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IHS Alcoholism/Substance Abuse Prevention Initiative

Indian Health Service, Rockville, MD.

DJ. Youtz

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THE IMPACT
OF IHS
TRIBAL
EVALUATION
CONTRACTS

A REPORT
DHEW - HSA 78-54 (8)
September 1978
D. J. Youtz, Contractor
THE IMPACT OF
IHS TRIBAL EVALUATION CONTRACTS

A Report of Five Case Studies

Dorothy Jane Youtz, Contractor
September 1978
DHEW - HSA Contract No. 78-54 (8)
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Sincere thanks is expressed to Ms. Bertha Jennings for her preparation of the cover and title page, and to Ms. Billie Callahan who was responsible for travel arrangements, typing and reproduction.

September 10, 1978
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PURPOSE AND METHOD
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Purpose

The purpose of this evaluation is to determine the impact of Tribal Evaluation contracts on the subject program and on Tribal management capabilities, and to identify some factors that influenced these outcomes.

Program evaluation has been an important component of the Indian Health Service (IHS) program from the time of the transfer to the Public Health Service. The outside comprehensive assessment of Indian health needs and delivery problems was arranged in 1956—a baseline study that became the basis for future program planning and evaluation.

In fiscal year 1971 a formal evaluation strategy was initiated, and professional studies were performed of various aspects of the service program. This was consistent with the amendment to the Public Health Service Act authorizing 1% of the appropriations for evaluation studies. A major IHS goal has been to directly involve Indian consumers in the planning and evaluation of the health services provided to them. In fiscal year 1973, the evaluation program was expanded to incorporate evaluations by tribal evaluation organizations (TEO's). Forty contracts have been made with the TEO's since 1973 at an approximate cost of 1.8 million dollars.

Passage of P.L. 93-638 in 1975, the Indian Self-Determination and Education Act and P.L. 94-437 in 1976, the Indian Health Care Improvement Act, provided a framework within which the Indian people will be enabled to design and administer their own health and medical care programs. P.L. 94-437 requires "the maximum participation of Indians in the planning and management" of health care services be encouraged. With such a mandate, the IHS expanded its joint efforts with Indian consumers. Since 1975, 134 tribes or Indian organizations have been directly involved in P.L. 93-638 contracts and grants, and "approximately 70% of the Indian Health Service population has been affected either directly or indirectly."

To date there has not been any assessment of the effectiveness of contract evaluations by TEO's.

Method

Within the resources and time available it was determined that no more than five case studies could be undertaken.

The selection of the five TEC's as case studies was based on the following criteria:

- Differing subjects and purpose for the TEC
- Differing Indian Health Areas; geographic location, location and characteristics of tribes served, type of health delivery services provided
- Differing characteristics of the contractor organization
- Differing size of the contract payment
- Availability of the TEC project officer

In addition, sufficient time for some implementation should have elapsed following the completion of the TEC.

For each of the five tribal evaluations the headquarters contract files were reviewed to determine any actions that had been anticipated as a result of the contract when it was issued, and as might be reported.

Indian health headquarters staff knowledgeable and concerned with follow-up activity were contacted to learn of any evidence of implementation of the TEO report findings.

Approximately one week was spent in each Area concerned in obtaining information as to the effect of the tribal evaluation on the program and on tribal organizations concerned with the evaluation.

In each Area an oral report of findings was made at the close of the case study. Comment and recommendations were collected.

Oral reports of the findings of each study were made to selected IHS headquarters staff. Draft reports were circulated for headquarters comment. Following headquarters review and comment, the final study reports were prepared.
SUMMARY OF FINDINGS AND RECOMMENDATIONS
SUMMARY OF FINDINGS AND RECOMMENDATIONS

Since its initiation in 1973, the Indian Health Service Tribal Evaluation Program has had twin objectives: to generate data that will improve the health care for Indian beneficiaries and to contribute to the capability of Indian people to manage their health care system.

This study sought the evidence of change that resulted from five tribal contract evaluations in accordance with these objectives--program improvement and enhancement of tribal management skills.

The five evaluations studied represented wide diversity; three contracts were with authorities responsible to a single tribe, two were with Indian Health Boards with multiple constituents; four contracts were carried out by employees of the tribal contractor--one was performed by a subcontract with a University. Evaluation subjects and objectives were different. Contracts ranged in size from $24,000 to $230,000, and for a period of less than a year to three years. The IHS Area project officers were a physician, a social worker, two program planning officers and a planner for a community development.

Reports of all studies had the required distribution and some were widely disseminated. One study has been published and has been requested internationally.

The two tribal evaluations that reflected specific management and program needs by the contracting tribe produced reports which have been used extensively. The three tribal evaluation contracts that were directed toward guiding IHS policy and improving the IHS delivery of medical care services did not have any known effect on IHS operations, and no use was found for the findings and program implications for IHS Area operations that were reported in a fourth tribal evaluation. However, many recommendations to the IHS have been implemented--but not because of the respective tribal evaluations.

This study focussed attention on the unrealized benefits that might be realized from the five tribal evaluations and several actions have been initiated for use by Area staff and for tribal follow-up.

The difficulties experienced by tribal members and organizations with the completion of the tribal contract evaluation led to a greater understanding of management principles and organizational requirements, e.g., members of a Board of Health should not have a conflict of interest in health programs; program supervision required regular evidence of program accomplishment and accountability by its employees. A Board needs staff support if it is to make good decisions and to follow-up resolutions and directives. In order to be useful, contract findings must be translated into laymen's terms and include a summary of the implications of the data for program action.
RECOMMENDATIONS

Based on the findings of this case study, the following actions are recommended to make future IHS Tribal Evaluations more useful:

1. The evaluation contract guidelines should be revised to increase the use of such studies—(e.g., criteria for subject evaluation, study design, area program review).

2. The procedures for IHS monitoring revised to provide for routine "feed back" and follow-up of evaluation reports.

3. Technical assistance should be provided in each IHS Area, to encourage interest in tribal evaluations as a program and management tool; to focussing attention on the opportunities and lessons from previous tribal evaluation contracts; to sharpen area capabilities for assisting tribes to benefit from tribal contract evaluations.

4. The Director of the Indian Health Service should provide for discussion of the use of contract evaluation as an opportunity for improving health services with the National Indian Health Board. Through the National Board this understanding could be communicated with State and local Indian Health Boards.

5. A current digest of IHS evaluation reports—the methodology, principle findings and recommendations—should be made available to the Areas and tribal representatives on a regular basis, so that there will be greater opportunity for sharing the evaluation among areas and tribes concerned.
BACKGROUND
The Indian Health Service (IHS) is the primary health resource for approximately 700,000 Indians and Alaska Native people living on or near Federal Indian reservations or in traditional Indian country such as Oklahoma and Alaska. It provides a comprehensive program of preventive, curative, rehabilitative and environmental services. Under P.L. 94-437, the Indian Health Care Improvement Act, the Service may also provide limited assistance to approximately 500,000 urban Indians to enable them to gain access to those community health resources available to them as citizens.

The IHS goal is to elevate the health status of Indians and Alaska Natives to the highest level possible. Its mission is two-part: the first, to assure the availability of comprehensive health services in pursuit of the IHS goal. The second, pursuant to P.L. 93-638, the Indian Self-Determination and Education Assistance Act, and P.L. 94-437, is to provide opportunities for Indian management and operation of IHS health programs. The IHS also acts as the principal Federal health advocate for Indian people by assuring that they have knowledge of, and access to, all Federal, State and local health programs to which they are entitled as American citizens.

Concurrently, the Service works with the Federal, State and local programs with information regarding the entitlements of Indian people as citizens.

The passage of P.L. 93-638 and P.L. 94-437, culminates almost a decade of effort by the IHS and the Indian people to establish a framework within which the Indian people can effectively decide their role in health programs.

In the late 1960's, the IHS began to accelerate the process of Indian involvement in their health program decisions. In response, the Indian people, developing their own health boards and other tribal entities, began to play an increasingly greater role in the development, operation, and evaluation of three hospitals, and over one hundred health stations by Tribal organizations. Today, almost all tribes are providing some of their own health services under contract with IHS, and most are operating major health programs such as Community Health Representative programs and Native Community Health Aid Programs in Alaska.

The Indian Health Service program provides direct health services to American Indians, Eskimos and Aleuts through 50 hospitals, 99 health centers (including 23 school health centers) and several hundred other health clinics. These facilities provide as complete a range of health services to Indian communities as is possible. The IHS program includes a preventive health component consisting of sanitation, dental care, public health nursing, health education and field medical programs, such as mental health, alcoholism, eye care, public health nutrition, and social services.

* Taken from the Justification for the Appropriation to the Indian Health Service for the Fiscal Year 1979.
Contract care is used to supplement and complement other health care resources available to Indian people. Contractual agreements are made with private physicians and clinic groups, dentists, providers of ancillary health services and with state and local health departments.

Substantial progress has been achieved in coping with the health problems of the Indian people. However, in spite of the improvements made over the past two decades, the health status of the Indian people continues to lag behind the general population. The following ratios for Indians compared to the U.S. all races, gives some indication of the disparities still remaining.

| All causes of death                      | 1.3 |
| Infant deaths                            | 1.3 |
| Accidents                                | 3.7 |
| Influenza and pneumonia                  | 2.2 |
| Cirrhosis of liver                       | 5.1 |
| Homicide                                 | 2.9 |
| Diabetes                                 | 2.1 |
| Suicide                                  | 1.9 |
| Tuberculosis                             | 7.7 |

This disparity is accompanied by a large backlog of unmet health needs. P.L. 94-437 provides the mechanism through which these unmet needs can be eliminated and health levels raised. It is the stated intent of Congress that at the end of the seven year period covered by the Act, the Indian people should enjoy health levels comparable to those of the general population, with quality of service equal to that enjoyed by other Americans and health programs in place which will be able to sustain these achievements.

Many Indian families lacked the financial resources to acquire safe water supply and an adequate means of waste disposal. In 1959, Congress enacted the Indian Sanitation Facilities Act. This Act enabled the Indian Health Service to undertake cooperate projects with Indian tribes, bands and groups, to construct and provide essential sanitation facilities, including water supplies and waste disposal facilities for Indian homes and communities. Through 1976, over 2,330 sanitation facilities assistance projects have been undertaken.
An important element in this effort to improve the environment of Indians has been a cooperative agreement entered into with the Indian housing programs of the Department of Housing and Urban Development and the Bureau of Indian Affairs. Under this agreement the Indian Health Service provides sanitation facilities and/or technical assistance leading thereto, for new and improved homes constructed through the housing agencies. The needs of existing homes adjacent to housing project sites are also served as part of this effort.

The first community development projects were contracted in FY 1973. At that time $632,000 was appropriated to 16 tribal groups to organize health boards, provide training and outreach and other developmental activities and to facilitate self-determination. In the ensuing years a broad cross section of clinic development programs, outreach programs, sanitation maintenance organizations, health authorities and other activities were carried out. In FY 1978, $2,987,000 was appropriated to fund approximately 100 tribal community development projects.

The Community Health Representative (CHR) Program has increased opportunities for Indian participation and assisted in providing health care since 1969. Services provided by CHR's include transportation services, health education, and direct intervention in disease processes. The CHR program has grown from 167 positions and $500,000 a year in FY 1969 to a program which, at the end of FY 1977, employed 1,718 Indian Community Health Representatives. The Indian Health Service has 156 CHR contracts with 168 American Indian, Eskimo and Alaska Native groups in 24 states.

The Community Health Medic training program was developed in the early 1970's and parallels the development of physician extender programs. The concept was to develop health career opportunities for ex-medical corpsmen from the Armed Forces and other health professionals (RN's, Laboratory Technologists, etc.) for and with Indian people. 106 CHM's have been trained since the first class started in February, 1971.
SYNOPSIS OF FINDINGS IHS EVALUATION CONTRACTS
The purpose and objectives of this contract to evaluate the health problems facing the elderly Indian population, in order to formulate a comprehensive program of services were met. The Laguna Tribal Planning Commission has documented plans for a tribal multi-purpose agency. The multi-purpose agency will be built in modular style to accommodate the services for the first priority which is the elderly care and 24 hour housing apartments. 

To evaluate the overall health needs of the elderly through the identification of problems and the development of alternative solutions, projected costs and comparative savings.
SYNOPSIS OF FINDINGS

I. Evaluation of Elderly Health Needs on the Laguna Reservation - a contract with Pueblo of Laguna, contract number HSA-242-75-0075 for $24,000

A. Dissemination of Findings

An oral presentation was made to the Laguna Tribal Council, and copies of the report were distributed to each member of the Council, to IHS Area and Service Unit staff concerned, to IHS Washington Office and was put in the Albuquerque Area Office Library.

B. Program Impact

Evaluation findings were used by the Tribe as evidence that aged Laguna Indians would elect to live in group facilities for senior citizens, if available. This evidence was sufficient for BIA to support an award from HUD for construction of housing for the aged. Construction is reported to be under way.

The findings of the evaluation were the basis for the tribe's securing a transportation van, and are being used as justification of requests for additional vehicles.

The evaluation report is the foundation for a Tribal plan for the care of the elderly. IHS Area staff provides support for a number of tribal committees concerned with implementing this plan, and IHS Staff have prepared an operational plan including staffing requirements for the geriatric center under construction.

C. Effect on Tribal Management

Evaluations were found to be useful tools for program implementation. The Tribal Council delegated health program policy and management decisions to a special committee.

D. Potential Benefits

IHS could modify the delivery of health services for the aged so as to be more acceptable and effective--as indicated by the Evaluation Report.

A pamphlet is to be prepared describing the Laguna Tribe's comprehensive health program for the aged for distribution at the IHS National Conference on Aging, August 1978.
E. Influencing Factors

The tribal organization was established and had a specific management need for data to be obtained by the evaluation.

The project officer had program knowledge and professional interest in the evaluation subject, and is a respected long-time Area staff member.

The contractor had an incentive for making the report useful so that it could be replicated for other Pueblo tribes.

There has been national interest and resources available for improving services to the aged.

F. Method and Persons Interviewed

The subject file in the Washington IHS Office was reviewed and selected IHS program staff were contacted for knowledge of follow-up of the Evaluation.

The week of May 22-26, 1978 was spent in the Albuquerque Area reviewing files and talking with those staff suggested as persons who had a concern with the implications of the contract evaluation.

Interviews were arranged with representatives of the Albuquerque Service Unit Health Board, the All Indian Pueblo Council, the Laguna Tribal Office, and the Hospital Director of the Acoma/Canoncito/Laguna Service Unit.

Individuals interviewed included:

Mr. Will Frazier, Deputy Director, AAIHS
Ms. Vesta Starkey, Project Officer
Mr. Terry Housken, Chief, Sanitation Facilities, Const. Branch
Mr. George Fries, Chief, Facilities Management Branch
Mr. Delphin Calabaza, Executive Secretary, Albuquerque S.U. Health Board
Mr. Eusebio Toya, Albuquerque Service Unit Board
Ms. Marie Bradley, Albuquerque Service Unit Board
Mr. Roland Johnson, Asst. Area Director, B.I.A.
Mr. Jim Toya, All Indian Pueblo Council, New Mexico Intertribal Health Authority
Mr. Nicholas Redeye, Hospital Director, Acoma/Canoncito/Laguna Service Unit
Mr. Ken Hunt, Laguna Tribal Health Activities
Mr. Ken Wells, Laguna Tribal Health Activities
Mr. Tom Dailey, Director, Planning Commission, Laguna Tribal Office
Mr. Don Montoya, Housing Authority Laguna Tribal Office
Ms. Helen Fazio, IHS Portland Area Contract Officer
Ms. Margaret Lloyd, Chief, Health Records, IHS
Persons present for the presentation of these case study findings in the office of the Albuquerque Area IHS Director, May 26, 1978:

Mr. Will Frazier
Mr. Harold Savage, Chief, Office of Program Planning and Evaluation
Dr. Robert Vanderwagan, Program Director
Mrs. Helen Fazio
Mrs. Vesta Starkey

An oral presentation of findings was made to the IHS Headquarters staff concerned, June 5, 1978.
To ascertain the appropriate balance of preventive and curative health services in the Navajo Area Indian Health Service. To determine the current level of preventive care programs and their impact on mortality and morbidity rates and on clinical time. To design and develop a plan to allocate resources which effectively and efficiently address both preventive and curative health care modalities.

The proposed health program evaluation will result in a total profile of services provided by IHS and other delivery systems to the Navajo citizen. With the data acquired in a total system evaluation, the program planning process in the Navajo Area IHS can be designed to build upon the strengths and correct the deficiencies which will be identified in this evaluation.
II. Navajo Comparative Health Services Evaluation - a contract with the Navajo Health Authority, contract number HSA 245-75-0267 for $211,200

A. Dissemination of Findings

Oral presentations of the evaluation summary were made in Navajo to each of the 41 participating tribal chapters. Copies of the reports were distributed to the participating service unit, copies were sent to the Navajo Health Board, and multiple copies were made available to the Navajo Area office and to the IHS Washington office.

B. Program Implementation

The Evaluation report was used by the tribe as the basis for the State HSA Plan. It is the principle resource for the development of the Navajo Master Plan. Evaluation findings justified a demonstration transportation grant, and contributed to the decision to improve the road to Kayenta. As a result of the data reported, two positions were authorized by the Tribe for radio media health education.

One IHS Service Unit responded to the Evaluation findings with aggressive program measures to correct deficiencies revealed and used the report for training their community health representatives.

C. Effect on Tribal Management

Funds for the Evaluation enabled the Tribe to build an experienced research staff. The capability for enumerating the Indian population of the reservation has been recognized by IHS and State authorities.

D. Potential Benefits

IHS Area staff could use the perceived problems of the Service Unit staff and other IHS medical care providers as a basis for improving the delivery of health and medical care services.

- IHS Service Units other than Kayenta could use the Evaluation report to improve services and in the orientation of new service unit staff.

- Findings of the study might contribute to the justification of a request for funds to meet the unmet health needs.

- IHS Headquarters staff could make the enumeration methodology developed in the Evaluation available to other tribes with population definition problems.
E. Influencing Factors

The Tribe had an established, motivated research component of high quality which was related to ongoing planning and tribal service programs such as health education.

The study staff sought and used the technical advice of the foremost authorities to guide their population enumeration and questions.

Many IHS Area staff were unaware or indifferent to the Evaluation findings and conclusions.

F. Method and Persons Interviewed

The subject file in the Washington IHS office was reviewed, and selected IHS program staff were contacted for knowledge of follow-up of the Evaluation. The week of May 15-20, 1978 was spent in the Navajo Area with those staff who were suggested as persons concerned with the implications for follow-up. Prearranged visits to the Service Units of Crownpoint, Kayenta and Fort Defiance were made, and at each location the acting Service Unit Director (SUD), and other staff as indicated, were contacted. Where possible local Tribal Chapter representatives were visited.

Discussions were held with staff of the Navajo Health Authority, the Executive Staff to the Health, Alcoholism and Welfare Committee of the Navajo Tribal Council and the Navajo Area Health Board, Office of Health Planning and Implementation, Navajo Health Systems Agency and Division of Health Improvement Services.

Persons present for the presentation of findings in the office of the Director of the IHS Navajo Area, May 19, 1978:

Marlene Haffner, M.D., IHS Navajo Area Director
Peter Nakamura, M.D., Asst. Area Director
Philip May, PhD., Project Director, Navajo Health Authority
Mr. Irvin Harrison, Executive Officer to the Navajo Area Health Board
Mr. Will Stapleton, Project Officer, Chief OPPAS, NAIHS
Edward Helmick, Chief, OPEL, NAIHS

An oral presentation of findings was made to the IHS Headquarters staff concerned, June 5, 1978.
To review the patient transportation system at each service unit within the Billings Area and develop and present various alternatives for providing the most efficient and effective transportation system to those Indian people seeking and obtaining health care at Indian Health Service facilities or referral to contract health service facilities.

Based on the findings of this study, a specific patient transportation policy will be formulated and implemented in the Billings Area. The study will also provide general guidelines for transportation policy development in other service areas.
III. Evaluation of Transportation for Health Services for the Blackfeet, Fort Belknap and Rocky Boy's Reservation - a contract with the Blackfeet Tribal Health Board, Contract number HSA 244-75-0159 for $50,000

A. Dissemination of Findings

Copies were forwarded to the Washington IHS Office. Technically, the contract is still not completed. No distribution was reported.

B. Program Impact

No evidence found.

The experience with this contract contributed to the establishment of revised reimbursement and accountability procedures for contracts with Indian tribes.

The need for IHS to provide technical help and training to assist the tribes in carrying out contract evaluations was defined.

C. Effect on Tribal Management

The experience with this Evaluation contract led to the appointment of a new Board of Health whose members did not have a conflict of interest in health program responsibilities.

The function and responsibilities of the Board of Health were defined, including the requirement to supervise and monitor contract activity.

Members of the Tribal Council and the Health Board became aware of the need to employ persons with the special skills and experience that are required to perform an assignment.

D. Potential Benefits

The establishment of a single policy and a plan for the use of IHS for scheduling of transportation services would extend the benefits of these resources to Indian health.

IHS could give leadership to the development of improved communication and transportation resources for remote communities, (e.g., shared systems with BIA, Forest Service, etc.)

E. Influencing Factors

Political conflict and lack of continuity by the Tribal Council.

A newly established Board of Health and Tribal Health Department with evolving definition of roles and staffing requirements.

Multiple responsibilities of the original Area Project Officer and a reassignment after his transfer to another Area contributed to delayed and intermittent monitoring and assistance.
F. Method and Persons Interviewed

The subject file in the Washington IHS Office was reviewed and selected IHS program staff were contacted for knowledge of follow-up of the Tribal Evaluation Report.

The week of May 8 to 13, 1978 was spent in the Billings Area with those staff suggested as persons who had a concern with the implications of the Tribal Evaluation Study.

Discussions were held with persons in the Blackfeet Service Unit; The Service Unit Director; Director of the Tribal Health Department and one of his staff, members of the Blackfeet Tribal Health Board; the Tribal Council including the Treasurer and the Lawyer for the Council.

Persons present for the presentation of findings in the office of the Billings IHS Area Director, May 12, 1978:

Ms. Jerry Adams, Grants Management Specialist
Mr. Harvey Lich, Area Program Planning and Statistical Officer
Mr. Bob Lafromboise, Assistant Area Director, Indian Community Health Development Programs

An oral presentation of findings was made to the IHS Headquarters staff concerned, June 5, 1978.
To evaluate health services supplied by County Health Departments to the Indian people of the Portland Area.

Many people from Tribes, Service Units, and Counties noted inaccuracies in the number of Indians to be served. The list of services to be provided according to the contract rarely describes the programs currently being offered by Counties. By reviewing the annual statistical reports, it appears that one could find Counties where either some service specified by the contract has not been performed, or was not reported to Indian Health Service as is also required. The funding for many of these programs does not include that needed for case finding, administration, and other personnel support. This study should provide the Portland Area Indian Health Service with a better understanding of the contractual relationship with a Health Department and a basis for evaluating service contracts with County Health Departments.
IV. **Evaluation of Health Services Supplied to the Indian People of Portland Area by County Health Departments under contract with the Indian Health Services** - a contract with the Northwest Portland Area Indian Health Board, contract number HSA-248-75-203 for $40,960

A. Dissemination of Findings

Report distributed to the members of the NWPAIHB.

Copies were forwarded to Portland Area Office, to the Service Units concerned and to the Washington Office.

B. Program Impact

No evidence of change in procedure or program as a result of the Evaluation was reported.

Although the contract evaluation is not considered as an influencing factor, almost all the recommendations of the report have been implemented. Two are considered potential benefits. The judgement of the Area Director is that "any good derived from this evaluation is outweighed by the bad."

C. Effect on Tribal Management

The negative repercussions of this evaluation led to the replacement of the Board's Project Officer and the difficulties experienced with the supervision of the evaluation by the Director of the Board of Health contributed to his dismissal. Replacement staff were selected on the basis of professional qualifications and perceived willingness to serve the Board and the Indian people it represents.

D. Potential Benefits

Indian people could have greater benefit from contract county health services if at least semi-annual meetings of tribal representatives, local health department staff and the Service Unit staff concerned were held to discuss health program problems and priorities.

There would be great advantage in establishing a more accurate estimate of Indian population residing in the local health department service areas. The number of Indians eligible for service is the basis for contracts and health program plans, and the U.S. Census number is recognized by IHS and the county health officials as under-enumeration.

The knowledge and skills in planning and evaluation that may be gained by Indian participants in local health department contract review should contribute to the effectiveness of Indian consumer participation in the development of a Tribal Specific Health Plan and that for their HSA.
E. Influencing Factors

Difficulty with the personal inter-action between the Board's Project Director and IHS and health department staffs generated barriers to the acceptance of the Evaluation Report.

The persons who were closely associated with this contract evaluation—the IHS Project Officer, contract staff concerned, and the Board's Project Director—are no longer concerned with the report and its follow-up.

The Washington State requirement for IHS to contract for local health department services with the State Health Department have changed so that agreements are now made directly with the respective local health departments.

IHS changed its policy from the shifting from direct services to indirect services through contract wherever possible to the replacement of contract services by IHS nursing and environmental staff.

F. Method and Persons Interviewed

The subject file in the Washington IHS Office was reviewed, and selected IHS program staff were contacted for knowledge of follow-up of the Evaluation.

The week of July 10-15, 1978 was spent in the Portland Indian Health Area with those staff who were suggested as persons knowledgeable of the Tribal Evaluation Contract and any follow-up actions taken as a consequence of the study.

In the Portland Area Office discussions were held with the Area Director, the Assistant Director for Planning and Evaluation, the Nurse Consultant and the Contract Specialist.

A meeting was held with the Evaluation Coordinator and other staff of the Northwest Portland Area Indian Health Board.

Field visits were made July 12, 13, 14, to county health departments and tribal representatives in the Puget Sound Service Unit in Seattle, Washington. The Service Unit Director, Mr. William A. Murdock, accompanied the writer for discussions.

Persons interviewed included:

Dr. C. S. Stitt, Jr., Director, Portland Area Indian Health Service
Mr. Al Cayous, Asst. Area Director, Planning and Evaluation, Portland Area Indian Health Service
Ms. Alice M. Haggerty, Nursing Specialist, Portland Area Indian Health Service
Mr. Ronald Popkin, Special Assistant for Environmental Concerns, Portland Area, Indian Health Service
Ms. Marlys Lamkin, Contracting Specialist, Portland Area Indian Health Service
Ms. Felecia S. Hodge, Executive Director, Northwest Portland Area, Indian Health Board and members of her staff
Dr. J. V. Deshaye, M.D., DPH District Health Officer
Thurston-Mason Health District, Olympia, Washington
Ms. Polly Van Alstein, RN, Thurston-Mason Health District
Ms. Francis Mills, RN, Thurston-Mason Health District
Ms. Maye Whitener, Community Health Representative
Supervisor, Olympia
Ms. Anne Pavel, Chairperson & CHR Supervisor, Kitsap County Health District, Skokomish Tribe
Dr. Willa Fisher, M.D., MPH, Director of Health
Bremerton-Kitsap County Health Department
Bremerton, Washington
Ms. Helen McCann, Public Health Nurse Supervisor
Bremerton-Kitsap County Health Department
Ms. Dorothy George, Community Health Representative, Port Gamble Branch of Challam Indians, Kingston, Washington
Ms. Thelma Fulton, Community Health Representative, Port Gamble Branch of Challam Indians, Kingston, Washington
Mr. Charles Deam, Community Health Representative
Squamish Tribe, Squamish, Washington

At Puget Sound Service Unit Meeting:

Ms. Mildred Ikibe, Community Health Representatives
Mr. Longie Kalama, Nisqually Tribe

Persons attending the presentation of findings in the Portland Area at the final meeting were:

Mr. Al Cayous
Mr. Ron Gilbert, Assistant Area Director, Quality Assurance
Mr. William Picotte, Assistant Area Director, Operations

An oral presentation of findings was made to the IHS Headquarters staff concerned, July 31, 1978.
To evaluate current effectiveness of services for selected ambulatory medical problems to analyze and interpret effectiveness data and make recommendations, to plan a follow-up evaluation after recommended changes have been made, to continue the development of techniques and methodologies to bring Native consumer involvement in health care evaluation to the highest possible level.

The results of this study will assist the Alaska Area Native Health Service in establishing standards of clinical problem solving for the most common outpatient problems. The data from this study can provide the basis and guidelines for ongoing monitoring and evaluation of health service programs. Insight will be gained as to the techniques of criteria development, conduct of record audits, and utilization of evaluation results. The ultimate objective is the development of a practical manual mechanism for quality assurance for ambulatory health care for Alaska Natives.
VI. Evaluation of the Quality of Medical Care Provided to Alaskan Natives - a contract with the Alaska Native Health Board, contract #HSA 243-75-0358 for $133,000

A. Dissemination of Findings

Status reports were made periodically to the Alaska Native Health Board (ANHB) and to the providers in each medical facility studied. Copies of the two reports were distributed widely by the IHS Area Office of Patient Care Services—including Area Office staff and multiple copies to all Service Units. Project staff distributed copies to State Health Department Officials, officials of the Southeast Alaska Native Health Corporation and to selected consumers and providers. Copies were forwarded to the IHS Washington Office.

Oral presentations of findings were made to the ANHB, to the Washington IHS staff, to the 1976 Annual PHS Clinical Director's meeting, to the planning and statistics staff of the Alaska Native Health Service administration, and at a meeting in Fairbanks with PHS Clinical staff and State of Alaska Health Officials. Discussion of the Evaluation was on the Agenda of a State Board meeting of Alaska Service Unit Directors.

Copies of the report have been requested from agencies and institutions in many states—and from abroad. The May 1978 Alasks Medicine had an article reporting this evaluation.

The ANHB sent a Resolution to the IHS Area calling for a careful examination of the evaluation findings and urging that corrective action be taken.

B. Program Impact

No change in program or performance as a result of the Tribal Evaluation was reported.

Although programs, resources and interests other than the Evaluation were stated as the basis for an activity, the result is that many of the deficiencies in performance and system have been corrected—e.g., the installation of a Statewide Computer patient care information system with a "Clinical Reminder" feature for the treating physician; the clinical awareness and treatment for iron deficiency anemia; the Communicable Disease Center program to establish an effective rheumatic fever surveillance and follow-up network; national, state and local emphasis on hypertension—its causes, disease characteristics, recognition and follow-up; and the teaching programs provided for health workers.
C. Effect on Tribal Management

From the experience with this evaluation the ANHB learned that studies must have a summary of findings in layman’s language if it is be be understood; a statement of the implications for action, and Board staff support if it is to follow-up on Board Resolutions.

The Board learned that health professionals do not automatically accept and act to correct "deficiencies" revealed by an evaluation —despite the quality of the study.

D. Potential Benefits

A "layman's summary" of the Evaluation findings and their implications is to be prepared by a physician hired by the Southeast Area Regional Health Corporation (SEARHC) and this summary is to be made available to Indian peoples by the Board. The SEARHC physician plans to use the Evaluation in his training program for Alaskan Health Aides.

The Evaluation will be used in developing and justifying the Tribal Specific Health Plan.

A request for $100,000 contract to follow-up on these Evaluation findings has been submitted to IHS, and supported by the Alaska Area office.

The Alaska State Office of Public Health Nursing suggested a plan for alerting local public health nurses to the Evaluation findings and for taking action on some identified opportunities for improving ambulatory services: preparation and distribution of a summary of Evaluation findings and their implications; the scheduling of joint discussions with Public Health Nurses, Service Unit staff and Health Aides to take corrective measures; the discussion of the opportunities for improving ambulatory services suggested by the Evaluation at the next quarterly meeting of IHS Area staff and representatives of the Alaska State Health Department.

Other IHS Areas may use the Evaluation as a model for evaluating ambulatory care services. The consultant for the Evaluation is now Chief of Quality Control for all IHS Areas and the project director is Chief of the Office of Planning Evaluation and Legislation, Navajo Area.

E. Influencing Factors

The Evaluation was conducted during a period of political tension between the sponsoring Board and another native health organization. Opposing agency members publically discounted all activity of the ANHB.
Some members of the ANHB were reported as not in favor of the Evaluation and gave little support.

Poor communication between the Evaluation Study Director and the members of ANHB resulted in mutual frustration and barriers to implementation.

F. Method and Persons Interviewed

The subject file in the Washington IHS Office was reviewed and selected IHS program staff were contacted for knowledge of follow-up of the evaluation. The period between July 16 and July 28, 1978 was spent in the Alaska Area with discussion of Area staff, Tribal representatives and persons in the State Health Department as suggested as persons familiar with the Evaluation and its follow-up.

Persons interviewed by Mrs. Dorothy Youtz during her visit to Alaska, July 17-28.

<table>
<thead>
<tr>
<th>NAME &amp; TITLE</th>
<th>LOCATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr. George E. Mumm, Chief, Planning Section</td>
<td>Anchorage</td>
</tr>
<tr>
<td>Dr. Stanley Hadley, Chief, Office of Patient Care Services</td>
<td>Anchorage</td>
</tr>
<tr>
<td>Dr. Charles Neilson, Area Deputy Director</td>
<td>Anchorage</td>
</tr>
<tr>
<td>Dr. Brian McMahon, Private Physician</td>
<td>Anchorage</td>
</tr>
<tr>
<td>Mr. Richard Zitzow, Chief, Program Formulation Branch</td>
<td>Anchorage</td>
</tr>
<tr>
<td>Dr. Kenneth Fleshman, Chief, Maternal &amp; Child Health Care Branch</td>
<td>Anchorage</td>
</tr>
<tr>
<td>Mr. Lucien Poussard, Chief, Social Services Branch</td>
<td>Anchorage</td>
</tr>
<tr>
<td>Dr. Ward Hurlburt, Service Unit Director</td>
<td>Anchorage</td>
</tr>
<tr>
<td>Mr. Lloyd Hermansen, Service Unit Director</td>
<td>Kanakanak</td>
</tr>
<tr>
<td>Dr. Dan O'Connell, Clinical Director</td>
<td>Anchorage</td>
</tr>
<tr>
<td>Ms. Ethel Gonzales, Chairman, Alaska Native Health Board</td>
<td>Juneau</td>
</tr>
<tr>
<td>Ms. Frieda Damus, Ex-Director, Sealaska Regional Health Corp.</td>
<td>Juneau</td>
</tr>
<tr>
<td>Dr. Jeff Harris, Clinical Director for SEARHC</td>
<td>Juneau</td>
</tr>
<tr>
<td>Mr. Robert Frances, Project Liaison</td>
<td>Juneau</td>
</tr>
<tr>
<td>Mrs. Evelyn Hamlin, Head Registered Nurse</td>
<td>Juneau</td>
</tr>
<tr>
<td>Mr. William L. Diebels, Director/Social Worker</td>
<td>Juneau</td>
</tr>
<tr>
<td>Mr. Terrance Hoeflerle, Director of Planning</td>
<td>Juneau</td>
</tr>
<tr>
<td>Dr. Donald Funk, Clinical Director</td>
<td>Mt. Edgecumbe</td>
</tr>
<tr>
<td>Dr. Lee Schmidt, Chief, Community Health Services</td>
<td>Mt. Edgecumbe</td>
</tr>
<tr>
<td>Mr. Frank O. Williams, Community Relations Officer</td>
<td>Anchorage</td>
</tr>
<tr>
<td>Dr. Martha Wilson, Chief, Program Development Section</td>
<td>Anchorage</td>
</tr>
<tr>
<td>Ms. Brenda Rodgers, Health Educator</td>
<td>Anchorage</td>
</tr>
<tr>
<td>Mr. Jeff Trenton, Project Liaison Officer</td>
<td>Anchorage</td>
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<tr>
<td>Dr. Thomas R. Bender, Director, Center for Disease Control</td>
<td>Anchorage</td>
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<tr>
<td>Dr. Kenneth Petersen, Medical Director</td>
<td>Anchorage</td>
</tr>
<tr>
<td>Dr. David Templin, Chief, Medicine</td>
<td>Anchorage</td>
</tr>
<tr>
<td>Dr. Richard Brodsky, Staff Physician</td>
<td>Anchorage</td>
</tr>
</tbody>
</table>
NAME & TITLE

Dr. Gloria Park, Director of Ambulatory & Community Health Service
Mrs. Sarah Zachares, Nursing
Dr. Uel Crosby, ANMC

LOCATION

Anchorage
Anchorage
Anchorage


Mr. Gerald Ivey, Area Director
Mr. Robert Swgyke, Area Executive Officer
Dr. Ward Hurlburt, Service Unit Director, Anchorage
Dr. Stanley Hadley
Mr. George Mumm

An oral presentation of findings was made to the IHS Headquarters staff concerned, August 31, 1978.
<table>
<thead>
<tr>
<th>Statute</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>25 U.S.C. 13 (1921)</td>
<td>Snyder Act</td>
</tr>
<tr>
<td>48 U.S.C. - 49 (1927)</td>
<td>Persons admitted to hospitals</td>
</tr>
<tr>
<td>PL 83-568 (1954)</td>
<td>Indian Health Service Transfer Act</td>
</tr>
<tr>
<td>PL 85-151 (1957)</td>
<td>Indian Health Facilities Construction Assistance Act</td>
</tr>
<tr>
<td>PL 86-121 (1959)</td>
<td>Indian Sanitation Facilities Construction Act</td>
</tr>
<tr>
<td>PL 89-702 (1966)</td>
<td>Fur Seal Act (Title II: Administration of the Pribilof Islands)</td>
</tr>
<tr>
<td>PL 90-174 (1967)</td>
<td>Partnership for Health Amendments of 1967 (Medical Care for Federal Employees at Remote Stations of the Service)</td>
</tr>
<tr>
<td>PL 93-197 (1973)</td>
<td>Menominee Restoration Act</td>
</tr>
<tr>
<td>PL 93-638 (1975)</td>
<td>The Indian Self-Determination and Education Assistance Act</td>
</tr>
<tr>
<td>PL 94-437 (1976)</td>
<td>The Indian Health Care Improvement Act</td>
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### INDIAN HEALTH SERVICES

Analysis by Activities

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount Available 1977</th>
<th>Amount Available 1978</th>
<th>Estimate 1979</th>
<th>Increase (+)</th>
<th>Decrease (-)</th>
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<tbody>
<tr>
<td>Patient Care</td>
<td>$178,578,109</td>
<td>$232,471,000</td>
<td>$249,002,000</td>
<td>+16,531,000</td>
<td></td>
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<tr>
<td>Ambulatory Care</td>
<td>64,436,447</td>
<td>76,828,000</td>
<td>83,867,000</td>
<td>+ 7,039,000</td>
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<tr>
<td>Preventive Health</td>
<td>99,002,143</td>
<td>128,646,000</td>
<td>135,926,000</td>
<td>+ 7,280,000</td>
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<tr>
<td>Program Management</td>
<td>3,713,359</td>
<td>3,990,000</td>
<td>4,057,000</td>
<td>+ 67,000</td>
<td></td>
</tr>
<tr>
<td>Sub-Total Obligations</td>
<td>345,730,058</td>
<td>441,935,000</td>
<td>472,852,000</td>
<td>+30,917,000</td>
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<tr>
<td>Unobligated Balance Lapsing</td>
<td>161,942</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Budget Authority,</td>
<td>345,892,000</td>
<td>441,935,000</td>
<td>472,852,000</td>
<td>+30,917,000</td>
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</table>

1/ Excludes reimbursements as follows: FY 1977 - $1,864,764 (PC $1,715,664; PH - $149,100); FY 1978 - $2,200,000 (PC - $2,050,000; PH $150,000); FY 1979 - $3,353,000 (PC - $2,742,000; PH - $611,000)

2/ Reflects 1978 comparative transfer to "Human Development" - $25,000* and a comparative transfer from "Alcohol, Drug Abuse and Mental Health Administration" - +3,663,000

3/ Reflects a 1979 comparative transfer to "General Departmental Management" - $722,000 for services currently funded through the working capital fund.

4/ Reflects proposed supplemental ($12,628,000) for 1978 pay act increases including nurse reclassification and ($1,138,000) for Passamaquoddy and Penobscot Tribes of Maine.

*Office of Native American Programs
## IHS Service Population Projections 1976 through 1982

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
<th></th>
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<th></th>
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<tbody>
<tr>
<td>All Areas, Total</td>
<td>633,862</td>
<td>655,554</td>
<td>677,531</td>
<td>699,792</td>
<td>722,320</td>
<td>737,485</td>
<td>752,892</td>
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<tr>
<td>Aberdeen</td>
<td>52,617</td>
<td>53,647</td>
<td>54,537</td>
<td>55,287</td>
<td>55,900</td>
<td>57,175</td>
<td>58,458</td>
</tr>
<tr>
<td>Bemidji</td>
<td>28,635</td>
<td>29,546</td>
<td>30,474</td>
<td>31,418</td>
<td>32,373</td>
<td>33,242</td>
<td>34,155</td>
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<tr>
<td>Alaska</td>
<td>64,121</td>
<td>66,252</td>
<td>68,620</td>
<td>71,229</td>
<td>74,085</td>
<td>75,368</td>
<td>76,650</td>
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<tr>
<td>Albuquerque</td>
<td>41,720</td>
<td>43,202</td>
<td>44,692</td>
<td>46,190</td>
<td>47,697</td>
<td>48,659</td>
<td>49,633</td>
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<tr>
<td>Billings</td>
<td>32,733</td>
<td>33,765</td>
<td>34,822</td>
<td>35,908</td>
<td>37,022</td>
<td>37,923</td>
<td>38,846</td>
</tr>
<tr>
<td>Navajo</td>
<td>122,964</td>
<td>128,000</td>
<td>132,895</td>
<td>137,654</td>
<td>142,275</td>
<td>145,657</td>
<td>149,072</td>
</tr>
<tr>
<td>Oklahoma City</td>
<td>119,602</td>
<td>123,204</td>
<td>126,881</td>
<td>130,622</td>
<td>134,440</td>
<td>137,332</td>
<td>140,275</td>
</tr>
<tr>
<td>Phoenix</td>
<td>66,169</td>
<td>69,158</td>
<td>72,232</td>
<td>75,373</td>
<td>78,597</td>
<td>80,037</td>
<td>81,495</td>
</tr>
<tr>
<td>Portland</td>
<td>31,527</td>
<td>32,621</td>
<td>33,804</td>
<td>35,081</td>
<td>36,421</td>
<td>37,132</td>
<td>37,847</td>
</tr>
<tr>
<td>Tucson</td>
<td>13,183</td>
<td>13,700</td>
<td>14,184</td>
<td>14,635</td>
<td>15,050</td>
<td>15,282</td>
<td>15,521</td>
</tr>
<tr>
<td>U.S.E.T. Total</td>
<td>20,640</td>
<td>20,995</td>
<td>21,315</td>
<td>21,601</td>
<td>21,849</td>
<td>22,075</td>
<td>22,293</td>
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<tr>
<td>U.S.E.T. (Old)</td>
<td>12,807</td>
<td>13,180</td>
<td>13,547</td>
<td>13,911</td>
<td>14,268</td>
<td>14,467</td>
<td>14,665</td>
</tr>
<tr>
<td>New York (including 1 county in Pennsylvania)</td>
<td>7,833</td>
<td>7,815</td>
<td>7,768</td>
<td>7,690</td>
<td>7,581</td>
<td>7,608</td>
<td>7,628</td>
</tr>
<tr>
<td>California</td>
<td>39,951</td>
<td>41,464</td>
<td>43,075</td>
<td>44,794</td>
<td>46,611</td>
<td>47,603</td>
<td>48,647</td>
</tr>
</tbody>
</table>

### Total excluding New York and California

| 586,078 | 606,275 | 626,688 | 647,308 | 668,128 | 682,274 | 696,617 |

| Maine   | 1,885   | 1,935   | 1,987   | 2,042   | 2,099   | 2,125   | 2,149   |

Population Branch
OPS/DRC/IHS
December 8, 1977
### NUMBER OF INDIAN HEALTH SERVICE FACILITIES BY TYPE AND AREA AS OF OCTOBER 1, 1976

<table>
<thead>
<tr>
<th>Area</th>
<th>Service Units</th>
<th>Hospitals</th>
<th>Health Centers</th>
<th>School Health Centers</th>
<th>Health Stations</th>
<th>Health Locations 1/</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total, All Areas</strong></td>
<td>88</td>
<td>51 2/</td>
<td>73</td>
<td>26</td>
<td>108</td>
<td>961</td>
</tr>
<tr>
<td>Aberdeen</td>
<td>13</td>
<td>9</td>
<td>4</td>
<td>3</td>
<td>24</td>
<td>167</td>
</tr>
<tr>
<td>Bemidji</td>
<td>13</td>
<td>2</td>
<td>1</td>
<td>-</td>
<td>8</td>
<td>76</td>
</tr>
<tr>
<td>Alaska</td>
<td>8</td>
<td>9</td>
<td>6</td>
<td>1</td>
<td>10</td>
<td>207</td>
</tr>
<tr>
<td>Albuquerque</td>
<td>4</td>
<td>4 2/</td>
<td>4</td>
<td>2</td>
<td>19</td>
<td>14</td>
</tr>
<tr>
<td>Billings</td>
<td>8</td>
<td>3</td>
<td>8</td>
<td>1</td>
<td>3</td>
<td>100</td>
</tr>
<tr>
<td>Navajo</td>
<td>8</td>
<td>6</td>
<td>10</td>
<td>10</td>
<td>21</td>
<td>217</td>
</tr>
<tr>
<td>Oklahoma City</td>
<td>9</td>
<td>6 2/</td>
<td>17</td>
<td>5</td>
<td>13</td>
<td>13</td>
</tr>
<tr>
<td>Phoenix</td>
<td>10</td>
<td>9</td>
<td>7</td>
<td>3</td>
<td>1</td>
<td>115</td>
</tr>
<tr>
<td>Portland</td>
<td>11</td>
<td>-</td>
<td>10</td>
<td>1</td>
<td>4</td>
<td>35</td>
</tr>
<tr>
<td>Tucson Program</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>-</td>
<td>-</td>
<td>5</td>
</tr>
<tr>
<td>United Southeastern Tribes</td>
<td>3</td>
<td>2</td>
<td>4</td>
<td>-</td>
<td>5</td>
<td>12</td>
</tr>
</tbody>
</table>

1/ Communities where intermittent health services are provided but where no fixed Public Health Service treatment facility is available; e.g., small Alaska villages, mobile unit sites, etc.

2/ Current number of IHS hospitals is now 53, including Acomita (Albuquerque), under construction and Ada (Oklahoma), under design.