistic barriers to the Alaska Natives' accessing of the system.

Discussions were held in Juneau, Alaska, with representatives of four Alaska Native Health Associations during the Alaska Health Directors' Association meetings in February 1984. These associations are described below.

Cook Inlet Native Association: The Cook Inlet Native Association (CINA) is located in southcentral Alaska, approximately bounded on the south by the Cook Inlet, the Kenai Mountains, and the Gulf of Alaska; the Alaska Range on the north, and the Wrangell Mountains on the east. This area comprises on estimated 38,000 square miles. There are seven Alaska Native villages in the CINA service area with a population of about 14,000. This Association serves five of these villages which represents a service population of about 8,000. The remaining two villages are served by the Alaska Area Native Health Service.

The Association is governed by a Board of Directors which is made up of two representatives from each village. There is a standing committee on health under which the villages are also represented. The primary function of the Committee is to draft and review contract proposals. CINA has been contracting since 1975. Service components that are contracted include: Tribal management support, dental, family health services, community injury control, emergency medical services, community health aide, mental health, rural alcohol, community health representatives, and radiology programs. An IHS service unit is also located in Anchorage, thus extending further health care to Alaska Natives in this jurisdiction.

Tanana Chiefs Health Authority: The area of the Tanana Chiefs is perhaps the largest of the Alaska Native jurisdictions. It is located in interior Alaska and covers a land area in excess of 237,000 square miles. There are 44 Native villages within this area with a population of 14,200.

The Tanana Chiefs began contracting with the IHS for health care delivery in 1974. The contracts were then under the Buy Indian Act (25 U.S.C. 47), but were converted to Indian Self-Determination Act contracts when the law became operable. The program consists of basic primary care for the villages. Their contract also includes maintenance services at the Yukon Flats Health Center which is a subregional ambulatory care referral center for the Fort Yukon community and six subregional villages. State funding also enables the provision of 24-hour emergency care for those villages.

Aleutian Pribiloff Island Association: This Association has been established to serve the Alaska Native population residing on
the Aleutian and Priboloff Islands in southwestern Alaska. The area encompasses approximately 128,000 square miles which also includes the southwestern portion of the Alaskan peninsula. There are 11 villages served by the Association, representing a population of about 2,200 Aleuts on the islands and on the peninsula.

The Association has contracted for the delivery of health services with the Alaska Area Office for the past seven years. The program services are contracted under the authority of P.L. 93-638, and include the following components: community health care, community health representatives, emergency medical care, support services, alcoholism programs, and tribal management services. The closest hospital facilities, which are operated by the Indian Health Service, are located in Anchorage. The Association's Board of Directors consists of representatives from the villages and this body presides over the operation of the health program.

Yukon-Kuskokwim Health Corporation: This corporation developed as a result of ANCSA legislation to serve Alaska Natives in the Yukon-Kuskokwim Basin. There are 22 members on the Board of Directors representing the areas within the basin region. Of them, seven members make up the Executive Committee for the health corporation. The region lies on the west coast portion of the State with a land area of about 50,600 square miles, dissected by the Yukon River which flows into the Bering Sea just south of Norton Sound. There are 48 villages within this service area, with an Alaska Native population estimated at 17,000. The major centers are St. Mary's and Bethel. An IHS service unit is located in the latter of the two sites.

The health corporation operates a wide range of health programs and services contracted under P.L. 93-638. The programs under contract include community health aides, dental, emergency medical services, health education, eye care, community health services, remote maintenance program, alcohol and drug abuse treatment, medical records, and various hospital housekeeping services. The corporation's health contract includes an extensive outreach program in the villages and communities within the region. The Board of Directors provides the direction for the development, implementation, monitoring, and evaluation of the health plan, which is updated on a regular basis.

ISD Implementation

1) ISD Process as a Whole: Alaska Native groups see P.L. 93-638 as a logical mechanism to be used in concert with the ANSCA legislation. For one thing, it places the planning and decision-making level at the regional and village levels in direct contact with health consumers. This has enabled many relevant changes to past delivery mechanisms such as replacing doctors with qualified and supervised paraprofessionals in areas where professional medical services were not essential. The law has also helped to extend health care into villages where services were not previously available. This is seen as one of the most positive aspects of local control.
Contracting under P.L. 93-638 is perceived by both the APO and the regional health corporations as an effective tool for improving the health status of Alaska Natives. Regional corporations and health boards are seen as essential vehicles to meet village needs. A decentralized system has been successfully implemented in Alaska where village residents trained as primary health providers serve on-going health needs, provide education, and serve as emergency liaison for ambulatory patients from villages.

The level of understanding of the IHS and contracting under P.L. 93-638 by the corporations has increased substantially. This is perceived by Alaska Native corporations as an outgrowth of their experiences and not necessarily as a result of APO initiative. However, it was reported that there have been vast improvements by the APO in communicating the Indian self-determination message to the villages.

Contracting under P.L. 93-638 is seen as more flexible in enabling regional corporations to plan health delivery systems based on their own perceived needs, taking into account the villages and people who would otherwise be isolated from needed health care.

Respondents were able to discuss P.L. 93-638 in terms of both concepts and intent. There was acceptance on the part of both IHS and the health organizations for the contracting provisions under the law. The ISD Process as a whole is seen as being very positive in terms of intent and purposes. Corporations see its implementation as attempting to meet mandated time lines. The ISD Process is seen as a good mechanism for establishing and maintaining rapport between corporations and the Alaska APO. The APO is perceived as making a good effort to improve the process and to make the system work.

Basicall y, the ISD Process could be generalized in terms of the stages and steps involved, indicating that there is wide understanding on the part of IHS and Alaska Natives. The APO has not assisted the corporations in the recruitment of qualified personnel in the health professions although the IRLS has been helpful with IPA assignments.

2) Planning Stage: The Alaska APO has organized a Leadership Team and appointed a CPLO as directed under ISDM 81-3. Based on our discussions, there seems to be a well organized approach for responding to the Alaska Native contracting requests. ISDMs, ISDAs and Area Circulars are provided on a timely basis to corporations, health boards and associations.

Direct APO involvement with tribes has not been extensive. Both APO staff and corporation discussants felt there is still a communication gap between Alaska Native communities and the APO, although substantial progress has been made in this regard. With respect to the intent of P.L. 93-638, the APO sees that there is more support from administrators than from medical personnel who are sometimes perceived as putting their professional concerns before Indian self-determination expressions.
The major problem for health delivery relates to the geographic and sociocultural issues mentioned above. The APO Leadership Team seems to lack a full understanding of these, and appears to be committed to "modern medicine" approaches rather than to village-based systems.

3) Preproposai Stage: Contracting for health care is not a new process within the state, with some IHS staff voicing the opinion that 638 implementation was pioneered within the state. The Contracting Officer provides corporations with information on P.L. 93-638, Federal Procurement Regulations and other contracting information. This person is also responsible for giving current data for the current and coming fiscal years and for making decisions on special situations within the Area. Health Boards are the primary planning bodies for the corporations. They review health matters and set health program priorities. They also assist the Director in developing proposals. Villages have given the regional corporations primary responsibility for contracting health delivery systems. They generally have representation on the regional health board through village standing committees, and thus can provide village input into planning and program development. Most corporations have developed formal comprehensive health plans which are closely followed in developing proposals for contracts under P.L. 93-638. These are also monitored and updated with changes in perceived village needs and priorities.

However, a number of individuals feel that village input into planning through the regional health boards is not yet adequate. This concern extends to the APO and the need for more tribal dialogue in the formulation of health delivery systems. Planning on the part of the IHS was criticized, both within the APO and by the health corporations. The APO feels that its technical expertise is not adequate; tribes see this as an indication of a lack of commitment to the ISD Process by APO staff.

Procurement plans are developed without the input of the corporations. These plans set the budget and dictate the terms of the contract. There is not much flexibility in this regard. Preproposal conferences are scheduled but not always held due to travel difficulties. The APO develops a procurement plan consisting of a program description and a budget level for the program which enables the health board to plan and develop a proposal for submission consistent with the limitations set by the plan. Proposal scopes of work form the basic operating plans for a contract project. These generally follow the health plan of regional corporations with some variations to accommodate funding availability.

The APO offers technical assistance, but it is not requested or accepted by the corporations. In some discussions, indications were that tribes would have to come to Anchorage to receive technical assistance. Tribes are also reluctant to seek technical assistance from the APO because it is perceived as not relevant and of low quality. However, this situation seems to be improving. Two years ago, none of the health boards asked for technical assistance from the APO. Recently, it appears that more are coming for technical
assistance, and this is reflected in the improved quality of the proposals.

4) Proposal Assessment Stage: A Review Board for proposals has been established in the APO. The CPLO is responsible for ensuring that the Board reviews proposals, identifies threshold issues, and provides other substantive input on proposals. Most proposals are continuation funding applications from existing contractors. These contractors have gained much experience in working with the APO and are well aware of what is needed in a proposal. This has eliminated needless delays with threshold issues or other contracting matters. When proposal reviews are in process, contacts are made by telephone or meetings. Thus, corporations are kept informed of additional proposal needs. The corporation can then do the necessary followup to adhere to established schedules.

There were some comments that too many people at the APO are involved in proposal and contract processing, making it unclear to contractors who has responsibility. In addition, there is a perceived one-sidedness on the part of the Alaska APO in terms of implementing the ISM Process. The APO planning capability is considered weak and the corporations see the APO as not qualified to assist tribes in this area.

Threshold issues do not often present major problems as the Alaska APO has clarified the term as: (1) lack of necessary tribal resolutions; (2) proposal for services not defined as a Secretarial program; (3) lack of the proposal’s sanction by the umbrella corporation; and (4) programs that exceed available funding levels. Threshold issues pertaining to available funding are worked out by modifying the scope of work. This is unpopular, especially among tribes who are doing a conscientious job to conserve their health resources. Personnel issues rarely become a threshold or declination issue. The APO Personnel Officer reviews the contractor’s personnel policies to ensure they are appropriate for contracts.

The APO feels that delays are caused primarily by threshold issues which the tribes must resolve. The directives within ISDM 81-3 are followed in this respect in that the "clock stops" until these are resolved. Dealing with threshold issues such as the required number of resolutions to show tribal and/or village support are complicated by travel distances. This makes it difficult for villages to meet, especially when inclement weather occurs. Further, air travel within the state is expensive, and this sometimes affects the ability of tribes to secure the required resolutions.

5) Decision Stage: Most IHS personnel relate that decision making on proposals occurs within the required 60 days. This does not include the 5-day period in which the Office must prepare a letter to acknowledge proposal receipt. Time begins when the Area Director notifies the contractor that the proposal has been accepted and is suspended if threshold issues need to be resolved. The process within Alaska often exceeds the 60 day time frame. This is not indicated as a major problem because of carryover provisions of P.L. 93-638.
Some of the health corporations are dissatisfied with the negotiation process and feel there is contrivance on the part of the Alaska APO to work against the intentions of the tribes. One corporation reported that items which were agreed upon in the negotiation were not included in the final contract. They felt that specific training on negotiations was a definite need.

The Alaska APO has initiated the necessary actions to foster the purposes of Indian self-determination. This comes through general adherence to P.L. 93-638, and the regulations and directives of the ISDM/ISDA series. However, dissatisfaction among Alaska Native groups is beginning to develop over certain ambiguities in these sources. The Alaska APO appears to be very supportive of 638 contracting in that they do not present major obstacles to tribal contracting or refuse or decline any request for technical assistance submitted by the regional groups. Proposal scopes of work appear adequate in terms of goals, objectives and activities. This correlates with various discussants professing that the Alaska Native health groups have grown in terms of overall planning and development capabilities. The conclusion is that the Alaska APO has done an adequate job in pre-contract technical assistance. Many of the criticisms of technical assistance relate to post-contracting circumstances. The Leadership Team appears to be ready and willing to provide any technical assistance they can, but very little is requested. It was learned that many regional groups are receiving their TA through private firms or other native health organizations.

Site-Specific Recommendations

Under P.L. 93-638, IHS is directed to provide technical assistance in areas of weakness to enable tribes to assume functions and programs of the Secretary if that is their desire. Thus, some thought should be given to a technical assistance delivery mechanism that better addresses the capacity building needs of the Alaska Native corporations. This applies to both health systems development and to the administration and accountability areas defined under the law. In addition, an assessment should be made both of staff capabilities for providing technical assistance and the specific technical assistance roles of IHS personnel based on their strengths.

The Alaska Area Office may need some assistance in improving its perceived image with Alaska Native groups. Clearly, not much can be done immediately where barriers exist in the law or regulations. Some thought should be given to ways that communications might be improved given the geographic and cultural diversity and range of the region. Progress apparently has been made in this area which should serve as an incentive for continued improvement.
3.2.3 Bemidji Program Area

Description of the Program Area

The Bemidji Program Office was created on July 1, 1975, to serve tribes within the States of Michigan, Minnesota, and Wisconsin. Between 1955 and 1975, these States had been under the jurisdiction of the Aberdeen Area Office of the Indian Health Service. The Bemidji Program Office serves an estimated 40,000 Indians encompassing 29 federally recognized tribes, as well as an additional 105,000 persons of Indian descent. Among these are various Chippewa Bands, the Potawatomi, Menominee, Winnebago, certain Sioux Bands, and the Oneida and Stockbridge-Munsee Band of Mohicans. Of these, only the Oneida and Stockbridge-Munsee were resettled in the area from other states.

The provision of health services by the federal government is specifically mentioned in a number of treaties negotiated with these tribes between 1830 and 1890. In addition, a number of tribes terminated in the 1950s have successfully reversed their terminated status since 1970, and have petitioned Congress for special funds to establish health care services for their members. Accordingly, the Bemidji Program Area incorporates direct IHS provision of services through hospitals and clinics as well as a number of tribally-operated programs contracted under P.L. 93-638 or established through P.L. 94-437 (Indian Health Care Improvement Act), special Congressional Acts, or other federal and state agency assistance.

Considerable contracting under P.L. 93-638 has taken place within the Bemidji APO since the establishment of IHS rules and regulations for implementation. Virtually all tribes under the jurisdiction of the Bemidji APO have some program or service under contract. As a result, the majority of contracts processed by the Office are renewal contracts. It has also become exceedingly difficult for the Office to respond to tribal requests for new programs where tribes are located within an area where IHS services are provided. For non-assumption tribes, problems relating to budgets seem to affect the expansion of existing programs.

For a number of tribes under the jurisdiction of the Bemidji APO, contracting for health services under P.L. 93-638 has involved the takeover of existing IHS services. For others, notably several Wisconsin tribes, no IHS services were provided, requiring that the tribe and IHS work cooperatively in establishing tribal health programs. A notable offshoot of the differences and the geographic range of the BPO has been the establishment of two Field Offices in Rhinelander, Wisconsin, and Kincheloe, Michigan, to assure the provision of on-site technical assistance and coordination necessary for achieving tribal success. An additional characteristic of the Bemidji APO's orientation has been the need for a fairly extensive
construction program -- much of which has been contracted directly to tribes under P.L. 93-638.

Taken as a whole, health care services provided to tribes through the IHS and tribal programs encompass virtually all services included under comprehensive health care, including physicians, nurses, social workers, pharmacists, public health nurses, sanitarians, engineers, emergency medical technicians, physical therapists, community health representative programs, alcohol/drug abuse programs, laboratory and x-ray technicians, as well as administrative support and physician extenders. Some attempt is also made to include considerations of traditional tribal medicine as well. The overall budget for the Bemidji APO is broken down into two major categories: Direct Care Expenditures and Contract Care Expenditures. Construction projects are funded under a separate budget.

The NIHB/AITS field activity in the Bemidji Program Area entailed visits to the IHS Area Program Office in Bemidji and the Rhinelander Field Office. Additionally, four contracting Tribes were visited: Leech Lake, Red Lake, and White Earth Chippewa Reservations in Minnesota; and the Stockbridge-Munsee Reservation in Bowler, Wisconsin. Characteristics of these tribal programs are described below.

Leech Lake Reservation: The Leech Lake Reservation was established by treaty of March 19, 1867, and comprises 920 square miles just outside of Bemidji, Minnesota. The Reservation has a service population of approximately 4,124. Within the Reservation, IHS operates a 23-bed hospital at Cass Lake, with an ambulatory care facility attached. The hospital handles approximately 800 admissions per year, with an outpatient load of 28,000 per year. Clinics are also conducted regularly for blood pressure, pre- and post-natal care, maternal and infant nutrition, and optometric care. Several health programs are provided by the tribe under ISD contracts. These include a community health nurse, emergency medical services, a CHR program, a detoxification service unit, a chemical dependency prevention program, and sanitation, mental health and management contracts.

Red Lake Reservation: Located in Northcentral Minnesota, the Red Lake Reservation is unique in that none of their aboriginal lands were ceded by Treaty. Since no allotments took place, all lands are held in common by the tribe. This Reservation contains the newest major facility of the Bemidji Program Area -- an $8 million hospital constructed by the Tribe under a 638 construction contract which was turned over to IHS on February 13, 1981. Comprehensive health care combined IHS and tribally administered field health programs. The service population of the hospital is 3,327; most of whom reside around the communities of Red Lake, Redby, and Ponemah. IHS programs provided through the hospital include inpatient medical records, outpatient needs, pharmacy, x-ray and laboratory, dietetic, community health nursing, mental health, social services, optical and dentistry, the Ponemah clinic, property and supply, housekeeping, maintenance and repair, and environmental health. Programs for which the
Red Lake Tribe has ISD contracts include health education, social services, home health, school health, ambulance, transportation services, day care, physical therapy, hospital support staff, sanitation, alcoholism rehabilitation, a drug abuse program, an elderly nutrition program, and sanitation facilities.

White Earth Reservation: This Reservation, which was established by Treaty in 1867, consists of 1,926 square miles in northwestern Minnesota. It is the largest of the six member bands of the Minnesota Chippewa Tribe. It contains a Public Health Service Indian Health Center which serves approximately 5,000 on and off-reservation Chippewa. Two physicians and a community health care team provide services through two field clinics at Natawansch and Pine Point at regular intervals. Regular medical services, mental health services, dental care, and optometric services are provided. A CHR program, community health nursing, emergency medical services, and alcoholism programs are provided by the Tribe. The service population of the tribal program is 3,547.

Stockbridge-Munsee Reservation: This Reservation is comprised of two fused tribal groups -- the Stockbridge which moved from Massachusetts in 1785 and then to Wisconsin in 1822; and the Munsee which were incorporated with the Stockbridge in 1833. In 1856 they were moved to their present site near the Menominee and given 15,325 acres. The Stockbridge-Munsee have no IHS services in place. However, the tribe itself has under an ISD contract, an excellent ambulatory care facility staffed by a physician, a comprehensive health team, a physician extender, a nurse practitioner, and a community health nurse. In addition, contract health is also provided. The estimated service population of the facility is 1,268.

Impressions of ISD Implementation

1) ISD Process as a Whole: The Bemidji APO has contracted with tribes for over a decade, beginning with the contracting of programs under the Buy Indian Act. Thus, there is a clear understanding of the philosophy and intent of the Law on the part of IHS personnel, and a well established, fine-tuned set of procedures and staff assignments for implementing the process.

Functional statements have been prepared for each member of the Leadership Team that clearly delineate areas of responsibility at each Stage of the ISD Process. In the Bemidji APO, the Leadership Team is comprised of the CPLO, the Tribal Projects Officer, Program Services director, the Budget and Contracting Officers, and for a given tribe or contract, relevant Service Unit Directors and/or project officers along with professional discipline staff.
In addition, the Bemidji APO has developed manuals that detail the contracting process for:

- "new" 638 proposals,
- renewal proposals, and
- 638 OEH/SFCO construction proposals.

An informational packet used as a training aid for new IHS personnel serves to orient staff to the background and purposes of P.L. 93-638, as well as to describe the ISD Process and its implementation within the Bemidji APO. Finally, the APO prepares yearly Evaluation Reports, as suggested under ISDM 81-3, in which new 638 contracted proposals, non-contracted proposals or requests, and other tribal expressions of interest in contracting are summarized. A similar report is prepared for ISD construction contracts, and contract lists appear to be up to date.

With the support of the Bemidji Program Office, the Rhinelander Field Office functions to provide direct and on-going technical assistance and project officer monitoring to the tribes within Wisconsin. This office is geared to working with non-IHS service tribes, and its personnel are fairly positive about tribal innovations in planning and design, and supportive of tribally-based health programs. Project Officers assigned to Rhinelander work with tribes to develop and design tribally-sensitive plans and to obtain needed funding for them. This provision of technical assistance seems very strong and open to tribal ideas.

Taking the Bemidji Program Office jurisdiction as a whole, the tribes appear to have a basic understanding of the process as evidenced by the fact that all tribes have ISD contracts -- in fact, very few new contracts are processed by the APO. However, some tribes are not as well versed in what the process entails and there seems to be some confusion as to how to exercise their rights under ISD to the fullest extent possible. This emerges most clearly for tribes which previously had IHS services in place and who now desire to develop tribally-based plans which are different from the existing IHS services. Very little innovation appears to take place within the Program Office. The emphasis appears to be on maintaining the status quo and this may detract from the provision of technical assistance to tribes who are interested in redesigning or redirecting their health programs along more tribally-sensitive lines. Several problems exist in this regard. First, an existing IHS service delivery program establishes a model and set of expectations. It is difficult for a tribe to deviate from this precedent if it desires to assume the contract. Second, the budget level of the previous program also provides a constraint on the funding level of any proposed new services. Finally, IPAs and Commissioned Officers on assignment to tribally-run programs sometimes introduce additional budget strains (through their salary levels) and checks on innovation. These restrictions make it difficult or impossible for the Bemidji APO to provide support and adequate funding for innovative new programs proposed by tribes.
In contrast, tribes who did not have previously existing IHS programs are not constrained by a prior model which dictates the terms and funding levels of their contracts. This is the case in Wisconsin, for example, where programs have been built by tribes “from the ground up.” In some cases, their first involvement was not with IHS but with OEO, EDA, or some other federal or state agency. Once IHS has become involved, it appears that the Rhinelander Field Office staff have made a concerted effort to provide needed technical assistance in developing tribally-based health programs.

In both types of situations, tribes are actively pursuing opportunities to augment IHS dollars because these simply are not sufficient to provide an adequate level of services for tribal members. Accordingly, additional resources available through other federal and state programs, and third party payments such as Medicare, Medicaid, and employee insurance plans, are actively pursued. These resources enable tribes to develop a fairly adequate level of services through the combined resources provided under IHS 638 contracts, any existing IHS services provided, and the alternative resources identified above. IHS dollars, however, remain crucial to the operation of successful programs.

Both political change and staff turnover can present problems with respect to continuity in the level of expertise available within a tribe to contract and operate programs under the Process. Thus, there is a continuing need to provide anew the same types of technical assistance associated with the ISD Process whenever a new health director or administrator is brought on board as well as in new contracting situations. This seems to be somewhat problematic for APO personnel in Bemidji, who appear to associate tribal knowledge and capacity regarding the ISD Process more with the tribe as a whole than with individual staff. Thus, some health directors who are relatively new to the Process expressed that they tend to feel overwhelmed in their first years.

2) Preparation Stage: As noted above, a permanent Leadership Team is in place within the Bemidji APO. The Tribal Projects Officer (who was previously CPLO) and the CPLO have established a division of labor to coordinate 638 activities. In this regard, the CPLO is responsible for maintaining the flow, timelines, and notification requirements associated with 638 contracts, while the Tribal Projects Officer handles training of IHS staff and technical assistance and presentations to tribal personnel. Technical assistance is provided in the areas of planning, proposal preparation, accountability, finance, and contract administration. In addition, both the Field Office Director and Project Officers of the Rhinelander Office become involved in the Leadership Teams in processing proposals of Wisconsin tribes, and plan and assist in the negotiations with tribes in their jurisdiction.

Since all tribes within the jurisdiction of the Bemidji APO Office have ISD contracts with IHS, contract renewals constitute the primary activity of this Office’s contracting. The Bemidji Program Office has staggered the expiration dates of tribal contracts so that
they do not all come due at the same time. This enables more attention to be given to each tribe's renewal proposal. In addition, contracts tend to be three-year contracts with renewals in intermediate years consisting primarily of noting any staffing changes and the preparation of a new budget, based on available funds.

3) Preproposal Stage: Both the tribes and the IHS cited ISDM 81-3 as providing the backdrop for responses to tribal letters of intent to contract. Since most contracts are renewals, the preproposal stage generally consists of reminding the tribe of an upcoming contract expiration date, offering technical assistance in proposal preparation, and providing any available budget information. Tribal comments regarding the preproposal stage basically focused on the "cut and dry" nature of the renewals—no room for innovation or redesign of programs appears to exist. Tribes offered the view that in some instances they would like more flexibility to revise their scopes of work or to shift program emphases but that in many cases this is not possible given previously existing IHS service delivery models and restricted funding levels.

Tribes reported that they receive needed information regarding contract renewal well in advance of contract expiration and proposal due dates. Bemidji APO is reportedly excellent in adhering to ISDM imposed timelines. Preproposal conferences appear to be held on an as-needed basis. Sometimes renewals are very simply prepared from pre-existing proposals and only revised budget and staffing plan, along with minor scope of work changes are new elements.

If a tribe proposes to take over an existing IHS program or service or makes a request which is a marked departure from the existing scope of work, the preproposal conference provides an opportunity to assess the feasibility of such a takeover or revision. However, difficulties in obtaining from the Bemidji APO information on IHS program standards or on current IHS activities involved in takeover requests can impede contracting. Some tribes do not feel that IHS really tries to assist a tribe to take over an existing program. Tribes which expressed this view feel that the burden of proof for demonstrating capability is placed on the tribe rather than having the letter of intent trigger a cooperative effort between IHS and the tribe to bring about a takeover. Connected with this are issues of the divisibility of programs which frequently arise among smaller tribes, especially those with limited experience or infrastructure. In-depth preproposal conferences and technical input from professional staff are needed and provided in these instances, but the outcomes are not always perceived as helpful by the tribes concerned.

Bemidji APO staff maintain that adequate technical assistance is provided to new health directors or administrators who are preparing proposals for the first time. However, some tribes feel that they need more TA in this regard. Some health directors appear somewhat at a loss in planning programs and proposal preparation.
Taking the Bemidji Program Office as a whole, the provision of technical assistance appears to vary both in quality and quantity. While some tribes feel they do not need much, others stated that they cannot always obtain it. In some cases, travel budget restrictions on Bemidji APO staff were cited as problematic for both IHS staff and tribes. Some tribes questioned the relevance of the TA provided and suggested that more hand in hand determination of TA needs between the Bemidji and tribes, and joint design of content and delivery mechanisms might be helpful. In this regard, the Rhinelander Field Office was cited as particularly strong in providing both relevant and site-specific technical assistance to tribes.

Where health is a high priority within the tribe, capacity building and health planning appear to move ahead within the tribal structure itself. Again, it seems to be easier for tribes with no previous IHS services to coordinate their planning and capacity building with IHS; less so for those with previous or existing IHS services. Tribes with solid economic bases and/or political structures -- even those with existing or previous IHS services -- also seem better able to redesign programs within the ISD Process in keeping with perceived tribal needs.

4) Proposal Assessment Stage: The review process identifies any existing threshold issues for new takeover programs or new programs for tribes having no existing IHS services. Proposals are reviewed by the Leadership Team and the Project Officer as well as by the relevant technical (discipline) personnel. Proper timelines for response to the tribe are followed. Threshold issues occur most often with small tribes having little tribal resources to supplement IHS dollars, when divisibility issues arise, or when the level of funding available appears to be inadequate.

5) Decision Stage: Attempts are made to resolve all threshold issues and to negotiate all budget revisions or scope of work refinements at this time so that all matters are resolved prior to meeting for final negotiations and execution of the contract. Negotiations are cited by both IHS and tribes as not being true negotiations. Both tribes and IHS feel that budget and model restrictions can severely limit their flexibility. Tribes feel they have no options and that a "take-it-or-leave-it" situation applies. IHS personnel feel limited by budget restrictions which make it difficult to provide room for compromise or negotiation.

When a final contract award decision has been made, the Contracting Officer or Contracting Specialist deal with all matters relating to the preparation of the contract document and its readying for execution. ISDM procedures are followed here, and all timelines and reporting requirements as specified in ISDM 81-3 appear to be met.
Site-Specific Recommendations

Technical assistance from APO personnel in Bemidji needs to be improved in the following areas:

- new tribal health directors appear in many cases to be overwhelmed by the requirements of the ISD Process. Not only do they appear to need some technical assistance, but they seem unaware of the types of technical assistance that the APO staff may be able to provide.

- technical assistance skills of project officers should be assessed and determinations made concerning their strengths and weaknesses for providing technical assistance in specific areas.

- more direct provision of technical assistance in discipline areas by discipline staff appears to be needed.

In addition, it was noted that with the exception of Red Lake, very little coordination or cooperation appears to exist between IHS service units and tribal programs. The opportunities for improving the health care delivery system as a whole -- that is, tribal and IHS programs -- should not be overlooked. While the tribes involved may have made a conscious decision to run their programs completely separate from IHS programs, IHS rapprochement in this area may also be helpful in consolidating health resources.

Finally, it appears that communications among all Bemidji Program Office staff involved in a given tribal program should be improved, and a unified way of communicating with tribal health directors needs to be found. Tribes report receiving conflicting information from contracting, project officer, and discipline staff, which makes it difficult and frustrating for them to comply with IHS requests. In this climate, delivery of technical assistance also becomes problematic as well.
3.2.4 California Program Area

Description of the Program Area

There are several reasons why contracting is seen as an essential means of providing Indian health care in the California Program Office. The enactment of House Concurrent Resolution 108 in 1953, which terminated Federal supervision and services of the Bureau of Indian Affairs, specifically included the State of California within the provisions. Subsequently, all Indian social welfare responsibilities were assumed by the state, followed by a gradual withdrawal of Public Health Service functions in the ensuing years. Health care which the state was supposed to provide under this assumption was not adequately delivered, however, and in 1969, California admitted that "the health of California's Indians has deteriorated." In that same year, the Indian Health Service recommended to DHEW that health programs and services be provided to Indians in the State of California on the same basis as in other states. In the following year, DHEW reversed its policy on the provision of services to California Indians by providing "Federal Supplementation" for 7,000 Indians living on or near reservations in the State. The first IHS office in California, established in 1969 as a field office of the Phoenix Area Office, was expanded between 1969 and 1976 through appropriated funds and the addition of IHS personnel. Finally, in 1977, this office was officially approved as a separate California Program Office of IHS through an announcement in the Federal Register and the concurrence of the Office of Management and Budget.

The basic problem associated with the reassumption of services by IHS was that the infrastructure for providing them (facilities and personnel) no longer existed. Thus, the IHS reorganization plan for California designated contracts as the primary mechanism for service delivery. Between 1970 and 1971, two organizations -- the California Rural Indian Health Board (CRIHB) and the California Urban Indian Health Council (CUIHC) -- became the primary contractors for providing Indian health services. Through supplemental appropriations, operating funds gradually increased to their present levels. Indian contracting also dramatically expanded to include 20 rural health programs funded by the IHS, which provide care in 17 health centers (full-time clinics) and 18 health stations (part-time clinics) funded in whole or in part with IHS funds. In addition, there are eight contracts directly with the tribes which provide contract health care (CHS) and/or outreach services. In total, there are 21 health services contracts for these health programs throughout the State with some programs contracted directly with IHS and some programs subcontracted through consortium contracts. Of 21 prime contracts, 11 utilize P.L. 93-638; and 10 contracts are funded under the Buy Indian Act (25 U.S.C. 47).

The California APO is organized to provide direct support to contracting tribes and organizations. To accomplish this, the current operating plan provides for administrative, professional, and technical support in the following areas:
A "service area" concept, organized along geographic lines, has also been implemented and serves the towns and rancherias within those areas. There are 19 service areas within which Indian tribes, consortia, and health boards contract with the APO for the provision of services. These include approximately 52 urban and rural groups that contract for direct health care (outpatient, dental, etc.), nine CHS/CHR programs and 14 alcohol programs. There are no hospitals operated under the plan, but hospitalization needs are met through contracted health care.

The tribes and tribal organizations visited in addition to the California Program Office are described below.

Central Valley Indian Health, Inc. is a non-profit Indian organization developed in 1971 to provide health care for Indians in the Fresno, California, area. The corporation is located in Clovis, California, and serves seven Indian communities and rancherias within its jurisdiction. The service population is believed to be about 4,745 Indian persons within Kings, Madera, and Fresno Counties of Central California. This area excludes the city of Fresno. The tribal groups represented include Mono, Entipich, Wobunuch, Chukchansi, Choinumni, and Tachi.

The health program provided includes ambulatory, medical, and dental care in Clovis, through three satellite health clinics at the Cold Springs and Santa Rosa Rancherias and North Fork. Central Valley also has a contract health care program to pay for service costs that cannot be met by the program. These services are under a Buy Indian Act contract with the Indian Health Service. The organization has considered the contracting options under P.L. 93-638 but had not made a decision at the time of this evaluation visit. The major issues given in this regard is obtaining the consensus of support required under the latter act which is not a condition for the Buy Indian Act.

Southern Indian Health Council serves an Indian population of approximately 5,904 Indian persons in Southern San Diego County. This Indian population includes Sycuan Jamul, LaPosta, Barona, Viejas, Manzanita, and Cuyapaipe bands of the Diegueno Indian tribe. The organization is a non-profit corporation under which the Board of Directors serve from each of the seven Indian reservations.

The Southern Indian Health Center at Sycuan was opened in April 1980, and began operating under P.L. 93-638 in November 1982. The program provides ambulatory medical and dental care as well as contract health care. There are four "departments" that provide the
delivery services: medical, dental, mental health, and social services, community health nursing, and outreach and environmental health. IHS information on the program indicates that in 1982 the program had 3,360 medical and 2,992 dental visits.

Pi-Ma-Pa Indian Health Consortium is located in Susanville, California, in the northeastern part of the state. It serves Indians of the Pitt River Nation, Maidu Tribe and the Paiute Nation of the Fort Bidwell Reservation as well as the Susanville Rancheria. The consortium also operates field offices at Burney and Fort Bidwell, California. The consortium Board is made up of the tribal members that it serves. The estimated Indian population is about 500 persons from the three tribes shown above.

The Pi-Ma-Pa Indian Health Consortium operates primarily as a subcontractor of the California Rural Indian Health Board. Its range of services includes dental, home health aides, and medical services in each of its clinics. Contract health care and third-party billings allow the consortium to provide additional ambulatory and emergency health care. They have not considered contracting directly with the Indian Health Service since a direct contract would only amount to an estimated $40,000. Thus, they contend that the needs of the Indian population now served would go unmet.

Tule River Indian Reservation is located in Southeast Tulare County in Central California. It is located between Fresno and Bakersfield near Porterville and approximately 17 miles east of U.S. Highway 99. The reservation was established by Executive Order of January 9, 1873; subsequent Executive Orders of August 8, 1978, and January 17, 1912, have reduced the reservation land base to its present size. The reservation contains 54,116 acres in the foothills of the Sierra Nevadas, ranging in elevation from 900 feet to 7600 feet about sea level. Approximately 2,557 Indians comprise the population of Tulare County, with about 549 of these individuals living on or near the reservation. Other major Indian communities are found in Visalia, Porterville, Springville-Johnsondale and several other towns within the county.

The Tule River Indian Health Board presently contracts with the California APO to operate a clinic on the reservation and an outreach center in Visalia, California. The Health Board was initially chartered by the Tule River Indian Council in 1971 and incorporated on May 7, 1973. The program provides medical, dental, community health, optical, youth alcohol, and drug abuse services. The community health component includes community health nursing, CHR, nutrition and health education services. Some coordination exists with the county health board, although the IHS provides the major source of support for the Tule River Health Center.

1) ISD Process as a Whole: Basically, there is general satisfaction with the ISD Process. The particular arrangement of California tribes (many small enclaves of Indian population within a vast geographic expanse) appears to influence the choice to contract and the manner of contracting. Thus, many of the Indian tribes and
rancherias have chosen to be a part of an intertribal consortium or health board on the premise that this enables them to consolidate available resources. However, this mechanism has become cumbersome as previously terminated groups reestablish Federal recognition, and difficult in light of the government's desire to maintain a "government-to-government" relationship with tribes. Thus, there is a trend by more of the smaller groups to seek to contract directly. The consortium arrangement, however, is still seen as the most viable approach for meeting present needs.

Several concerns or problems were cited with the ISO Process as a whole. Most of the applications processed by the California APO are for the renewal of existing projects. The problems seen in this respect are that the APO rarely uses multi-year contracts which would reduce the extensive and burdensome proposal development functions associated with contracting. Although multi-year contracts are permissible under Section 106(c), the only reasons given for this was the uncertainty of funding for continuation.

The question was also raised as to whether all the steps of the contracting process as defined in ISDM 81-3 must be followed in a contract renewal. In addition, there are some expressions that multi-tribal contracts appear to be becoming less popular, particularly since these require resolutions from all of the tribes to be served. As stated above, this has been problematic especially for unorganized Indian communities and those terminated tribes that have just reestablished Federal recognition. This may also be a reason for some California intertribal groups to contract under the Buy Indian Act, since its requirements are less stringent in terms of the formal demonstration of community support.

Some questions were also raised regarding whether contract renewals need to be subject to all the steps in the process. Second, the assessment methodology for determining and developing accountability systems as defined under Section 103(a)(1-3) and Section 106 is seen to need upgrading or standardization. Specific technical assistance approaches can then be organized for developing the capabilities of "new" tribes or organizations to assume responsibilities for IHS services, programs, or functions. The issue of community support for a contract also needs review in terms of what constitutes a valid commitment of a tribe and who are eligible unorganized Indian communities.

2) Preparation Stage: The APO has designated a Leadership Team to centralize the development of contracts pursuant to P.L. 93-638. The CPLO function has been assigned on a permanent basis, thus complying with the directive of ISDM 81-3. Since most of the tribal contracts have been in place for some time, Project Officers provide an additional source of information on ISD planning decisions.

The strengths in this organizational concept are seen to lie in the centralization of ISD activities, and the permanent nature of the Team. This enables the tribes and/or organizations to become familiar with the APO personnel who will work with them through the various
stages of the process. However, staff expertise was raised as a problematic issue by a number of discussants. It is clear from discussions with APO staff that a good understanding of the law and process exists. There is a tribal view that some APO staff lack the commitment to Indian self-determination goals and philosophy, while others are pushing tribes to contract.

3) Preproposal Stage: According to APO staff, ISDM 81-3 provides an adequate framework for responding to tribal contracting requests. The California APO has gone beyond this to elaborate the ISD process for the needs in tribal contracting. This was accomplished with the development of a contracting manual entitled "California Program Office P.L. 93-638 Contracting Process: Functional Statements and Renewal Statements." In support of the manual's directives, a tracking system has been designed that allows close monitoring of the contracting process and adherence to mandated timelines. Thus, the CPLO has indicated that most contract requests that go into proposal development and assessment can be processed in less than the 120 day requirement defined in the APO manual.

The California APO generally follows the steps defined in the ISD contracting process. This starts with a preproposal conference with the proposing tribe or tribal organization. Within this meeting, the Leadership Team and professional disciplinary staff detail the needs and requirements for contracting. Information is also provided during these conferences on the time schedule for various steps of the process. Divisibility of IHS programs and services provides the basis for program descriptions within the proposal scope of work. In turn, the proposal's scope of work provides a basis for determining a budget. Information is then provided by the APO to new proposing tribes on the review process, copies of the ISDM/ISDA series and the content requirements for proposals which are all within the ISDM series. Preproposal conferences are optional for renewals but are often provided in cases where a tribe has proposed a change in its scope of work.

One of the primary concerns relating to tribal capacity-building expressed by APO staff is with the administration requirements defined under Section 106 of P.L. 93-638. For some new contractors, grants as allowed under Section 104 have been utilized for tribal capacity building. One of the primary concerns in this regard, expressed by both APO staff and tribes, is the level of technical assistance that can be provided. Some of the discussants felt that the TA given by APO personnel was entirely oriented to the mechanics of the ISD contracting process. Technical assistance on such issues as developing health delivery systems, accountability, or personnel systems was perceived as a major need, especially since most contractors have had some involvement with 638 contracting.

Under the California APO contracting approach, many tribes are subcontractors to a health board or organization. The APO has taken the position that it is the prime contractor's responsibility to provide technical assistance to its subcontracting tribes. This is viewed unfavorably by the tribes who feel that IHS is responsible for