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Evaluation of the California

Rural Indian Health Board:

FINAL REPORT

Rj associates



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Rural Indian Health Board:

FINAL REPORT

Prepared by: Rj Associates, Inc.,
1018 Wilson Blvd.,
Arlington, Va, 22209

(703) 524-3360

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Evaluation of the California Rural Indian Health Board: FINAL REPORT

I. INTRODUCTION

This Final Report on the Rj Associates, Inc. Evaluation of the California Rural Indian Health Board is a compendium of reports which have been issued prior to this time, as well as the additional material which is contained in this document. The reports which have been submitted to date include the following:

- Interim Report to the Board of Directors of the California Rural Indian Health Board, August 23, 1974
- Local Reports on each of sixteen CRIHB projects, issued during the week of October 21, 1974
- General Local Projects Recommendations report attached to each report on a specific local project, issued October 21, 1974
- Memoranda on specific issues including:
 1. Apportionment of CRIHB Funds, September 11, 1974
 2. Model Budget for Local Projects, September 18, 1974
 3. CRIHB Salary Schedule, September 18, 1974
 4. Board Meeting and Project Directors Meeting Costs, September 23, 1974
 5. Central Office Budget, September 25, 1974

In the present document our purposes are several. First, we will describe what we view as the accomplishments of CRIHB in its six year history, discuss recent problems and the board's response to them, and consider general issues which should take priority for the project in the coming year. Second, we shall discuss several other issues which should be examined and addressed by the CRIHB board of directors and, finally, we will clarify a number of issues which were raised in our Interim Report.

II. ACCOMPLISHMENTS, RECENT RESPONSE TO PROBLEMS, GENERAL PROBLEMS IN THE COMING YEAR

A. Accomplishments

Perhaps the most obvious and striking facts about the local projects is their enormous accomplishments in bringing needed health services to an underserved population. They have been able to translate small amounts of seed money into effective health programs that deliver outreach, dental, and medical services to the California Indian population. The projects have well-equipped, well-kept facilities, committed staff, and a continually growing number of Indians who look to the projects as their primary source of health services.

At almost all of the projects, ingenuity was used to put together the pieces of their program. Innovative methods were used to obtain facilities, supplies, equipment, etc. The staffs have also been extremely aggressive in locating sources of additional funding, such as Regional Medical Program, Revenue Sharing, National Health Service Corps, VISTA--pursuing those sources, and securing funds. They have also been able to tap local resources to secure donated accounting, medical, and technical support. The projects present an image of being growing, animated organizations, which seems to be one of the reasons they have been able to attract high quality professional staff to remote areas of California.

Noted below are some of CRIHB's specific accomplishments over the first six years of its life as it has brought health services to a large majority of California's 40,000 rural Indians.

- the development of 18 dental clinics throughout the state of California to provide dental services to the Indian population which had been without such services previously.
- the organization of medical services including five full-time primary care medical clinics, and the provision of medical care services through part-time physicians, screening clinics, contract care and referral systems in the eleven other projects. In the coming year four more projects will very likely have direct medical services available. Some projects have effectively used alternative approaches to providing medical care such as the development of referral systems or contract care arrangements.
- the development, procurement, and construction of outpatient clinic facilities largely without federal funds. Six projects have their own buildings for a total value of at least \$750,000. Another project is in the process of raising funds to complete construction of its facility. Other projects have rehabilitated or redesigned facilities utilizing donated funds and labor from many sources.
- the leveraging of other funds by local projects. The CRIHB funds have enabled the project to leverage a substantial amount of funding from other sources. The funds and resources in addition to facilities which have been gathered represent more than \$1,000,000 in the past year. Of particular importance we believe is the success of some projects in securing general revenue sharing funds for their programs from the county. Securing these funds in the face of the fact that local governments have generally spent minimal amounts of these dollars for social program purposes, and the fact that local government has a to the CRIHB board and IHS.

tradition of being unresponsive to the Indian population is a major accomplishment, and indicative of the reputation which the CRIHB projects have developed in their local communities.

In summary, the large majority of the Indians of rural California are now receiving some health services. There are still large gaps which must be filled if an integrated, comprehensive, accessible, and responsive system of health care delivery is to be achieved. Not only will additional financial resources be required for CRIHB, to achieve this objective, but CRIHB will also have to make increasingly better use of the resources which are already available and recognize that the health delivery system which it creates must also be a cost-effective system.

B. Recent Response to Problems

CRIHB is not without its problems. But in so far as those problems are concerned we have seen what can only be termed as astonishing progress in the past three and one-half months. In the Interim Report which Rj Associates issued in August we recommended a number of alternatives which CRIHB should consider in order to improve the operation of its central office, and a series of options for improving the operations of the CRIHB board itself. These recommendations coupled with the increasing recognition of their own problems which had been developing among many members of the CRIHB board have prompted significant actions to improve the situation. The following specific actions are indicative of the movement of CRIHB to solve its own problems in the past three months:

- A special committee of project directors working with the chairman and vice-chairman of the board was designated to improve the operations of the central office, and act on important issues such as insurance programs, financial management, and equipment procurement.
- the executive committee has hired as the acting executive director of CRIHB one of the project directors from the special committee mentioned above. That individual is moving forcefully to insure that CRIHB's proposal for the new contract is prepared in a timely and professional manner.
- the board of directors appointed a committee to review recommendations for streamlining the board and improving its operations. Regardless of the board's final action on the specific recommendations which Rj made, the ability of the board to act has vastly improved in past months, and we believe that the outcome of the analysis of our recommendations will bring even further growth and development.
- the finance subcommittee will review the fiscal and budgeting recommendations in the Interim Report, and another special committee including the special committee of project directors and the personnel committee is reviewing recommendations on central office reorganization.
- CFO hired a consultant to assist the local projects to prepare their proposals and budgets, which, for the first time, have been completed on time for submission.

- A new apportionment of CRIHB funds was made. Perhaps the most difficult question which Rj Associates was asked to consider in its evaluation was an approach to the allocation of new funds which are to become available to CRIHB under its new contract. This task was viewed by ourselves and by the CRIHB board with great trepidation since in the past it had caused such great conflict among projects and board members. Based on our review of the sixteen local projects, and other available data, Rj recommended a specific allocation level for each project in the coming year. The CRIHB project directors reviewed our allocation and modified it primarily to give greater weight to the effects of inflation. The revised allocation was then presented to the board and after some discussion was approved. The conflict and animosity which was present at previous meetings where allocation was considered did not arise, and we believe that most of the board members felt that the revised allocation was generally fair and equitable. Not everyone agreed completely; no one ever does. But the board had made the decision, utilizing professional inputs and its own staff of project directors, and this we consider to be a major accomplishment.

These developments are indicative of the capacity of CRIHB to resolve its own operational problems given good staff support and sound technical advice.

C. Issues in the Coming Year

Let there be no mistaking the fact, however, that there are numerous problems that the board and central office must still face in the coming year. Among the most important of these is the creation of a viable, functioning responsive central office operation. (Only the crisis issues have been addressed to date.) This is no easy task given the history of the operation of the office. However, with the recognition of the nature of the problems which have been hindering the effectiveness of that operation in the minds of most board members, the new executive director should have a good opportunity to create an organization which can perform the numerous tasks defined for the central office. The board must also work to better understand the complex issues which CRIHB now faces in terms of program expansion and operations, management of its finances, and monitoring of contract compliance on the part of CRIHB overall and each of the local projects.

These problems as well as the problems at the local project level which we have elsewhere discussed are all soluble. And once again, it is not money alone which will solve them. It is also strong guidance and technical support which must be forthcoming both from the Indian Health Service which has been increasingly responsive to the management assistance needs of CRIHB (though the problems of property management and procurement of equipment continue to be a major thorn in the relationship between CRIHB and its funding agency, these problems too can be resolved with improved management within the CRIHB central office and the creation of better mechanism to insure a prompt and clear federal response).

1. Needs of the Local Projects

At the local project level we have sixteen projects which are at various levels of development and sophistication. Some are fully developed and providing superb service to their communities, others are emerging into a position of great strength, others are still in the developmental stage, and a few need some restructuring in order to utilize fully their resources.

The strong projects must be helped to recognize the implications of their emergence as complete health delivery systems, and the related need to establish more sophisticated planning and management techniques which are required by any health delivery system and will be mandatory under National Health Insurance.

The emerging projects must be helped in the next year, to set up an operational plan so that as the new elements are added to their delivery system, their operations will continue on an efficient basis and will remain optimally responsive to the needs of the community.

For those developing projects that are moving into service delivery and the projects which require some restructuring full support must be available so that they can benefit from the experiences of other projects. These are the weaker projects in CRIHB and they must be carefully nurtured. There is a great reservoir of concern and interest expressed by the people who run these projects. In some instances the project directors themselves will require large doses of help to manage their programs and improve their operations; some projects may find that their project director is not well suited to the task and would serve the project better in another capacity. Major training and technical assistance support should be focused on these projects in the coming year with emphasis on problem areas identified in our local project reports. With the new level of funding available with the new contract the financial problems which have plagued so many of the projects should be largely eliminated. That is not to say that there is now enough money to fund all the services which the CRIHB projects would like to provide, but projects will have funds available to pay for the services which they propose and, therefore, should be able to concentrate their efforts on improving project operations.

With an improved central office grantsmanship capability, additional resources should become available during the course of the year. With the new funding allocations from IHS, a reexamination of the allocation of the new Regional Medical Program (RMP) slots funded to CRIHB is essential to assure that the projects receiving additional slots are not those that have already received expanded funds from CRIHB to cover these slots. Some of the smaller projects still in the developmental stage should not be glutted with new staff members, whereas other emerging projects could shift funds presently assigned to cover the costs of their CHA's to expand their operations.

Since CRIHB is now in the process of developing performance standards and criteria to measure the delivery capability of the various program components. The effectiveness of all projects should be much easier to measure in quantifiable terms in the coming year. We believe that this evaluation is critical to CRIHB. These criteria must be carefully applied to each of the projects in the course of the coming year so that problem areas can be identified and solutions to these problems developed. In addition, over the course of the year it will be possible to determine whether a project has the capacity to deliver the needed services in an effective manner; and if not, then new options for improving the service can be developed.

2. Health Planning

Of particular importance in the next year for CRIHB's local projects will be planning for the delivery of expanded services, particularly medical services. Up to this point, the projects have developed virtually in the same manner. First an outreach program was instituted; then a dental clinic was opened; now medical services are becoming increasingly available. In the future, expansion cannot take place simply on the basis of the assumption that if "other projects have a service, we want it also." For CRIHB to create a health delivery system for the rural Indians of California does not mean that every project must operate a dental and medical clinic. A delivery system is designed to insure that the target population is receiving essential services; the delivery system does not necessarily provide the service. For example, in many CRIHB project now there are no medical services being provided; however referrals to private practitioners exists to insure that patients needs are being met. In some projects where there are small populations or the population is dispersed, the operation of a medical clinic by a project will not necessarily meet the needs of the community. It is possible, in some cases that the organization of a delivery system, using fee-for-service or contract care arrangements, would be more responsive to the medical needs of the members of the Indian community. It is possible that fee-for-service or contract care arrangement could provide more responsive and cost-effective dental services in some cases, also.

In addition, when thinking about the delivery of medical care the projects must move beyond the idea that a doctor is needed for everything. In several projects nurse practitioners are delivering excellent primary medical care. These persons, who require less training (Indian R.N.'s can be upgraded) are far less expensive and can, under the guidance of a physician, offer much of the care provided by a physician. Furthermore, the physician providing the back-up service need not be a staff person of the project. He or she might simply be a volunteer or a contract care physician. The projects might also consider the possibility of sharing the services of a physician for this purpose, if geography makes for a suitable arrangement.

We would strongly urge that as the CRIHB projects move toward further expansion of medical care, they recognize the numerous ways in which that care can be delivered, and the fact that the presence of a medical clinic does not necessarily guarantee that people will utilize the service. Data on the utilization of existing, medical facilities is imperative prior to developing a facility. The central office of CRIHB should develop a set of guidelines for the planning of a medical facility and also provide the local projects

with far more information on how they can use a referral system, contract care arrangements, or other alternatives to meet the health needs of their target population. Within these guidelines, projects can then more effectively plan for the type and scope of service which they should be providing to their Indian population. CRIHB should not overlook the impact of National Health Insurance on all health delivery, or the Jackson Bill on health delivery to Indians. Both of these pieces of legislation, which are expected to pass in the next congressional session will have major impact on the local projects and, therefore, should be included in CRIHB planning.

3. Reporting Systems

a. Basic Data Reporting System

In our report of general local issues, we discussed the need for CRIHB to implement a comprehensive statewide reporting system. We also emphasized the fact that the data from this system was crucial to future allocations of funds, since the data would offer a clear picture of the number of Indian people in the service population of each of the local projects--a primary criteria under any allocation formula.

Rj would like to reaffirm this recommendation in this Final Report to the CRIHB board, given the importance we attach to it. A reporting system must be set in place as early in the new contract year as possible. The system should standardize the record-keeping systems of each of the local projects, drawing on the best forms and systems now being used locally, as well as systems which have been developed for similar programs. Family and individual records, patient encounter forms for medical, dental and community health aide services, medical and dental records, referral forms to other agencies, etc. must all be standardized to enable CRIHB to apply its performance standards equitably to all projects, and also to enable CRIHB to summarize the services which are being provided to the service population under a set of common definitions. The system must enable a project to track an individual through the different components of a project. It should also identify how many people are involved in the number of visits which are reported each month by the project. For example, projects now report 150 visits to the dental clinic per month. The question is whether this represents 150 people or only 120 people, 30 of whom are returning for a follow-up visit. The system must also enable the project to identify new patients, as opposed to those already in the service population. Unless the system reports monthly on the number of persons registered at the project (registrants are defined as people who have utilized the services of the program in some form within the past three calendar years) and from the number of new registrants, it will be impossible to determine just how many persons are in the service population at any given time. *

The development and implementation of this system would, we believe, be a difficult task for the central office at the present time. The central office must rebuild its organizational capability to respond effectively to the immediate day-to-day needs of the local projects. It must also respond to all the backlog of unfilled needs that have been identified and have been ignored or responded to inadequately by the past central office administrations. It cannot do all these things and simultaneously develop the reporting system which is required. We suggest, therefore, that the board seek outside assistance to develop and install the system in consultation with the central office and the local projects.

We do not believe that the system will represent a major new burden for the local projects. An appropriate system should add only minimally to the day-to-day reporting tasks of local projects and their staff; they will simply be doing what they now do in a different way. It will, however, enable the projects to utilize the information which they collect in a functional manner for project management purposes and enable them to report more effectively to IHS. The data generated will also provide the statistical base for congressional testimony, and applications to other funding sources.

b. Financial Reports

The CRIHB board of directors is ultimately responsible to HEW for the funds contracted to CRIHB. Similarly, a local project board is responsible to CRIHB for the use of its funds. The monthly and quarterly financial statement must give the board the information necessary to enable it to carry out this responsibility by:

- Giving the board a working understanding of the financial status of the contract, and
- Highlighting potential problem areas so that the board can act to remedy them before they become serious.

The financial statements, such as the one dated June 30, 1974 and submitted to the CRIHB board, is a series of charts and figures, with no text or explanation. For those unaccustomed to fiscal reporting data, the report is virtually incomprehensible save for total figures. The report would be more informative if it contained a narrative which interpreted the data contained in the report and highlighted the key information. The report should also offer alternative actions that the CRIHB board might take to remedy identified problems. }

The report should also contain an early warning system directing the board's attention to emerging problem areas. This can be no more complicated than an asterisk next to the data that indicates that a line item is more than 10% over or underexpended in relation to their monthly allocation. Any local project that is 15% over or underexpended should also include an attachment containing a line item breakdown of that project's budget and present level of expenditures and that project's explanation of the reason for the variance. In this way, the CRIHB board can effectively monitor local project expenditures, and insure that no local project will be over or underexpended at the end of the year.

The report should also indicate whether CRIHB, as a whole, is operating within the line item budget which has been approved by HEW. The entire CRIHB budget is presently subject to a restriction which allows the project to transfer only 5% of a given line item category or \$5,000, whichever is less, from one line item to another without seeking special approval from the contracting officer. While similar provisions do not apply directly to the local projects, CRIHB central office must insure that local projects are not shifting their funds to such an extent that the CRIHB overall budget is modified beyond the authority vested in the project. It is for this reason that we noted in our local reports that local projects must, in fact, operate as though they had a line item budget, and the central office must monitor the local projects budget in that manner. Otherwise the central office cannot keep the entire CRIHB budget within its line item restrictions. If this information is forwarded regularly to the central office, and is properly monitored, the central office can request the necessary approval for modifications from the contract officer in time to assure no repetition of the financial difficulties that have plagued the local projects in the past.

c. The Quarterly Performance Report

The quarterly report is the primary means of communication from the central office to the CRIHB board and to the funding sources. The quarterly performance report for the period of February 28, 1974 through May 28, 1974 is an unorganized compilation of reports, letters, memos--many not written for the quarterly report. The outline format used in it gives only the sketchiest information and does not highlight the information which is most critical for the board, and upon which they should be taking action. A narrative format might be more useful in presenting this information in a usable manner. The report should also contain cumulative information collected from the local projects, based on information recommended in the section in the local project report on "Reporting Systems."

Finally, the report should contain a specific section on activities of the central office in the previous quarter. (We would recommend, in fact, that during the initial months of the new contract year that the central office should report on a monthly basis to the executive committee, so that the committee could closely monitor the services of the office.)

Additionally, the CRIHB board should understand that provision of a quarterly report is part of their contract with IHS. Unless a report is submitted within 30 days of the end of the quarter, CRIHB

is not in compliance with its contract. Furthermore, unless the CRIHB board expressly delegates responsibility for the quarterly report to the central office, a report submitted by the central office, that is not approved by the board, is not an official submission.

Noted below is a preliminary outline which CRIHB might consider utilizing for its quarterly reports:

- A. Problem areas requiring immediate action by the project office or the contract office. The problem should be discussed in depth, and a clear statement of the required course of action by IHS suggested.
- B. Accomplishments of major importance by the central office and/or the local projects should be highlighted.
- C. Services provided by the local projects in the previous quarter should be summarized along with an analysis of the extent to which each individual project is meeting the performance standards which have been established for it.
- D. Activities of the central office in the previous quarter should be summarized; a list of specific requests for service from the local projects should be summarized along with the nature of the service offered by the central office in response to that request; finally, the activities of the central office should be examined in relation to the performance standards set forth for the central office.
- E. Other operating problems requiring CRIHB action which have been identified in the central office and the specific courses of action which are being taken to address these problems. (This need not be included in the submission to IHS.)
- F. Financial report for the quarter (see above).

4. Development of an Overall Funding Strategy for CRIHB

At the present time CRIHB does not have an overall strategy for securing the funds which are required to maintain and expand its program. CRIHB focuses most of its fund raising efforts on the IHS resources which are appropriated by Congress. Local projects have placed a great deal of effort into securing special grants and contracts from local, state, and federal agencies, and to a lesser extent from foundations. Projects are also billing patients directly for services rendered to varying degrees and billing third party sources. An integrated approach to these various funding sources should be developed and responsibility for dealing with those sources clearly placed within the CRIHB central office. A discussion of approaches to each of these funding sources is outlined below: ★

- a. IHS Funds: Over the past several years, in its requests for funds to Congress, CRIHB has continued to present a bleak picture of the health services status of the California Indian. CRIHB has not, in our opinion, made a strong presentation as to the extent to which it has impacted that problem, which generated the CRIHB contract in the first place. In our experience, Congress is far more responsive to needs when they are convinced that the funds which they have appropriated have been used constructively rather than continually hearing about the same problems. We would strongly recommend that CRIHB, in its next Congressional testimony, provide the following information:
 - its accomplishments to date,
 - it plans for meeting the gaps which still exist in health services to the Indian population, and related cost factors,
 - an indication of the portion of the funds supporting CRIHB which come from other federal, state, and local sources and that funds to replace these grants and contracts when they run out must be made available. This approach should enable CRIHB to successfully present its case before the Congress.
- b. State and Federal Grant Programs: In our Interim Report we recommended that the CRIHB central office should assume responsibility for seeking and securing grant and contract funds from agencies other than IHS. We would reaffirm that recommendation. The goals of CRIHB TO provide services to rural Indians in California make it preferable for funds to be channeled through CRIHB, so they can be allocated to areas of greatest need. If the present system is continued, those projects which are

the best grantsmen or have the strongest political connections will very likely continue to secure the lion's share of the funding. This does not take into consideration where the funds are most urgently needed.

- c. Local Funds: In the Interim Report, we recommended that the local projects should be responsible for securing funds from local sources, i.e., revenue sharing, United Way, etc. The central office should, of course, be available to assist any local project which needs help in the development of its proposal.
- d. Foundations: In the Interim Report Rj Associates compiled a list of foundations in the State of California which might offer funding to CRIHB projects. The central office should develop a strategy for dealing with these foundations on behalf of CRIHB.
- e. Third Party Billing and Direct Billing of Patients: Third party funds are one of the most important sources of funding available to CRIHB. Unless CRIHB maximizes its billings, it is unlikely that it will be able to achieve the comprehensive health services delivery system which it seeks. It is particularly important that CRIHB bill non-Indian patients and/or third party sources for services to the non-Indian service population. These individuals are not in the primary service population for which CRIHB was created; while those in need of service should be served, they should be required to pay. (Non-Indian indigents referred to the project should be eligible for Medi-Cal.) When non-Indians enable a project to earn income, this income can then be directed at expanding health services to Indians.

In our General Local Recommendations we have discussed the need for projects to develop a reporting system to account for these funds, and to report their collections to CRIHB. Rj has also recommended that a policy be established by the CRIHB board that all income from third party billings or directly from patients generated through CRIHB funds should be spent for health project purposes.

Summary

If CRIHB carefully plans its strategy for maximizing its resources from these various sources, it should be possible for the projects to continue to expand their services, and for them to be prepared for the major additional resources which are likely to be available in the near future through the Jackson Bill and National Health Insurance.

III. OTHER ISSUES FOR BOARD AND CENTRAL OFFICE CONSIDERATION

A. Training and Technical Assistance

1. CRIHB Training Plan

Throughout our local reports and the General Recommendations to Local Projects, as well as in the Interim Report, we have emphasized the importance of the development of a comprehensive approach to training within CRIHB. The importance of this activity cannot be overstated. The weaknesses which exist in the CHA programs in particular, as well as in other aspects of local project operations, will be resolved only if carefully planned training, followed by technical assistance, is offered. The design of such a training plan, integrating the various resources which have been developed by the local projects, and the capability of the local projects should be an immediate priority of the central office.

2. Use of Technical Resources of the Colleges and Universities

The central office should also establish more formal relationships with the institutions in the community college, state colleges, and the University of California systems, and other private institutions, to insure that CRIHB is taking full advantage of services which they offer.

- Special Clinics - We found different local projects making varying use of some of the services offered by the universities. CRIHB central office should attempt to develop an agreement with the universities that would apply to all relevant projects to utilize these services.
- Health Planning Programs - There are several programs in health planning in the state, particularly the one for Native Americans at the University of California at Berkeley. Students in these programs could be enlisted to perform specific work for CRIHB as part of their field work experience or as part of a special project taken on by the institution.
- Medical Schools - The resources of the medical schools should be tapped. One of the CRIHB projects was using a third-year medical student as a physician's assistant during the summer. This individual was able to provide services similar to that performed by a nurse practitioner. CRIHB should examine the possibility of using medical students from the five medical schools throughout the state in this role during the summer and possibly on weekends, and also explore other ways in which the medical schools might assist the project.

B. Legislative Analysis and Input

The CRIHB central office has, in the past, been particularly weak in its efforts to maintain close watch on legislation at the federal and state levels which impact the program's ability to assure that legislation and regulations are written in such a way that CRIHB can qualify for funding. Developing the capability to monitor legislation, analyzing its impact on California Indians, and influencing its final wording, should be a priority for the CRIHB central office in the coming year.

There are two pieces of legislation of special importance at the federal level which CRIHB should be following right now:

1. Jackson Indian Health Bill, S. 2938. This bill will provide substantial new monies for health services to Indians. As presently written, funds for off-reservation Indians are designated for "Urban Indians." In order to avoid any problems with access to these funds for CRIHB in the future, the language of the pending legislation should be changed to include rural Indians not directly served by IHS.

CRIHB should take immediate action to try to modify these provisions to insure that the California Indians will have the full benefit of this legislation.

2. National Health Insurance. Most of the present National Health Insurance bills do not consider the unique problems of Indians in securing health services. Little has been done by Indian organizations to examine the different legislative proposals and develop an Indian position on the legislation which would take into account their special problems. CRIHB should review the various proposals and, together with other Indians groups, seek to develop a position that takes into consideration the needs of Indians not served by IHS. A strategy should be developed to influence the development of the legislation in a direction favorable to CRIHB local project needs.

C. Future Decisions on Allocation of IHS Resources

In preparing the apportionment of CRIHB funds under the new IHS contract, Rj Associates did not develop a specific formula which could be applied to all future allocation decisions. This occurred for two primary reasons. First, sufficient hard data were not available from CRIHB to enable us to prepare such a formula. Secondly, we realized in the course of our field work that the growth and development of the various projects was proceeding at vastly different rates; a project which had the need among its service population for more funds, might not have the capacity to utilize the funds effectively, and, therefore, the funds should go to another project. We were able to define a number of different criteria which should be considered in the allocation of funds, however, and we believe that these criteria are valid and data relating to them should be developed to the extent possible in the coming year.

These data will make the decision on allocation of funds much easier in the future. A full scale evaluation of all local CRIHB projects should not be necessary. However, we believe that the CRIHB board should consider utilizing the services of an outside consultant to assist in the allocation decisions. Up until this year, allocation has been a difficult problem. With outside assistance the procedure was simplified. For the CRIHB central office to be faced with the task of allocating the funds is likely to place that office in a position where it can only make enemies of some projects. An executive director would be very wise to seek outside help in dealing with such a delicate problem.

IV. CLARIFICATION OF ISSUES IN THE INTERIM REPORT

A. Financial Management

In our Interim Report we recommended that each of the projects should have available on a regular basis an accountant to train the bookkeeper, if necessary, and assist her to prepare an operational budget, develop monthly financial reports and other financial reports required by CRIHB or the IRS. In addition, we recommended that a financial management specialist be made available, preferably by the Indian Health Service, to assist local projects to be sure that their books were in order, to establish operational budgeting and financial reporting systems, and to identify and orient a local accountant. We would like to reinforce this recommendation in this Final Report.

As CRIHB grows more complex, its financial problems become more complex. It is imperative that the projects have a workable financial management system. Some of the projects have good systems, but we believe that a review of their operations would still be useful. The consultants did not conduct an audit, but the system of accounting was reviewed and the effectiveness of its operations discussed with the project directors. Below we have categorized the different projects in terms of our assessment of the need for financial management assistance. The projects have been placed in three groups. Group A should have assistance first, then Group B and finally Group C.

Group A

Hupa Valley
Northern Sierra
Round Valley
United Indian Health Service

Group C

Central Valley
Mendocino
Modac-Lassen
Riverside-San Bernardino
San Diego
Sonoma
Tuolumne

Group B

Lake County
Northern Valley
Shasta-Trinity Siskyou
Tri-County
Tule River

B. CRIHB Insurance Programs

In our Interim Report we indicated our concern that the CRIHB insurance program was not adequate to meet the requirements of the project, that some of the local projects seemed to be duplicating insurance that was already being

carried by CRIHB central, some projects seemed to be paying too much for their insurance, while others seemed to be paying too little. Since that report, a review of the insurance program has been undertaken in the central office and we trust that it will now be clear to CRIHB exactly what insurance it has, what the local projects have, and whether each project is adequately, but not excessively covered. Let it be clear that we were not recommending that CRIHB change insurance carriers, that is a decision for the CRIHB board. If the present carrier is offering good coverage, at a good price, with good service, then there would be no reason to change. However, in the absence of the ability of the central office to indicate to us just what insurance coverage the projects had; in the face of situations such as the Round Valley project not knowing the status of its insurance claim, although the insurance agent had a check for \$16,000 that the project did not know about it; the fact that some CHA's had no automobile coverage; the fact that local project insurance costs for some projects seemed very high and some very low; the implication that some projects did not have proper coverage for malpractice and liability; the fact that staff people were being told by Blue Cross that they were not covered even though the project had been paying premiums; for all these reasons we raised the question concerning insurance. We trust that our having raised the insurance issue has resulted in the clarification, which is obviously necessary. That as CRIHB enters the new contract year, it will have adequate coverage in all necessary areas, and an effective system for checking.

C. Subcontract between CRIHB and the Local Projects

We recommended in the Interim Report that CRIHB should subcontract between itself and the local projects in order to clarify the obligations of the local projects to CRIHB, and the obligations of the CRIHB Central Office to the local projects. We would reaffirm this recommendation. We believe that subcontracts will help to clarify the relationships between the parties and eliminate some of the confusion which has characterized central office and local project relations in the past. It will also protect projects that are in compliance from being subject to controls placed on projects that are not.

D. Contract Officer

We recommended in our Interim Report that CRIHB consider requesting that IHS name a contract officer who would be responsible for all IHS Community Development projects, or in the alternative ask for the CRIHB Contract Officer to be located in the San Francisco Regional Office of HEW. When that recommendation was made, we had not had the opportunity to meet with the present Contract Officer. Having had that opportunity and considering the pros and cons of changing Contract Officers, we would like to change our recommendation. We recommend that CRIHB retain the present Contract Officer.

There have obviously been problems in CRIHB's relations with the Contract Officer, most obviously on the issue of equipment. However, with the staff changes in the Central Office, and the willingness of the Contract Officer to work out mechanisms which will enable her to respond more quickly to CRIHB requests, we believe that problems of the past can be resolved with the cooperation of the present Contract Officer. To have to teach a new Contract Officer the intricacies of CRIHB would be a most time-consuming task, and CRIHB would likely suffer from the process.

We would remind the Board here that the Contract Officer has indicated her willingness to secure an advance of funds for the project, if the new proposal is available in sufficient time.

E. Purchasing Systems

In the Interim Report we recommended that CRIHB establish a centralized system of purchasing in order to cut the cost of many items. We still believe that such a system can work effectively for many items needed by the project. It may well be that more than one vendor is needed for some items to insure availability and respond to the geographical dispersion of the projects; however, being able to negotiate for bulk purchases is obviously a financial advantage.

In so far as equipment is concerned, we believe that the projects should be able to utilize vendors near their own location, if that vendor is going to also provide the needed maintenance for the equipment. Having good maintenance service available is critical to continued service delivery and a reasonable trade-off for extra dollars that might be saved by purchasing centrally. Local purchasing of equipment can also be an important source of good will in the local community.

We also found that some projects were making excellent use of GSA contracts to purchase certain items, while others were not. Being able to purchase at GSA prices can save substantial funds for both the project and its consumers. For example purchasing glasses at GSA prices can save about 50% of the cost to the consumer. CRIHB should work out a system where each of the projects has its own GSA purchasing number, or if this is not possible, where CRIHB itself can enable the local projects to purchase through the CRIHB GSA number.

F. Equipment Purchase

At the present time there is no system for reviewing local project requests for equipment in the CRIHB Central Office. As a result projects are purchasing equipment that may be more expensive than is necessary, or not mandatory for the specific service which they wish to deliver.

In order to insure that equipment purchased by local projects is both needed and being secured at the best possible purchase price, we would recommend that a technical review committee be constituted including a project director, a project Dentist and/or Doctor and an outside technical consultant, who probably could be secured voluntarily. The committee would review only major invest-

ments in equipment. We would suggest that the criteria for items to be reviewed by the committee be single items valued at more than \$1,000 or a combination of different items required for a specific purpose whose total value is more than \$1,000. By using this criteria the committee will not become simply another hurdle over which all projects must go on all equipment requests, but rather a source of guidance to projects when they are about to make major investments of resources. When the wrong equipment is purchased it cannot be returned, therefore we believe that it is worthwhile to take the little extra time to review the need. This review would also help to justify the need for major equipment items to the Contract Officer when the request is finally forwarded.

We recognize that adding this level of review will require the project to plan for the purchase of specific items of equipment further in advance. But such planning, as we have mentioned earlier, is necessary and should in fact be considered mandatory by the local projects, and the CRIHB Central Office.

G. Board Training

As we have said previously the operations of the CRIHB Board have improved substantially during the period of the evaluation. There remain, however, a variety of areas where the Board should have training, and we hope that the Board will take action to provide itself with those services. Specific areas where assistance is needed are:

1. Communication and Decision Making
2. Financial Management
3. Reporting Systems and their Utilization and Importance
4. Health Planning and Health Delivery Systems
5. Monitoring Local Project Performance

H. The Capability of Local Project in Specialized Areas

In our Interim Report, we recommended that CRIHB should begin to utilize the talent and knowledge of its project directors to a much greater degree. Since that time, two meetings of the directors have been held to seek resolution of common problems of the projects. We anticipate that such meetings will continue to occur in the coming months as the central office seeks to develop an operating system which is responsive to the needs of the local projects. As it begins to organize its own activities, the central office should be aware of the significant expertise in specialized areas which is available in the various local projects and their staffs. Listed below are examples of areas of special expertise in some of the projects which we believe would be helpful to other projects in the coming year.

1. Mendocino County: Development of fixed and mobile dental units; design and implementation of extensive training programs for dental para-professionals.
2. Sonoma County: Utilization of the Peg Board system and systematized record keeping.
3. Round Valley: Utilization of nurse practitioners to deliver primary medical care.
4. Tri-County: Manual for CHA activities and a home health guide for mothers and infants.
5. Modoc-Lassen: Data system for measuring improvement in health levels of the service population.
6. San Diego: Fund raising with foundations and local private and public organizations.
7. Riverside-San Bernardino: Development of a complex health services delivery system.
8. Shasta-Trinity-Siskyou: Identification of sources for financing health services.
9. United Indian Health Service: Coordination of multiple sources of funding; development of a sophisticated training system for CHA's relationship with other local health, welfare, and county agencies.

10. Central Valley: Use of performance criteria to measure project performance and application of an operating budget to financial management; development of close working relationship with other local agencies.
11. Northern Valley: Utilization of part-time CHA's in remote areas with limited population.
12. Hupa Valley: Development of federal administrative and congressional relationships.
13. Tule River: Utilization of volunteer doctors for screening clinics.

These are only some of the most outstanding programs being operated by local projects. As a need is identified by one project, other projects should be polled to determine if other projects have addressed and found solutions to the same problem.