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Descriptive analysis of tribal health systems: Operational data reported for the period October 1, 1984 - September 30, 1985.

LE Berg

G. Rummelt

L. Preston

FINAL REPORT

DESCRIPTIVE ANALYSIS OF TRIBAL HEALTH SYSTEMS

MAY 1987

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Health Resources and Services Administration
Indian Health Service

DESCRIPTIVE ANALYSIS OF TRIBAL HEALTH SYSTEMS

Operational Data Reported for the Period
October 1, 1984 - September 30, 1985

Prepared by:

Division of Health Services Systems Development
Office of Health Program Development
Indian Health Service
7900 South J Stock Road
Tucson, Arizona 85746

FINAL REPORT

DESCRIPTIVE ANALYSIS OF TRIBAL HEALTH SYSTEMS

May, 1987

U. S. Department of Health & Human Services
Public Health Service
Health Resources and Services Administration
Indian Health Service

Results of this project are reported in six parts. An Executive Summary presents the highlights of the results of the project and recommendations. The Introduction section relates the events which lead to the development of this project, selection of project design, purpose and the types of Tribal Health Systems included in the project. The Methodology section describes the processes used to assure the collection of accurate information and the involvement of IHS and Tribal staff. It also describes the instruments used in the implementation of the project: Profile, Site Criteria, IHS Area Management Perception and Tribal Management Perception. The Results section presents information reported on the various instruments. This includes Tribal Health Systems costs, services, staff and recipients of services; existence of administration and program effectiveness issues; and opinions of IHS Area managers and Tribal managers on the management and operations of the Tribal Health Systems. There are sections on Conclusions and Recommendations as a result of the project. In addition, an Appendix is attached which includes a glossary of terms, a detail of all information reported and copies of the instruments used.

The information in this report was made possible only through the integrated efforts of the dedicated and concerned individuals who participated in this massive project: Tribal participants, Tribal Health Evaluation Coordinators, Steering Committee and Design Committee members. Equally important to the successful completion of this project was the support provided by the IHS Director, Associate Directors and Area Directors. A critical requirement for the successful design, implementation and completion of a project of this magnitude was the commitment of the project staff.

This report was prepared by Lawrence E. Berg, Ginny Rummelt and Lisa Preston.

DESCRIPTIVE ANALYSIS OF TRIBAL HEALTH SYSTEMS

PRINCIPAL PROJECT PARTICIPANTS

Everett R. Rhoades, M.D.,
Assistant Surgeon General and Director, Indian Health Service

Luana Reyes,
Associate Director, IHS, Office of Planning, Evaluation & Legislation, (OPEL)

Eleanore Robertson, R.N.,
Associate Director, IHS, Office of Health Program Development (OHPD)

Steering Committee:

Anthony D'Angelo, Co-Chairperson, IHS/OPEL
Stephen Permison, M.D., Co-Chairperson, IHS/OHP
Tonya Blocher, IHS OTA
Ed Castor, IHS/OAM
Anabel Crane, HRSA/OPEL
Steve Lillie, OASPE replaced by Mary Burns, OASPE
Bill Millar, IHS/Nashville Program
Rae Snyder, Seneca Nation
Susan Vieira, CHN, IHS/Bemidji Program

Design Committee:

Marilyn Anderson, Seneca Nation
Gary Breshears, Creek Nation of Oklahoma
Bill Millar, IHS/Nashville Program
Rae Snyder, Seneca Nation
Kathleen Sutcliffe, Aleutian/Pribilof Island Association

Area Coordinators:

Aberdeen	Dennis Renville
Alaska	Carol Sudder
Albuquerque	Nelson Clay
Bemidji	Orville Night Pipe (Wisconsin)
	Ed LeBeau (Minnesota)
Billings	Adlai Falls Down
California	Oliver Forrest
Nashville	Bill Millar
Navajo	Ellouise DeGroat
Oklahoma	Bill Wilson
Phoenix	Vince Pourier
Portland	Victor LaCourse
Tucson	Don Donaldson

OHPD Project Staff:

Lawrence Berg, Project Director
Patricia DeAsis
Ray Grandbois
Lori Miller
Lisa Preston
Ginny Rummelt

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December 12, 1985

Dear Tribal Leaders and
Tribal Health Directors:

The Indian Health Service (IHS) is conducting a project to obtain national aggregate and Area level data which describes the types and magnitude of health programs and services operated by tribes and tribal organizations.

The purpose of the project is 1) to obtain more comprehensive data in order to effectively respond to questions asked by the IHS Health Resources and Services Administration (HRSA), the Congress, the Office of Management and Budget, the General Accounting Office and others regarding the range of health services provided by tribes and tribal organizations, and 2) to provide IHS Headquarters, tribes and IHS Area Offices information to use in making management improvements. It is important that tribes and tribal orgnaizations participate in this project so that the report has maximum value.

Responding to your concerns, the following summarizes the issues raised during the review and comment period:

Use of Information: The graphic presentation of data and the narrative report will present a description of the extent of health programs and services operated by tribes and tribal organizations collectively by IHS Area, geographic region and nationally. Individual tribal data will not be presented in the final report. However participants will receive their survey results and the summary by IHS Area.

Funding Resources: One question in the project survey asks for information about other funding sources that support health services in your community. This is part of the project objective to identify the total health program profile - programs funded by IHS and by all other resources, and emphasizes the need to make use of all funding sources to help improve the health status of Indian people.

Patient Registration and Eligibility: The question has been raised how patient registration and eligibility relate to this project. This project is independent of the patient registration activity and the Notice of Proposed Rule Making on eligibility.

Project Funding: This is an evaluation project funded for $65,000.

Recently the Steering Committee for this project met and, taking your comments into consideration, make two major changes which will reduce the amount of time and effort required to complete the survey. First, the user and provider perception survey will not be conducted at this time. Second, the on-site criteria survey forms will be self-administered with validation (site visits) by project staff of approximately one-third of the participants.

The general schedule for project implementation is:

December 1985 - Begin the program profile survey
January 1986 - Train Area staff on the use of the on-site criteria form
February 1986 - Prepare draft report of program profile survey results
March 1986 - Begin on-site criteria survey
May 1986 - Prepare draft final report
July 1986 - Distribute draft final report for comments
August 1986 - Print and distribute final report

If you have questions regarding the project design or implementation schedule, please call Larry Berg, Project Director or Mr. Ray Grandbois at (602)629-6206 or FTS 762-6206. If you have any questions regarding the IHS Headquarters requirements, please call Ms. Juana Casillas, Chairperson, Steering Committee at (301)443-3024.

Thank you for your participation in this project and for your dedication to help improve the health of American Indian and Alaskan Native people.

Sincerely yours,

Everett R. Rhoades, M.D.
Assistant Surgeon General
Director, Indian Health Service

cc: IHS/ES
Area/Program Directors
Area Tribal Health Evaluation Coordinators
Mr. Larry Berg
Ms. Juana Casillas

Prepared by: IHS/OTA/IRL/JCasillas:dfb/11-19-85/443-1044/Doc ID 2935D

EXECUTIVE SUMMARY
DESCRIPTIVE ANALYSIS OF TRIBAL HEALTH SYSTEMS, FY 1985

Need for Study -- The IHS has been negotiating P.L. 93-638 and Buy-Indian contracts for health services for more than a decade. This project was developed to create a basis for an on-going equitable and uniform system which would accomplish two objectives: one to monitor the performance of these Health Systems and two, to identify needs for technical assistance to these Health Systems by IHS Area Offices.

Purpose of Study -- The purpose of this study is: 1) to obtain more comprehensive data in order to effectively respond to questions asked of the IHS by the Health Resources and Services Administration (HRSA), the Congress, the Office of Management and Budget, the General Accounting Office and others regarding the range of health services provided by Tribes and Tribal organizations; and 2) to provide IHS Headquarters, Tribes and IHS Area Offices information to use in making management improvements.

Each of the IHS Areas have been monitoring Tribal Health Systems (THS) since the inception of the program under P.L. 93-638 in 1975. This study is the first uniform national descriptive analysis of Tribal Health Systems being funded through award instruments between Tribes or Tribal organizations and the Indian Health Service under the Indian Self-Determination and Education Assistance Act (P.L. 93-638). The time period covered by this report is fiscal year 1985. Tribal alcoholism and Community Health Representative (CHR) programs that are "stand alone"; i.e., not combined with any other types of health services being provided by the Tribes, are not part of the scope of this project.

Methods and Response Levels -- The study methodology and information collection forms were finalized by an appointed Design Committee and approved by the Steering Committee for application at eight Tribal Health System pilot sites. Experience from the pilot test and comments from a concurrent review process by IHS and Tribal organization staff were included in the final application. Information was reported on a voluntary basis by the Tribal Health Systems since scopes of work in contractual award instruments made no provision for this reporting. Information reported was for the period October 1, 1984 to September 30, 1985.

Four information collection forms were used in this study. Key functions of each instrument were:

1) Profile - describes the characteristics of the Systems, population served, services, staffing and costs;

2) Criteria - identifies those administrative and program issues which depict the most effectively managed and operated program;

3) Tribal Management Perception - obtains opinions of Tribal managers on the Systems, knowledge of P.L. 93-638 and opinions of IHS technical assistance; and

4) IHS Area Management Perception - obtains opinions of IHS area managers about the Systems, knowledge of P.L. 93-638, opinions of how the area was managing the 638 process, and the need for additional training of IHS staff.

EXECUTIVE SUMMARY (Cont'd.)
DESCRIPTIVE ANALYSIS OF TRIBAL HEALTH SYSTEMS

Identified as within the scope of this study were 174 Tribal Health Systems. Of these, Profiles were received from 150 (86.2%) of these Systems. Complete Profiles were received from all Tribal Health Systems within seven of the 12 areas. The remaining areas varied from 94% to 50% complete reporting. There were Site Criteria received from 95 (or 54%) of the Tribal Health Systems included in this study. Also received were 539 Tribal Management Perceptions and 176 IHS Area Management Perceptions.

This was the first effort of this nature and although training was provided, definitions of terms used varied for the self-selected respondents. The reader is cautioned on the use and interpretation of the data presented in this report. There is not 100% reporting from all Tribal Health Systems defined as within the scope of this project. The data presented are as reported by the Tribal Health Systems that participated in this project.

NATURE OF TRIBAL PROGRAMS -- Total dollars allocated by IHS to Tribal Health Systems for FY 1985 were $206,502,848. Of this amount, $23,711,270 is funded for Tribally operated alcoholism programs and $28,495,161 is funded for Tribally operated Community Health Representative (CHR) programs. Tribal health costs funded by IHS dollars from Tribes reporting in this study amount to $136,340,376. An additional $31,629,208 was reported obtained by the Tribal Health Systems from sources other than IHS for funding their programs.

In terms of costs for specific types of services being provided by Tribal Health Systems, 44.4% of all costs is spent for community health, 32.3% is spent for outpatient, 16.7% is spent for inpatient and 6.6% is spent for dental services.

TYPE OF CONTRACTUAL AWARD INSTRUMENTS -- Approximately 90% of the contractual award instruments with the Tribal Health Systems were made through the P.L. 93-638 contractual mechanism. Six percent of the award instruments were made through grants and 4% were made through the Buy-Indian contractual mechanism. Overall, 76.2% of Tribal Health Systems reported receiving IHS funds to provide health services for six or more years. An additional 14.3% reported receiving funds for 3-5 years and 9.5% for less than three years.

SERVICE POPULATION -- The Tribal Health Systems reported 686,800 eligible persons in their service population. Of these, 94.9% are American Indians and Alaska Natives. Tribal Health Systems provide some selected services to non-Indians since some non-IHS funding sources require them to provide the funded services to all eligible persons, as defined by the funding source, without discrimination. The Tribally reported service populations include people that are served also by the IHS direct programs. In addition, different Tribal programs may be serving the same people where different types of services are involved.

AVAILABILITY OF SERVICES -- Analyzing the mechanism through which acute episodic medical care services were reported to be available or provided to the service population, 28% of the Tribal Health Systems responding reported they provided this service; 27% reported this service available or provided by IHS; 36% reported this service available or provided by contract care, 6% through an unknown source and 3% reported this service was not available.

In respect to inpatient care, these Health Systems reported approximately 10% of the inpatient care was provided or available through the Tribal Health System, 30% through IHS, 66% through contract care, 6% through another unidentified source and 7% reported inpatient care was not available to their population.

In addition, physical therapy, podiatry and medical specialty consultation support services were most generally available through contract care. Dental preventive, diagnostic and treatment services were reported to be provided about equally by the Tribal Health System, IHS and through contract care. The vast majority of community health services was reported to be provided directly by the Tribal Health System. The five leading services reported least available to the persons served by the Tribal Health Systems were adolescent care (as a separate program), nursing home services, health education (as a separate program), services for the aged and podiatry.

On the average, approximately 80% of the people served were reported to be within one hour of inpatient, outpatient, dental and community services for free or for a small fee to the patient.

SERVICE WORKLOAD -- The 90 Tribal Health Systems providing outpatient services reported 946,412 outpatient visits; 49 THS reported providing 230,110 direct dental services; 128 THS reported providing 2,606,592 community health services and 8 THS reported providing 15,143 direct inpatient days.

COST PER UNIT OF SERVICE -- Cost per unit of service for all Tribal Health Systems reporting, excluding Alaska, were found to be: $663. per inpatient day; $42. per outpatient visit; $36. per dental service and $23. per community health service. Costs for Tribal Health Systems reporting in Alaska were found to be: $64. per outpatient visit; $42. for dental visit and $94. for community health services. These figures are System costs and should not be compared to general U.S. consumer expenditures for health care. Tribal Health Systems have different accounting and reporting systems and varying types of costs.

STAFFING -- Services per staff ratios were calculated for Tribal Health Systems that reported both provider staff and number of services provided.

Type of Provider	Health Systems Reporting	FY 85 Services Per Staff
Primary Care Provider (PCP)*	63	2802
Community Health Aide (Alaska)	15	796
Dentist	41	1680
Communtiy Health Provider	128	1055

* Includes Physician, Community Health Medic (CHM), Physician Assistant (PA), Pharmacy Practitioner, Nurse Practitoner and Nurse Midwife, Community Health Aide (Alaska only), Optometrist and Audiologist

ADMINISTRATION/PROGRAM CRITERIA -- Criteria documents were completed for 95 different Tribal Health Systems which represents 55% of the THS defined within the scope of this project. Some Tribal health managers expressed appreciation for the administrative and program criteria. These managers plan to use the Criteria as guides for those functions or activities which need to be in place for the most effective program. In the five IHS areas where project staff directly assisted in the implementation of the project, Health System managers and area staff were receptive to the Criteria document. One IHS area (Nashville) has expanded and adopted the criteria developed in this project as a component of their contracting process. This report provides the detailed responses to each Criteria item and summarizes those items most frequently found to be present and absent. Criteria issues relating to accreditation and financial management were found to be most frequently present. Formal processes for quality assurance, patient advocacy and patient rights were found to be most frequently absent in the Criteria issues.

TRACKING AND MONITORING SYSTEMS -- Tribal Health Systems identified the major health problems of their service population for which a monitoring system was in place. The major health problems and the percent of THS reporting monitoring systems for these health problems follows: 80% reported Diabetes Systems; 52% Immunization; 48% Hypertension; and 40% reported Prenatal Systems.

TRIBAL MANAGER PERCEPTIONS -- Ninety percent of respondents reported familiarity to some degree with P.L. 93-638; 80% were satisfied with their overall THS operations with approximately 40% partially satisfied and 28% mostly satisfied with the assistance being received from the IHS area managers. The issues identified by these respondents for additional technical assistance were categorized. The major categories and number responding per category were: general program development (58), management (51), clinical/professional staff issues (42), health care/concerns (24), contracting (21), funding (15) and information on "638".

IHS AREA MANAGER PERCEPTION -- Overall, 115 or 69% of the respondents reported that from their perception the IHS Area office was managing THS contracts at a good to outstanding level; 51 or 31% reported the IHS Area office was doing a fair to poor job. Data were also obtained on what additional training area staff would like and what their recommendations were for improving the management of Tribal Health System contracts. Over one-third of the respondents identified a requirement for additional training in contracts, procurement, fiscal management and funding sources. The predominate recommendation was increased resources committed to 638 management.

Nationally, there is the equivalent of one full-time project officer for each $4.5 million of these contracts. This is not inconsistent with the IHS Resource Requirements Methodology (RRM) standard for contract supervision of one person per $5 million in contracts.

Project staff found a great deal of variability in accounting and reporting conventions as to documentation of costs (e.g., administrative vs. direct services and types of services). Considerable staff time was required for contacts with Tribal Health Systems to achieve some uniformity in definitions and reporting.

Recommendations

Based on the findings of the study and the discussions of the Steering Committee and project staff, it was recommended that:

1) IHS and Tribal managers finalize the development of an on-going capability for routinely monitoring the efficiency, effectiveness and acceptability of services being provided by Tribal Health Systems.

2) Concurrent with development of on-going capability for monitoring Tribal Health Systems, IHS initiate and apply this same process to health systems being operated directly by IHS.

3) In addition to the dollar amount of the contract, factors which determine the amount of attention a project requires be included in the Criteria for establishing the number of IHS project officers required. These expanded criteria should be examined to ascertain whether a change is required in staffing policy.

4) In those instances where the Area staff collectively reported a relatively low opinion of how the Area is managing these Tribal Health Systems, the underlying issues be identified and constructively addressed.

5) Each IHS Area review the results of the Criteria applications to Tribal Health Systems in their Area for identification of needs for technical assistance that are common throughout their area.

6) An independent routine evaluation process needs to be initiated and institutionalized which provides to the IHS Management an overview assessment, and recommendations for improving the relative effectiveness and efficiency with which the IHS is implementing the P.L. 93-638 process.

7) A documentation and assessment of the patient's current health status be included in the future design of health care systems. It is recognized that the only true measure of effectiveness of a Health System is the relative change in patient's health status as a result of interacting with the services of that System.

DESCRIPTIVE ANALYSIS OF TRIBAL HEALTH SYSTEMS

SECTION I. INTRODUCTION

STATEMENT OF NEED

The Indian Health Service has been negotiating P.L. 93-638 and Buy-Indian contracts for health services for more than a decade. Requirements for reports of activities and services and the process for monitoring these programs have been individually negotiated and specified in scopes of work between the specific IHS Area or local administrative components (Service Units) within the Area and the contractor. A map of the IHS Areas can be seen on the following page. The extent to which Tribal Health Systems are monitored, and the extent to which requirements for technical assistance are identified and assured, vary widely from Area to Area within the IHS. In order to create a basis for an equitable and uniform monitoring and assessment of the performance of these programs, there is a need for the standardization of these processes.

BACKGROUND

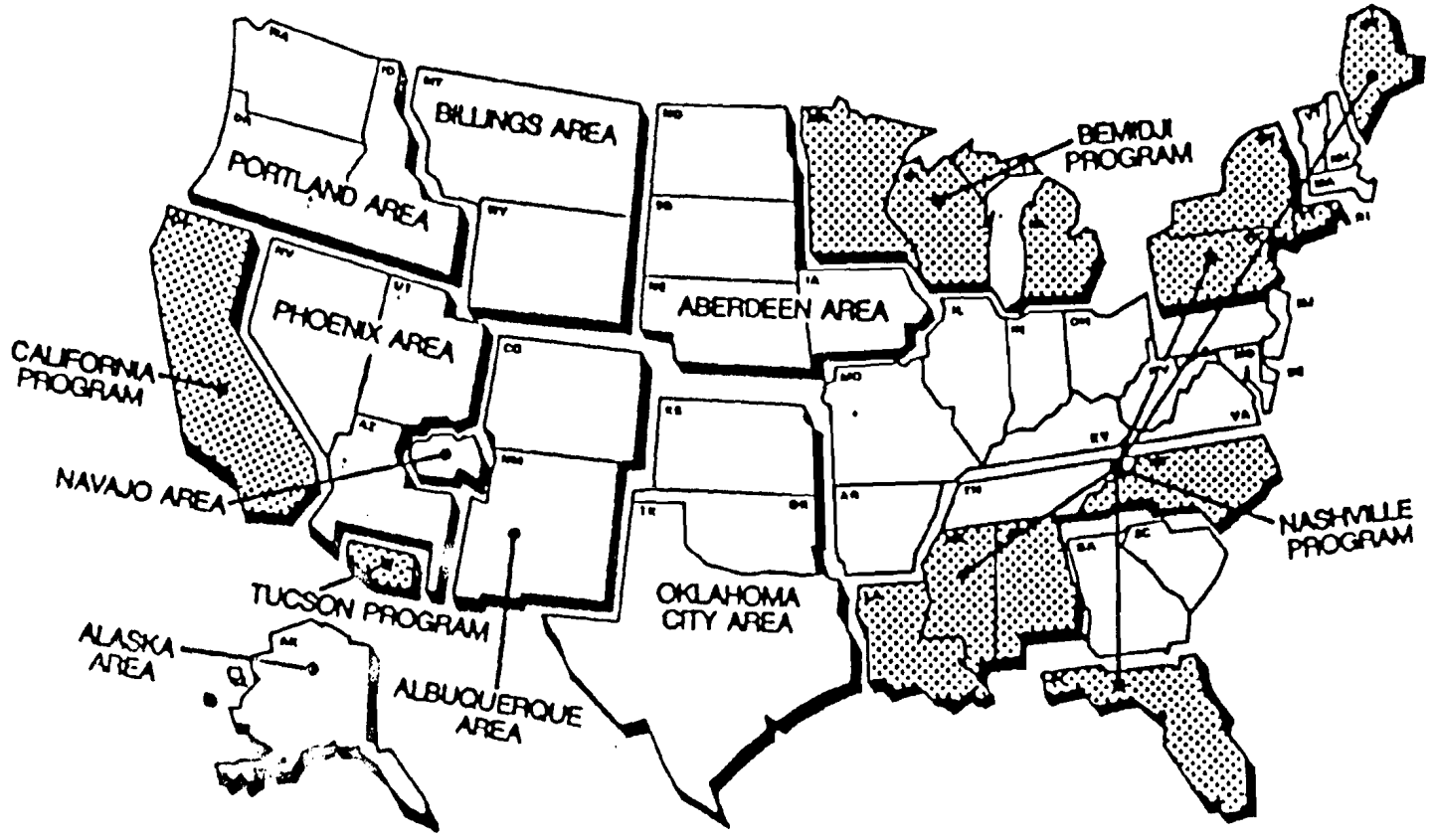
To address these identified needs, this project was proposed by Dr. Joseph Exendine, former Associate Director, Office of Tribal Activities, IHS. A steering committee was formed comprised of representation from the Office of the Assistant Secretary for Planning and Evaluation, DHHS, Health Resources and Services Administration, each of the IHS Headquarters Offices, IHS Area project management and Tribal Health managers. This committee initially met in April, 1985 at which time they reviewed several alternative approaches to this project. The decision was made to use the approach employed in the recent evaluation of urban Indian health programs as a model in developing a methodology to collect and analyze the information required for this project.

The urban model was the most recent application of an integrated set of evaluation methodologies and processes that have been evolving from previous studies designed and conducted at Office of Health Program Development (OHPD) since 1972. This set presents the concept that the relative quality of health care services can be described by looking at the efficiency, effectiveness and acceptability of the services and the interactions of these parameters. For the purpose of this set, efficiency was defined as cost per unit of service and number of services per provider. Effectiveness* was defined as the presence of administrative and operational process issues that are believed to be causally related or at least highly correlated with successful outcomes. Acceptability was defined as the integrated subjective perceptions of the health system by the managers, employees and users of the system on issues which are believed to be highly correlated with successful outcomes.

The responsibility for the design and conduct of this project was assigned to the staff of the Office of Health Program Development based on their previous experience in the evaluations of urban Indian health projects funded by Title V, P.L. 94-437, as well as evaluations of Tribally operated health components. The committee also established a minimum set of information requirements for the project.

* For further comment, see Recommendation section of this report.

MAP OF UNITED STATES SHOWING AREAS OF INDIAN HEALTH SERVICE



DESCRIPTIVE ANALYSIS OF TRIBAL HEALTH SYSTEMS

PURPOSE

This project is assessing all recurring Tribal Health System contracts and grants administered by American Indian Tribes, American Indian organizations and Alaska Native Health Corporations under the authority of P.L. 93-638 or the Buy Indian Act. The purposes of this assessment are to:

1) obtain more comprehensive data in order to effectively respond to questions asked of the IHS by the Health Resources and Services Administration (HRSA), the Congress, the Office of Management and Budget, the General Accounting Office and others regarding the range of health services provided by tribes and tribal organizations;

2) provide IHS Headquarters, Tribes and IHS Area Offices information to use in making management improvements;

3) establish and apply a uniform process for assessing the management and conduct of the Tribal health systems administering these health services; and

4) establish an additional basis for reviewing the 638 and Buy-Indian contractual process which will include individual Tribal and IHS managers' perception of this process, and their recommendations for further improvement.

Also provided was a process for developing self-administered action plans for tribal managers' use in addressing issues identified as a result of this project.

This study is the first uniform national descriptive analysis of Tribal Health Systems being funded through award instruments between Tribes or Tribal organizations and the Indian Health Service under the Indian Self-Determination and Education Assistance Act (P.L. 93-638).

SCOPE OF PROJECT

Included in the scope of this project are Tribal Health Systems administered by American Indian tribes, American Indian organizations and Alaska Native Health Corporations funded under the authority of P.L. 93-638 or the Buy Indian Act.

The project management by definition excluded certain types of contracts from the scope of this project. Excluded were contracts or grants negotiated only for administration or developmental activities where IHS was not funding any portion of the patient care services. Examples of tribally contracted activity which are not within the scope of this project are: facility construction and other one-time health related projects; projects exclusively funded by Title V, P.L. 94-437; urban health programs, free standing alcoholism and/or CHR programs and contracts or grants providing funds for the exclusive purpose of tribal health management or developmental activities. The urban, alcoholism and CHR programs already have on-going reporting, monitoring and evaluation processes.

SECTION II. METHODOLOGY

The Steering Committee made the decision to use the components of the recent evaluation of urban Indian health programs as a model in designing components for this project in June, 1985. A Design Committee was established consisting of representatives from three Tribal programs and three IHS "638" project officers. Tribal committee members selected represented large, medium and small programs and programs which had been funded by IHS for varying lengths of time.

PHASE I - PROJECT DESIGN AND FIELD TEST (AUGUST - NOVEMBER, 1985)

The Design Committee worked with project staff in developing the project design and processes to be used. Through their joint efforts, they: 1) reviewed and modified the Urban components to make them applicable and appropriate for use in this project; 2) distributed draft project materials to appropriate individuals and organizations for review and comments; 3) field tested the proposed project instruments and processes; 4) requested that the IHS Area Directors select Tribal Health Evaluation Coordinators (THEC) who would be responsible for assuring implementation of the project in their respective Areas; 5) defined a process for collection of project information; and 6) developed preliminary plans for presentation of results of the project.

Project staff designed and conducted training for the THECs in their tasks toward completion of this project.

The instruments designed to collect project information included:

1) Tribal Health System Profile (Appendix, page 111) which describes the characteristics of the Tribal Health Systems, the population served, the services, staffing and costs of the administration of these health systems by source of funding;

2) Site Criteria (Appendix, page 129) for the Descriptive Analysis of Tribal Health Systems which identifies those administrative and program issues which if in place in a program would depict the most effectively managed and operated program;

3) IHS Management Perception of Tribal Health Systems (Appendix, page 144) which allowed IHS area managers to candidly give their opinion on the IHS management and operations of the Tribal Health Systems in their areas, determine their perceived knowledge of P.L. 93-638, obtain their perceptions of the technical assistance being provided by IHS staff and identify the need for additional training of IHS staff;

4) Tribal Governing Body Perception of Tribal Health Systems (Appendix, page 146) which allowed Tribal Governing Body members and Tribal Health System managers to candidly give their opinion on the management and operations of the Tribal Health Systems in their areas, determine their perceived knowledge of P.L. 93-638, and obtain their perceptions of the quantity and quality of the technical assistance being provided by the IHS staff; and

5) Action Plan (Appendix, page 149) - an optional process which can be used by participants as a basis for developing future plans. They can prioritize issues to be addressed, identify what needs to be accomplished, how it will be accomplished, by whom it will be accomplished and on what schedule. When remedial action is indicated the variance report, a necessary component of the process, can be used as documentation of the alternate plan.

The Steering Committee in November, 1985 reviewed and approved the forms designed and the proposed methodology established by the Design Committee and Project Staff. The information collection forms used in this study are provided in the Appendix.

Project purpose and materials were presented and distributed to all IHS Areas, all Tribal leaders, the National Congress of American Indians (NCAI), the National Tribal Chairmen's Association (NTCA) and the National Indian Health Board (NIHB). These groups were asked to review the project plans and provide written comments to the project staff. Project materials distributed included a description of the project, information collection instruments to be used, a schedule of activities for implementation of the project, and the benefits to be received by the Tribal health systems and by IHS.

The members of the Design Committee volunteered to field test the instruments developed by this process in their Tribal Health Systems or Tribal Health Systems they serve. The project was field tested at eight sites which included large and small programs, varying components of care and programs new to the 638 contracting process and programs contracted under this process almost since the law was passed. The comments received and changes suggested from the field test were incorporated into the final project design.

Besides improvements made for clarity and ease in completion of the project instruments, the major changes suggested and adopted by the Steering Committee were:

1) exclusion of user and provider perception from this study with the recommendation that such data be collected at a future date for both IHS and Tribal health services.

2) criteria to be self-administered by 100% of Tribal Health Systems included in this study; each IHS area to administer criteria at representative 1/3 of project sites to validate reliability of self-administered criteria.

3) all study reports prepared for general use will summarize data by IHS area without Tribal specific identification.

In addition, the field test program participants reported some positive perceived benefits of the study. These included their belief that this study would provide: 1) uniform, accurate data for IHS Headquarters and Areas; 2) an identification of those issues needed for improving the management of the 638 process, and 3) criteria with which Tribal management could assess and further enhance their Health Systems.

DESCRIPTIVE ANALYSIS OF TRIBAL HEALTH SYSTEMS, FY 1985

IHS Area Directors selected persons as Tribal Health Evaluation Coordinators (THECs) who would be key in assuring the implementation of this project in their respective Areas.

PHASE II - PROFILE INFORMATION (DECEMBER, 1985 - MARCH, 1986)

During this phase of the project, an orientation was provided to the IHS Area THEC's on the objectives, process and design of the project, and how they could assure effective implementation of the overall project activities. The Profiles were distributed to the THECs who in turn distributed them to each of the Tribal Health Systems within the scope of this project. Profile forms were completed by 150 of the 174 Health Systems included in the scope of this study, and returned to the THECs for their edit and forwarding to the project staff.

The project staff conducted further editing of the Profiles and contacted appropriate IHS and Tribal staff for verification of information reported in the Profiles. Based on the results received through February 11, 1986, an interim report was prepared for the Director, IHS. The balance of Phase II was devoted to attempting to obtaining the remainder of the Profiles from Tribal Health Systems and completing the verification process of the Profile information.

Also during this phase, training was conducted by project staff for the THECs in their responsibilities during Phase III of the project. These responsibilities included: the assurance of the distribution and completion of the Site Criteria, the perception instruments and the action plan, and the conduct of training sessions for Area and Tribal staff who would be engaged in the processes of the project in their respective Areas.

PHASE III - CRITERIA AND PERCEPTIONS (FEBRUARY - SEPTEMBER, 1986)

During Phase III, the THECs distributed the Site Criteria and Perception Instruments to Tribal Health Systems within the scope of this project in sufficient time to allow Tribes the opportunity to self-administer the criteria before site visits which were scheduled to be conducted by IHS Area staff. The Steering Committee believed that a comprehensive program review should be be conducted at a minimum of once every three years on all Tribal Health Systems. Therefore, they established the requirement that a "representative" sample of a minimum of one-third of the Tribal Health Systems should be visited. The sample Tribal Health Systems were to be selected by Area staff in such a way that they represented varying sizes of operations and varying number of years they were funded by IHS.

Also during Phase III, the criteria were applied on site by an IHS area representative, and the perception instruments were completed by the appropriate individuals. Project staff analyzed the information gathered through the various instruments and presented the draft results to the Steering Committee in July, 1986.

As a follow up to this phase, Action Plans for ameliorating those issues that were identified by Tribal health managers as needing change will be developed at their option. The Tribal Health Evaluation Coordinators will be encouraged to assist the Tribal health managers in the design and implementation of their action plans.

DATA ANALYSIS AND PREPARATION OF FINAL REPORT

The project Profiles were submitted to three screening edits:

1) internal consistency within sections; in other words, agreement between totals and the sums of columns and rows of the data provided.

2) consistency between sections in the types of information reported; that is, were the resources, services and staff relatively consistent. For example, if direct dental costs were reported, were there corresponding reports of direct dental staff and services; if contract dental costs were reported, were there corresponding reports of contract dental services.

3) relative ratios between resources, staff and services to determine relative internal consistency; in other words, if cost per unit of service and services per provider were within 3.5 standard deviations from the means of these distributions.

These three levels of editing resulted in a significant proportion of Profile instruments requiring follow-up with the IHS Area Coordinators for verification of data. In some instances, with the Area Coordinator's permission, follow-up was made with the Tribal Health System directly.

In contrast to completion of the Profiles, project staff created the opportunity to conduct a training session with all the Area Coordinators in the completion of the Criteria instruments. Very little editing was necessary on receipt of the Criteria instruments. Responses on the Criteria issues were coded as either yes, no, not applicable or no response. In those instances where an entire subsection of the criteria were not applicable to a subset of Tribal Health Systems, the denominator for calculating the percent of criteria present was changed to reflect only those Tribal Health Systems for which the criteria were applicable.

The major editing and synthesis required on the Perception instruments was the summarization of the voluminous open ended responses into major categories for easier analysis. Members of the Steering Committee participated in this activity to obtain a better understanding of the exact interests of and problems identified by the respondents.

On completion of editing and reduction of the data, all data were entered into a Data Base III Management System specifically designed for this project.

Project staff drafted an outline and tables for presentation of the data and presented these materials to the Steering Committee for their review. Based on the results of this process, a draft final report was prepared in August, 1986. This draft report was distributed to national Indian organizations, the IHS Director, Associate Directors, Area Directors, and Area Coordinators, Steering Committee members and Design Committee members for their review and comment. All comments received were consolidated and presented by project staff at the September, 1986 Steering Committee meeting. Each recommendation or comment was reviewed and discussed jointly at this meeting, and the decision made as to the appropriateness for inclusion in the final report.

SECTION III. RESULTS

EXTENT OF COVERAGE

Based on information from the IHS Division of Contracts & Grants, Office of Administration and Management for FY 1985, the Indian Health Service allocated $206,502,848. to Tribal Health Systems for the provision and administration of health services. These allocations were in the form of P.L. 93-638 and Buy Indian contracts and P.L. 93-638 grants.

FY 1985 IHS-Award Instruments

P.L. 93-638 contracts	$168,071,158
Buy Indian contracts	29,246,403
P.L. 93-638 grants	9,185,287
Total	$206,502,848

Source: IHS Division of Contracts & Grants, IHS Office of Administration and Management

Tribal health costs funded by IHS dollars from Tribes reporting in this project amount to $136,340,376, or approximately 67% of the above figure. Tribal Health Systems costs reported are expenditures, not allocations.

If a program consisted of more than a CHR and/or alcoholism component, it was included in this study. The Tribal alcoholism and CHR programs that are "freestanding", i.e.; not combined with any other types of health services being provided by the Tribes, are not part of the scope of this project.

DESCRIPTIVE ANALYSIS OF TRIBAL HEALTH SYSTEMS, FY 1985

In an attempt to give a more complete picture of the total IHS costs being allocated for Tribal health systems, presented below is a summary of the costs and staff of Tribal Health Systems reporting within this project, and costs and staff of all alcoholism and CHR programs funded by IHS and administered by Tribes or Tribal organizations.

Distribution of IHS Funds and Staff Reported
for Tribally Operated Programs, FY 1985

IHS AREAS	Tribal Health Systems 1/		Alcoholism Program 2/		CHR Program 3/	
	IHS $	Staff	IHS $	Staff	IHS $	Staff
All IHS Areas	136,340,376	5,184.0	23,711,270	1076.5	28,495,161	1,455
Aberdeen	13,604,886	543.7	2,714,338	147.5	3,572,000	204
Alaska	37,604,886	1,127.0	1,542,980	NR	1,743,600	100
Albuquerque	1,007,650	47.4	1,755,588	169.0	2,118,137	120
Bemidji	20,344,172	752.0	1,741,000	NR	1,788,600	126
Billings	4,708,928	309.0	1,749,344	94.0	2,042,643	130
California	8,299,449	301.1	2,826,052	116.5	927,122	67
Nashville	21,672,122	537.0	1,262,323	68.0	1,683,036	41
Navajo	7,938,973	375.0	2,122,000	214.0	4,372,100	143
Oklahoma	7,568,167	379.4	1,925,685	NR	4,396,523	202
Phoenix	5,882,365	345.5	1,922,942	79.0	2,804,000	164
Portland	5,658,090	346.9	3,779,185	171.5	2,041,400	129
Tucson	2,012,146	120.0	369,833	17.0	1,006,000	29

1/ Reported on Profiles in the Descriptive Analysis of Tribal Health Systems
2/ Source: IHS Office of Alcohol Programs, Rockville, MD; excludes information from three IHS Areas for which no information was reported.
3/ Source: IHS Community Health Representative (CHR) Program, Rockville, MD

It is estimated there is approximately 10% overlap in the dollars and staff reported above, however the exact numbers are not known. In other words, approximately 10% of alcoholism and CHR dollars have been reported in the Tribal Health System; e.g., they are components in a more comprehensive system. It can be seen that the largest numbers of staff and dollars reported in this study were for contracts in the Alaska, Nashville and Bemidji areas. In the alcoholism programs, the largest amounts are for contracts in the Portland, California and Aberdeen Areas with the most alcoholism program staff funded in the Navajo Area. In the CHR program, the largest amounts are for contracts in the Oklahoma and Navajo areas with the most staff funded in the Aberdeen and Oklahoma areas.

RESPONSE TO STUDY

The Tribal Health Evaluation Coordinators (THECs) within each IHS area prepared a list of all projects funded in their respective areas that were not excluded by definition from this study. A total of 174 Tribal Health Systems were identified as being within the scope of this study.

As previously stated, there were four information instruments used in the collection of information for this study. These were the Profile, Site Criteria, Tribal Management Perception and IHS Management Perception instruments. Responses by instrument are listed below.

Instrument	Number of Health Systems Reporting
Profile	150
Site Criteria	95
Tribal Management Perception	539
IHS Management Perception	176

Since the requirement for reporting the information needed for this study was not included in the contractual award instruments with the Tribal Health Systems, the reporting of this information was optional by Tribal Health Systems. IHS Area Offices were instructed to furnish the Profile information from their records when the tribe elected not to participate; however, this information was not available in all Areas. Most IHS area offices were instrumental in facilitating the Tribes in the provision of complete and accurate data. In a few instances, the Profiles were completed by IHS area staff at the area office with Tribal input.

The results of this study are summarized below based on the specific information collection forms used in this project. A detail of information reported in all collection forms can be seen in the Appendix, pages 51 to 110.

DESCRIPTIVE ANALYSIS OF TRIBAL HEALTH SYSTEMS

CHARACTERISTICS OF TRIBAL HEALTH SYSTEMS

Responses received in the Profiles describe the characteristics of the Tribal Health Systems, the population served, the services, and staffing and costs of the administration of these health systems, both direct and contract. Table 1, page 51, in the Appendix presents a distribution of Tribal Health Systems that come within the scope of this project as furnished by the Area THECs. It also presents the number and percent of Profiles received from each of the Areas as of June 16, 1986, the deadline date for all information being furnished. Information was received from 86.2% of the Tribal Health Systems that are in the scope of this study.

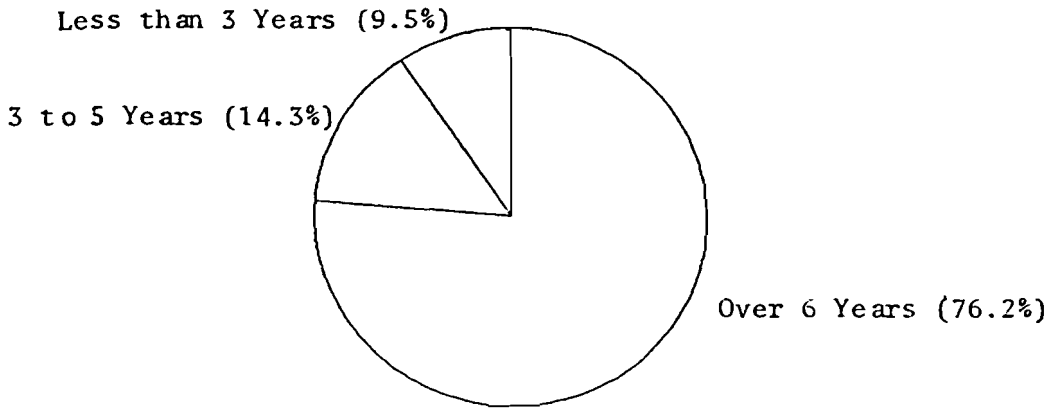
Types of Award Instruments

The IHS had 232 contractual award instruments with the 150 Tribal Health Systems that completed a Profile. Approximately 90% of these awards were made through the P.L. 93-638 contractual mechanism. Six percent of the award instruments were made through grants and 4% were made through the Buy-Indian contractual mechanism. Table 2, page 52, in the Appendix shows a distribution of the type of award instrument by IHS area for those Systems reporting.

Years of IHS Funding

Information was collected in the Profile on the length of time the Tribal Health System has had contracts or grants with the IHS to provide health services (see Table 3, page 53 in the Appendix).

YEARS OF IHS FUNDING
(For 147[1/] Tribal Health Systems)



[1/] Excludes 3 Tribal Health Systems that did not report this item.

Overall, 76.2% of Tribal Health Systems reported receiving IHS funds to provide health services for six years or more. An additional 14.3% had been receiving funds for 3-5 years and 9.5% for less than three years. All Tribal Health Systems reporting from the Billings area have been funded in IHS over six years. In the California and Nashville areas, approximately half of the Tribal Health Systems reporting have been receiving IHS funds less than six years.

DESCRIPTIVE ANALYSIS OF TRIBAL HEALTH SYSTEMS, FY 1985

Service Population

There are 686,800 eligible persons in the service population as reported by the 148 Tribal Health Systems that reported in this study (see Table 4, page 54, in the Appendix). Of these, 651,715 or 94.9% are American Indian and Alaskan Native. In many of the health systems reporting, funds are received from other than IHS with requirements that all eligible persons, as defined by the funding source, that seek the service are to be served without ethnic discrimination. Therefore, services are provided in some instances to non-Indians. The programs in the Billings, Navajo and Tucson areas reported all Indian service populations. The following table presents the reported Indian and Alaskan Native population being served for each of the IHS areas.

Reported Indian Service Population, FY 1985
Aggregated for Tribal Health Systems Reporting
by IHS Area

IHS Area	Number of Health Sys. Reporting	Reported Indian/ Alaskan Native Population Number
All Areas	148 1/	651,715
Aberdeen	16	68,092
Alaska	18	79,903
Albuquerque	2	3,595
Bemidji	29	55,040
Billings	7	39,252
California	13	25,939
Nashville	16	32,938
Navajo	3	109,885
Oklahoma	5	136,060
Phoenix	16	43,644
Portland	21	38,730
Tucson	2	18,637

1/ Excludes 2 programs that did not report data for this item.

DESCRIPTIVE ANALYSIS OF TRIBAL HEALTH SYSTEMS, FY 1985

The total reported Indian population being served by the respondents to this study represents approximately 68% of the total FY 1985 IHS service population (964,326) as furnished by the Division of Program Statistics, IHS, Rockville, MD. The service population data was obtained by the Tribal Health Systems from various sources as can be seen in the Appendix, Table 5, page 55.

It should be noted that the service populations reported by Tribes overlap with service populations for IHS programs, and may overlap to a small extent among the Tribal programs.

The source of the population data was predominantly from Tribal enrollment or projected from the 1980 census. Many times Tribes reported using more than one source to obtain the total information requested.

Services Available

Within the Profile, the Tribal Health Systems were asked to check the source which best describes how specific types of services are provided or available. The sources listed were: Tribal Health System, Indian Health Service, Contract Care, other and not available. Available was defined as "within one hour commuting distance and for free or a small fee to the patient". The major categories of services were inpatient, outpatient, community health and dental services, and administrative and other support services. Although only one source was to be checked for each type of service listed, in many instances, the Tribal Health Systems reported more than one source through which a particular type of service was available (Table 6a, page 56 in the Appendix). Information on services available when only one source was identified by the Systems reporting was summarized and a percentage distribution is presented in Table 6b, page 57 in the Appendix. It is should be noted that the number of Tribal Health Systems (N) checking only one source varies for each type of service listed.

Looking at sources reported for the provision of acute episodic medical care (Table 6b), it can be seen that the Tribal Health Systems reported 28% of this service available or provided through their System, 27% through the IHS, 36% through contract care, and 2% through other sources. Three percent of the Tribal Health Systems reported acute episodic medical care service was not available and 4% did not report their source for this type of service.

The Tribal Health Systems reported approximately 60% of the inpatient medical, obstetric, pediatric and surgical care were available through contract care. In addition, physical therapy, podiatry and medical specialty consultation support services were most generally available through contract care.

Dental preventive, diagnostic and treatment services were reported to be provided about equally by each of the three major sources: Tribal Health System, IHS and Contract Care.

DESCRIPTIVE ANALYSIS OF TRIBAL HEALTH SYSTEMS, FY 1985

Listed below are the types of services where the Tribal Health Systems reported at least 50% of these services are provided or available through their Health System for their service population.

Type of Services	Percent Services Available Through Tribal Health System
Primary Care - Outpatient	
Child Periodic Screening	50.8%
Well Adult Care	51.3%
Well Baby Care	54.9%
Well Child Care	56.6%
Community Health Services	
Alcoholism	75.2%
CHR Generalist	81.3%
Community Health Nursing	50.0%
Drug Abuse	64.7%
Health Education	64.9%
Home Health	54.8%
Outreach & Referral	85.7%
Social Services	50.4%
Transportation (non-emergency)	72.4%

Services Not Available

Based on the information checked by the Tribal Health System in the Profile on the source for specific type of services, the leading services reported NOT available to persons served by the Tribal Health Systems were:

Type of Services	Percent Services NOT Available
Adolescent Care (separate program)	37.5%
Nursing Home	35.0%
Health Education (separate program)	24.2%
Podiatry	19.3%
Physical Therapy	18.0%

Accessibility of Services

As a separate question in the Profile, Tribal Health Systems were asked to estimate the percent of their service population within one hour commuting distance from an inpatient, outpatient, or dental facility or community health office where services could be obtained for free or for a small fee to the patient. The results are reported in Table 7, page 58 in the Appendix. Of the 144 Health Systems reporting, an average of 77.3% reported service populations within one hour of an inpatient facility, 84.5% within one hour of an outpatient facility, 82.1% within one hour of a dental facility and 79.2% within one hour of a community health office.

Services Provided

The Tribal Health Systems reported the numbers of services (workload) being provided directly by them for inpatient, outpatient, dental and community health. The vast majority of Tribal Health Systems reported providing some type of direct community services. Slightly over half are providing some type of direct outpatient services and approximately one-third are providing some type of direct dental services. Based on the editing of the Profiles with the Tribal Health Systems, dental procedures in many instances were reported as dental visits. Since many visits include multiple procedures or services, this would account for the difference in direct Tribal visits reported to IHS (128,000) and those reported within this project (230,110). Some Tribes also reported workload for services being provided through contractual agreement between the Tribe and another organization (other than IHS). This workload is not being presented in this report since in many instances, these data were not available and not reported. Tables 8-10, pages 59 to 61 in the Appendix, present an area distribution of the number of Health Systems providing direct outpatient, dental and community health services and the actual workload for each type of service.

Reported Direct Services Provided by
Tribal Health Systems, FY 1985

Type of Service[1/]	Number of Health Systems	Percent Direct (N=150)	Number of Services Reported
Inpatient Days	8	5%	15,143
Outpatient Visits	90	58%	946,412[2/]
Dental Visits	49	33%	230,110
Community Health Services	128	85%	2,606,592

1/ The Tribal Health Systems reported providing these types of services. In some instances, these Systems may be the exclusive source of these services but in many instances, they are being offered also from IHS or other sources.

2/ The IHS Division of Program Statistics shows 667,651 Tribal direct outpatient visits exclusive of Community Health Aides (CHA) in Alaska. This difference, in addition to the CHA factor, is probably due to the fact that some Tribal Health Systems reported outpatient visits using a broader definition of outpatient visits than that employed by the IHS; e.g., pharmacy and lab visits.

DESCRIPTIVE ANALYSIS OF TRIBAL HEALTH SYSTEMS, FY 1985

Direct outpatient services are being provided by all of the Tribal Health Systems reporting from the Alaska, Albuquerque and Navajo Areas. The types of services considered as direct outpatient services are those provided by a primary care provider (MD, CHM, PA, Pharmacy Practitioner, Nurse Practitoner and Nurse Midwife), Community Health Aide (Alaska only), Optometrist and Audiologist. Direct community health services are being provided by all of the Tribal Health Systems reporting from the Albuquerque, Bemidji, Billings, Navajo, Oklahoma and Tucson Areas.

Costs

Tribal Health Systems were requested to report all health related functional costs for the time period 10/1/84 through 9/30/85, on an accrual basis. The information was requested by type of service (inpatient, outpatient, dental and community health), by source of funding (whether IHS or other source), the amounts used by Tribes to provide direct services and the amounts used by Tribes to provide services through a contractual agreement between the Tribe and a non-IHS organization. These award instruments may be via contract with a local private or public corporation including other Tribes or Tribal organizations.

A distribution of the use of funds from all sources for direct and contract services by type of service can be seen in the graph on the following page.

The project staff found a great deal of variability in practice among Tribal Health Systems as to what is being charged to administration and that which is charged to direct program operations. In some instances, administrative costs of the Tribal Health Systems were in a separate contract from the contract which covered the provision of health care. On the average it was found that approximately 20% of costs were charged to administration. This represented a range of 0 to 60% of total costs charged to administration for those Tribal Health Systems reporting. In those Tribal Health Systems where no administrative costs were reported, separate funding mechanisms exist to make provision for administrative costs. The source of these funds may be Tribal or government other than IHS. For those Tribal Health Systems that are reporting higher percentages of administrative costs, it is probably true that they are employing different conventions for what constitutes administrative costs as compared to those that reported lower percentages of administrative costs.

It should be noted that Tribal Health Systems may not fund the same specific program services within a particular type of service. For example, transportation and emergency medical services are funded by some Tribal Health Systems in outpatient and in other Systems in community health.

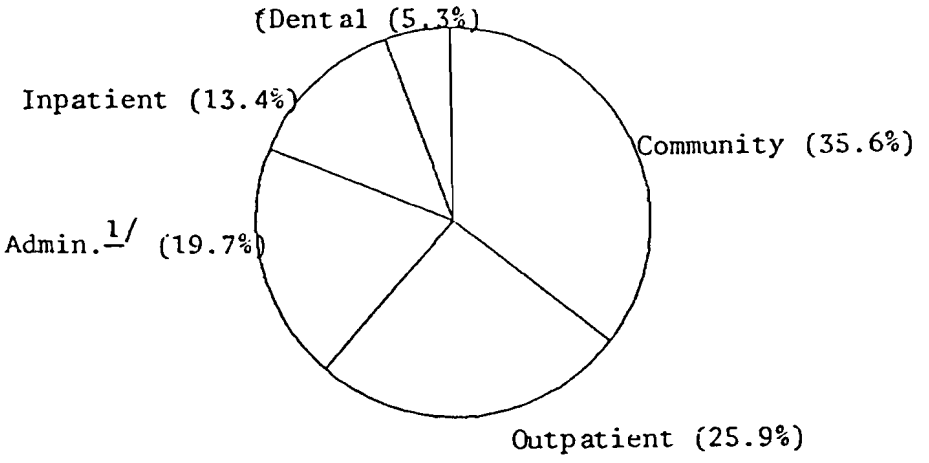
Also, Community Health Aides (CHAs) in the Alaska programs may be funded in either outpatient or community health services. Every attempt was made, however, to consider each of these instances in the editing process such that the specific programs were shown funded in the same major categories of service.

DESCRIPTIVE ANALYSIS OF TRIBAL HEALTH SYSTEMS, FY 1985

It should be noted that some health needs identified and provided by the Tribal Health Systems may not be included at all or to the same extent as in the current IHS health programs. For example, many Tribal Health Systems have established community service programs or alternative supplements to secondary prevention (e.g., nutrition, recreational therapy) for the aging population that provide services beyond dealing with acute medical problems or chronic disease maintenance.

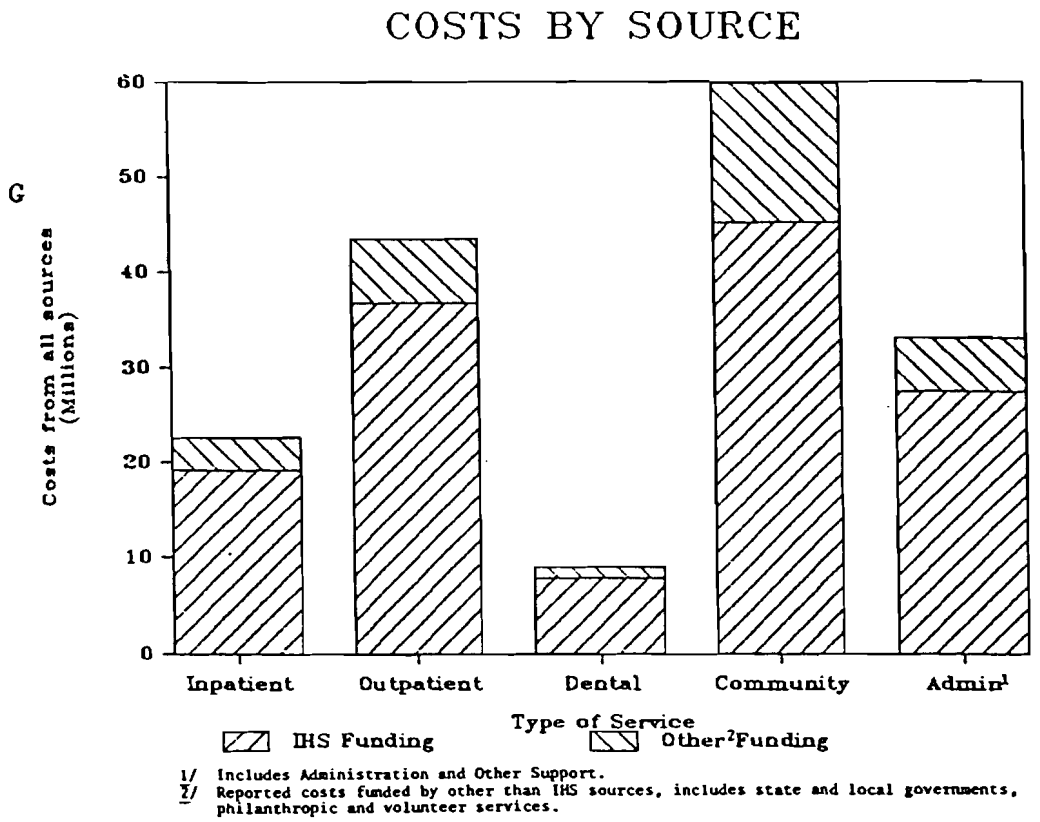
Costs expended by the Tribal Health Systems by type of service, by source and for direct and contract care are presented in Tables 11 through 11b.2, pages 62 to 68 of the Appendix. A total of $167,969,584 was expended from all sources by the 146 Systems reporting cost data to provide inpatient, outpatient, dental and community health services, and the administration of these services. The graph below displays the percentage distribution of all costs expended by type of service.

COSTS BY TYPE OF SERVICE
(For 146 Tribal Health Systesm)[2/]



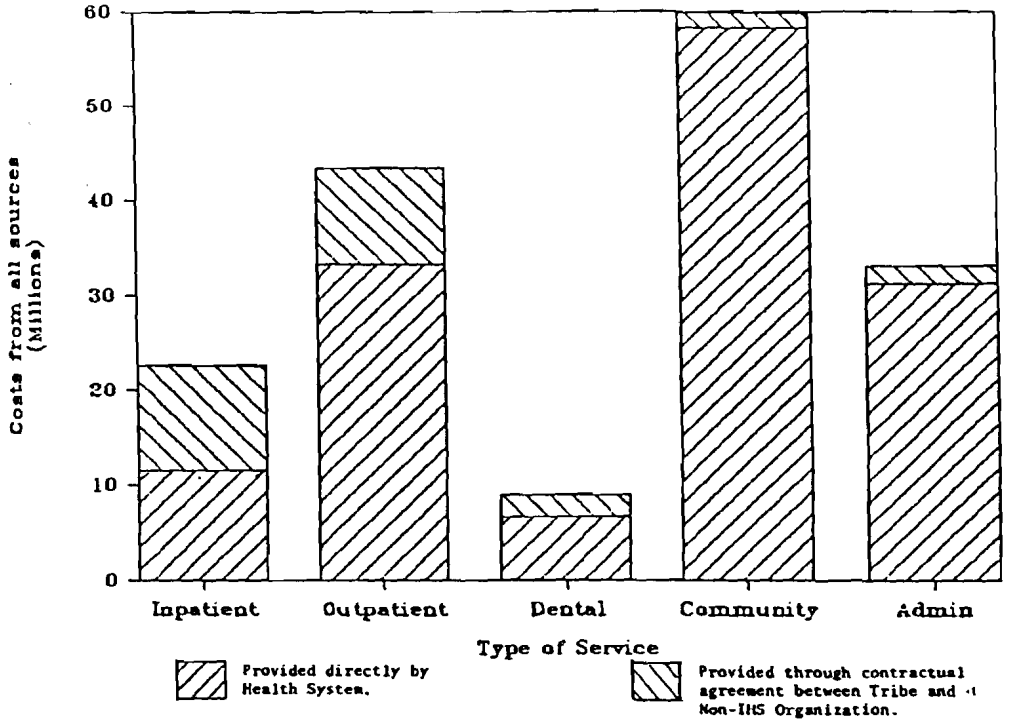
[1/] Includes Administration and Other Support
[2/] Excludes 4 Tribal Health Systems that did not report costs.

The Indian Health Service provided $136,340,376 or 81.2% of these funds. The remaining $31,629,208 or 18.8% of the funds reported were received from such sources as third party payers, state and local governments, philanthropic and volunteer services. The Tribal Health Systems, have more latitude for obtaining alternate resources and appear to be more resourceful in obtaining funds for community health and outpatient services. It can be seen from the graph on page 23 that IHS provides 75% of the funding for all types of services being provided directly or administered by the Tribal Health Systems reporting.



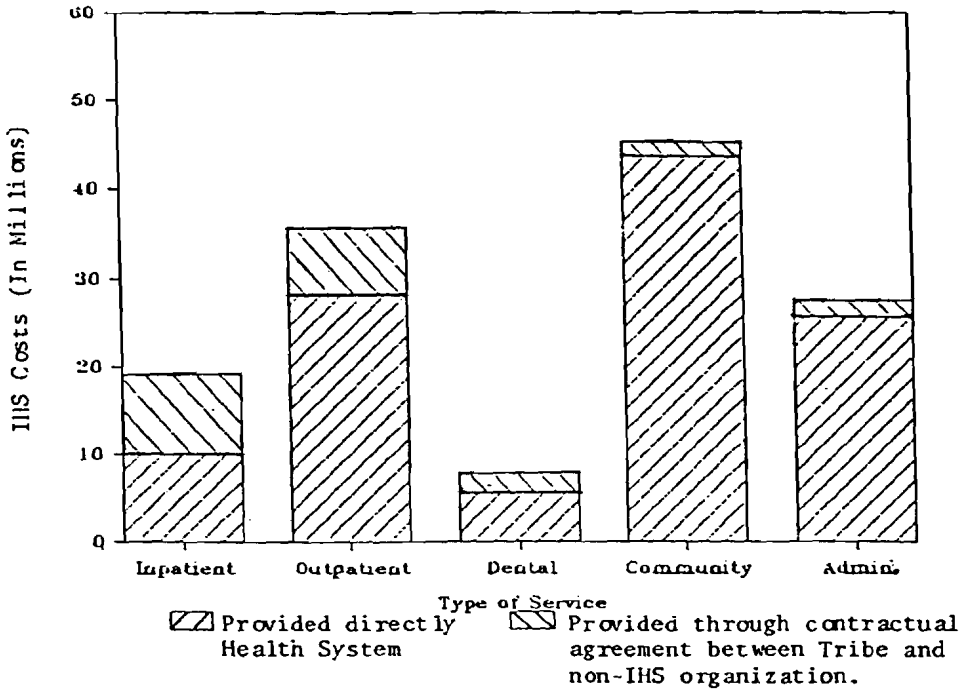
Tribal Health Systems provide services directly and/or negotiate for the provision of the services through contractual agreement between their organization and a non-IHS organization. The graph on page 23 shows a distribution of all costs for direct and contract services by type of service (also see Table 11b, page 66 in the Appendix). The Health Systems provide 97.3% of the community service and provide administration for 94.2% of their own programs. Approximately three-fourths of outpatient and dental services, and half of the inpatient services are reported provided directly by the Tribal Health Systems with the remainder provided through contractual agreement between the Tribe and a non-IHS organization.

ALL COSTS, DIRECT AND CONTRACT



A distribution of the use of IHS funds for direct and contract services by type of service can be seen in the graph below and on Table 11a.1, page 64, in the Appendix.

IHS COSTS: TRIBAL DIRECT AND CONTRACT SERVICES
(For 146[1/] Tribal Health Systems



[1/] Excludes four programs that did not report any IHS costs.

Of the IHS contractual dollars reported received by Tribal Health Systems for community health services, 99% of these resources were being used to provide these services directly by the Tribal Health Systems. Of the IHS contractual dollars reported received by Tribal Health Systems for outpatient and dental services, almost 75% of the these resources were being used to provide these services directly and one-fourth are being used by the Tribal Health Systems to contract for these types of services. Forty-five percent of the IHS contractual dollars reported received by Tribal Health Systems for inpatient services were being used to provide these services directly by the Tribal Health Systems and 55% used by the Tribal Health Systems to contract for inpatient services. At least 81% of funds received from other than IHS sources was reported used by the Tribal Health Systems to provide direct services (Table 11a.2, page 65).

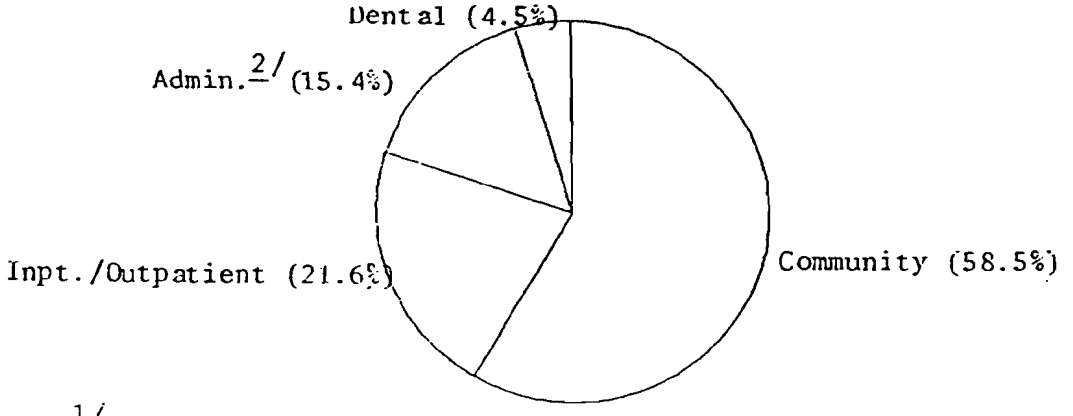
Staffing

Information was reported on all personnel in full time equivalents employed during the period 10/1/84 through 9/30/85. Personnel were reported by major discipline and designated as either a provider or non-provider as shown on page 2 of the Profile (see Appendix, page 112). The discipline categories were adopted from the IHS Resource Requirements Methodology (RRM).

A provider is defined as someone who provides direct health services to an individual. One provider discipline category is a Primary Care Provider (PCP), defined previously. A non-provider is defined as someone providing support to these direct health services such as administrative, maintenance or clerical staff.

The 150 Tribal Health Systems reported a total of 5,184 staff, the equivalent of full time persons employed to provide inpatient, outpatient, dental and community health services or the administration and support of these services. The following figure graphically illustrates the percentage distribution of these staff by type of service. Over half of all staff are employed in community health services.

TRIBAL FTE'S[1] BY TYPE OF SERVICE
(For 5,184 FTE's in 150 Tribal Health Systems)



[1] Full Time Equivalents - rounded to the first decimal; in some instances Tribal Health Systems included personnel staffed through Interpersonal Agreements (IPA's) and Memorandum of Agreement (MOA's) during the period 09/30/85; excludes staff of IHS direct operations regardless of funding source.

[2] Includes Administration and Other Support.

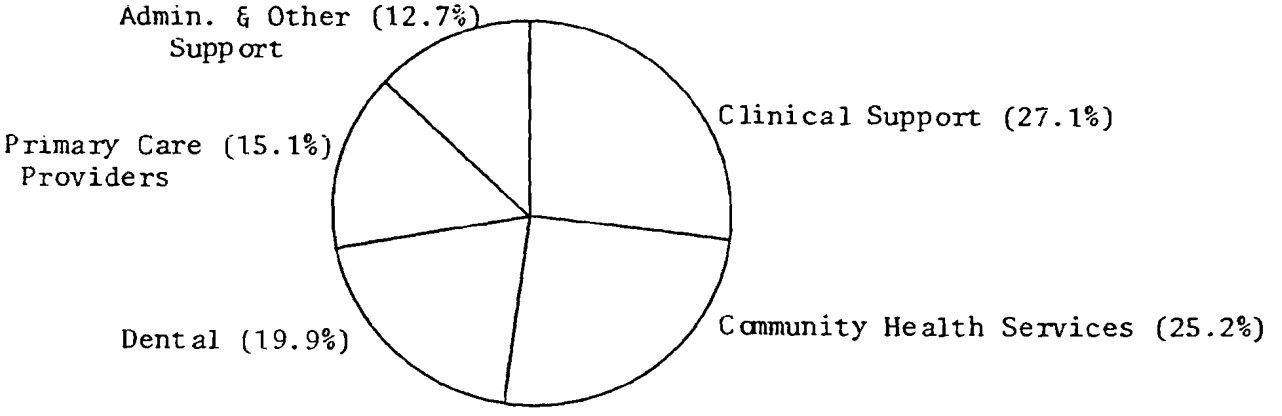
DESCRIPTIVE ANALYSIS OF TRIBAL HEALTH SYSTEMS, FY 1985

Presented in Tables 12, 12a and 12b pages 69 to 71 in the Appendix, is the distribution of Tribal FTE's by IHS Area and by discipline.

In addition to persons hired directly by the Tribe, some IHS staff are employed to provide services for the Tribes under P.L. 93-638 (direct hire), through Intergovernmental Personnel Act (IPA) transfers or Commissioned Officer assignments. Table 13, page 72 of Appendix, presents a distribution of these 251 FTE's by discipline and by IHS area as reported from the IHS Division of Indian Resources Liaison, Office of Tribal Activities, Rockville, MD. In some instances these personnel were included in the identification of Tribal Health System staff and in other instances they may not have been. Presented below is a graph showing the percentage distribution of these personnel by type of service. The major types of services in which persons with this type of assignment are employed are clinical support and community health.

IHS EMPLOYEES ASSIGNED/TRANSFERRED TO
TRIBES BY TYPE OF SERVICE

(For 251 FTE's*)



*Full Time Equivalents

Services per Staff

Services per staff were calculated for Tribal Health Systems that reported both services and staff. The data used for these calculations can be found in Table 14 page 73 of the Appendix.

Provider Group	Health Systems Reporting	FY 1985 Services Per Staff
Primary Care Provider (PCP)	63	2,802.3
Community Health Aide (CHA), Alaska only	15	796.7
Optometrist/Audiologist	29	1,402.9
Dentist & Dental Hygienist	41	1,680.8
Community Health Provider	128	1,055.5

Cost per Unit of Service

For the Tribal Health Systems that reported providing specific types of services (inpatient, outpatient, Dental, Community), the number of services provided were divided into the costs for that type of service (if reported) to arrive at a mean cost per unit of service. All mean costs for each type of service were summarized by Tribal Health System and an average mean cost per unit of service was calculated by type of service. The mean cost per unit of service for Tribal Health Systems in the "lower 48" was $41.60 per outpatient visit, $36.10 per dental visit and $22.70 per community health service. The mean cost per unit of service for Tribal Health Systems in Alaska only was $64.20 per outpatient visit, $42.50 per dental service and $93.90 per community health service.

Published data on the cost per unit of service for the general U. S. population are based on the payor's expenditures and not the health system's costs as derived in this study. Costs reported in this study for a given health system may include the costs which may be incurred by systems such as Tribal government such as land rent, reserve for replacement of buildings and permanent structures malpractice insurance and in some instances utilities.

For Tribal Health Systems reporting both services and cost, a mean cost per unit of service was calculated by type of service (see Table 15, page 74 in Appendix). Since costs for programs in Alaska are a special case, mean costs were calculated for Tribal Health Systems in Alaska only, for the "lower 48" and for all Systems combined. Costs for inpatient were calculated for the total Systems reporting since small numbers would identify the specific Tribal Health System.

DESCRIPTIVE ANALYSIS OF TRIBAL HEALTH SYSTEMS, FY 1985

CRITERIA - ADMINISTRATIVE AND PROGRAM ISSUES

It is believed that the standards or criteria used in this study are surrogates for direct measurements of effectiveness and identify those administrative/program issues which if in place in a program, would depict and assure an effectively managed and operated program. These criteria were developed in part from criteria used in previous studies conducted by the Office of Health Program Development, IHS, Tucson. Criteria for the previous studies were derived from standards used by national and state accrediting entities including the Joint Commission for Accreditation of Hospitals (JCAH). The criteria were developed in such a way that the assessment could be conducted based on the presence or absence of objective evidence rather than specialized professional judgment by the assessor. This unique design aspect was introduced in order that the Criteria could be applied by a wide range of health professionals and still maintain a satisfactory level of reliability of the data. Criteria used in this study were divided into the following categories: Governance, Administration, Financial Management, Medical Program - Inpatient, Medical Program - Outpatient, Dental and Community Health.

The study design called for the Criteria to be voluntarily self-administered by the Tribal Health Systems and then for one-third of the Systems to have criteria administered also by an IHS representative. Instructions from the Director, IHS were for IHS areas to complete the criteria for those Tribal Health Systems that did not choose to participate in the study.

Criteria statements were completed only for those categories which were appropriate to the Tribal Health System; i.e., if the System did not provide or administer outpatient services, that section of the Criteria was not completed. Also, the study design prescribed that if a Tribal Health System was providing or administering an inpatient medical program and that program was currently accredited by Joint Commission for Accreditation of Hospitals (JCAH), Joint Commission for Osteopathic Hospital Accreditation (JCOHA) or Health Care Financing Administration (HCFA), it was not necessary for them to complete that particular section of the Criteria. In some instances, criteria statements may not have been appropriate. For example, the criteria statements in the Facility category would not be appropriate if that Tribal Health System had no inpatient or outpatient facility.

The Criteria were self-administered by 80 or 46% of the Tribal Health Systems that are within the scope of this study. This represents a non-random self-selected sample. There were 15 Tribal Health Systems for which the Criteria documents were completed only by an IHS Area representative. There were 32 Tribal Health Systems for which both a self-administered criteria and one administered by an IHS representative were completed. A summary of the documents received can be seen on Table 16 page 75 in the Appendix.

DESCRIPTIVE ANALYSIS OF TRIBAL HEALTH SYSTEMS, FY 1985

Presented below are the numbers of service components within the Tribal Health Systems for which Criteria were completed.

Number of Service Components and Tribal Health Systems for which Administrative/Program Criteria were completed.

Type of Service Component	Number of Health Systems
Inpatient	6
Outpatient	44
Dental	35
Community*	223

* A Community health program component is an organizational element which is providing direct community health services, is distinctly identified on the Tribal Health System organizational chart, and has a separately identified manager, staff and budget. Practices vary widely among Tribal Health Systems as to whether the community health services are integrated into a single administrative component or subdivided into separate administrative components based on program emphasis, e.g., nutrition, mental health, environmental health.

Responses to each of the 80 self-administered Criteria documents and the 15 Criteria documents administered by IHS Area representatives which were the only documents available for that specific Tribal Health System were combined. The responses to each of the Criteria issues for all 95 Tribal Health Systems for which a Criteria instrument was completed are shown in Table 17, pages 76 to 96 in the Appendix. Area specific data will be presented in individual Area reports and are not presented within this report.

Information was obtained for each of the Criteria statements as to whether that particular statement was true for that Tribal Health System or not. All percentage calculations using responses in the Criteria were based on only those issues that were perceived to be applicable by the person applying the Criteria. Percent reporting was calculated by the number of "yes" responses divided by the total "yes" plus "no" responses and multiplying this proportion by 100. Criteria items that were blank or reported as not applicable were not included in the percentage calculations.

DESCRIPTIVE ANALYSIS OF TRIBAL HEALTH SYSTEMS, FY 1985

Listed below are the number of Criteria issues and the mean percent reporting Criteria issues present for each sub-section of the Criteria instrument. On the average, 76.5 percent of the 263 Criteria issues were found to be present nationally for all 95 Tribal Health Systems reporting.

Descriptive Summary of Criteria Responses by Sub-Section

Criteria Section	Health Systems Reporting	Number Criteria Issues	Mean Percent Reporting Criteria Present
All Criteria	95	263	76.5
I. Governance	95	24	78.1
A. Governing Body Operations		14	79.4
B. Health Director Functions		10	76.2
II. Administration	95	44	77.9
A. Management	95	20	84.9
B. Personnel Files	95	13	66.3
C. Performance	95	2	83.4
D. Transportation	95	9	78.1
III. Financial Management	95	22	89.0
A. Policies and Procedures	95	12	93.9
B. Procurement	95	4	89.0
C. Billing System	95	6	79.0
IV. Facilities and Environment	95	13	75.6
A. Health and Safety	95	11	74.4
B. Accessibility	95	2	82.0
V. Medical Program - Inpatient	6	3	100.0
VI. Medical Program - Outpatient	44	68	74.2
A. Accreditation	15	2	96.9
B. Protocols and Screening	29	5	69.0
C. Chart Review	29	10	87.7
D. Medical Records	29	4	77.2
E. Medical Records System	29	6	95.9
F. Tracking and Monitoring	29	7	73.7
G. Quality of Health Care	29	5	41.1
H. Appointments	29	5	72.2
I. Staff	29	6	78.3
J. Support Services	29	13	70.2
K. Patient Rights	29	2	62.4
L. Patient Advocacy	29	3	51.3

Descriptive Summary of Criteria Responses by Sub-Section (Cont'd.)

Criteria Section	Health Systems Reporting	Number Criteria Issues	Mean Percent Reporting Criteria Present
VII. Dental Program	35	60	73.5
A. Accreditation	35	2	91.6
B. Protocols and Screening	25	3	83.5
C. Chart Review	25	10	78.5
D. Dental Records	25	4	65.8
E. Dental Records System	25	6	84.0
F. Tracking and Monitoring	25	3	88.2
G. Quality of Care	25	5	60.2
H. Appointments	25	5	88.0
I. Staff	25	6	68.9
J. Support Services	25	11	70.4
K. Patient Rights	25	2	68.8
L. Patient Advocacy	25	3	65.9
VIII. Community Health Program	223	29	73.0
A. Program Administration	223	20	79.5
B. Referral Services	223	4	83.0
C. Patient Rights	223	2	60.1
D. Patient Advocacy	223	3	64.9

It appears that the most frequent positive responses relate to the Criteria issues which are most subject to external review. All six inpatient medical programs operated by Tribal Health Systems that were operating during FY 1985 were reported to be accredited by JCAH or HCFA, reported to have a written plan for implementation of recommendations and documented evidence that items in the plan were being addressed. Over 90% of the Criteria issues associated with accreditation for Medical Program - Outpatient and Dental programs were found to be present in Tribal Health Systems that were providing these services. Second only to the accreditation issues was the high percent of presence (89%) of the issues in the Financial Management section of the Criteria.

The least frequent positive responses related to those Criteria issues which have the least external review; those relating to Quality of Care procedures, Patient Rights and Patient Advocacy. This does not necessarily indicate that the programs were providing a low quality of care but frequently noted were: an absence of written procedures for a quality assurance program; an absence of documented evidence of internal quality assurance activities such as peer review; and, an absence of documented evidence that the results of a quality assurance program were being assessed by the Governing Body. The absence of a posted patient rights policy and in many instances the lack of formulation of a patient rights policy reduced the percent present in this section. The absence of a person formally designated as a patient advocate was the lowest in the Patient Advocacy category.

Tracking Initiatives

Within the Medical Program - Outpatient section of the criteria, Tribal Health Systems were asked if tracking systems or special registers existed for monitoring specific activities or patients. Of the 44 Tribal Health Systems with outpatient programs, 29 responded to this question.

Activity or Type of Patient	Percent of Health Systems with Tracking Systems or Special Register
Immunizations due	82.8%
Off-site referrals	79.3%
Diabetic patients	75.9%
Prenatal patients	75.9%
Abnormal lab results	72.4%
Hospitalizations	69.0%
Hypertensive patients	55.2%

Comparison of Tribal and IHS Applications of Criteria

There were 32 Tribal Health Systems for which Criteria documents were applied independently by both a representative of the Tribal Health System and a representative of the respective IHS Area. The number of Tribal Health Systems for which each of the Criteria categories was completed in the applications, both self-administered by the Tribal Health Systems and those administered by an IHS representative, can be seen in Table 18, page 97 in the Appendix.

A percentage distribution of Criteria issues present in each of the eight categories as applied in the self-administered applications and the applications by the IHS representative, and the percent difference in the two applications can be seen in Table 19, page 98 in the Appendix. Overall in the self-administered Criteria, the mean percent Criteria present for all categories was 76.8%. For the same 32 Tribal Health Systems in the application by an IHS Area representative, the overall mean percent Criteria present was 73.7%, for a net percent difference of only 3.1%. In six of the eight Criteria categories that were applicable, very little difference in mean percent of the Criteria present can be seen in the results of the self-administered Criteria and that administered by a IHS representatives. In the Facilities and Environment and the Financial Management categories, it appears that IHS representatives may have used a slightly more conservative interpretation of the presence or absence of the Criteria.

The Criteria can be used as guides for Tribal Health Systems to look at themselves, to see what management procedures are in place and identify areas for change. Area managers may also wish to review the Criteria as a potential management tool. In fact after participating in the pilot of this study, the IHS Nashville Program Office has expanded the Criteria employed in this Description and have placed these Criteria in the contractual work statements for the Tribal Health Systems in their Area.

PERCEPTIONS OF TRIBAL HEALTH SYSTEM AND IHS MANAGERS

Information collection forms were designed by the Design Committee and Project Staff to provide Tribal and IHS managers with an opportunity to candidly give their opinion on the management and operations of the Tribal Health Systems in their areas, their knowledge of P.L. 93-638, perceptions of the quantity and quality of the technical assistance being provided by the IHS staff and the need for additional training of IHS staff. The information forms were distributed by IHS Tribal Health Evaluation Coordinators to the appropriate Tribal and IHS staff. They were returned by the individual respondent to the Tucson IHS office. No individual identifying information was on the forms other than the IHS Area and the type of position of the respondent. A distribution of the Tribal and IHS forms returned by IHS Area can be seen on Table 20, page 99 in the Appendix.

Tribal Management Perception

Tribal Management Perception forms were distributed to each member of the Tribal Health System's governing body and the executive officials of the Tribal Health System management. The respective Tribal Health Systems distributed the perception forms to the persons they deemed as executive officials. There were 539 forms returned. Not all respondents answered every question. The responses for each question can be seen in Tables 21-23, pages 100-104 of the Appendix. Presented below is a summary of the responses from all Tribal Management staff and the approximate percent responding in the affirmative.

Issue	Percent Affirmative Responses
Familiar to some degree with P.L. 93-638 and related IHS regulations & policies governing Tribal Health Systems	90%
Should have more involvement in developing IHS Area/S.U. policy	90%
Uses Tribal Health System as a patient 85%	
Tribe is likely to assume/develop more health programs (in respondent's opinion)	84%
Involved in policy meetings or developing policies for Tribal Health System	80%
Satisfied with overall Tribal Health System operations	80%
Attend Tribal health department policy meetings	77%
Change is needed in Tribal health programs	75%
Would like more technical assistance from IHS	71%
Satisfied with quality of IHS technical assistance	69%
Satisfied with amount of IHS technical assistance	68%
Attend IHS Area/S.U. policy meetings	38%

DESCRIPTIVE ANALYSIS OF TRIBAL HEALTH SYSTEMS, FY 1985

There were 82 or 15.5% of the respondents who stated they did not use the Tribal Health System. Some respondents gave more than one reason for not using the System. Reasons included not eligible for services (44), the service was not comprehensive enough or service needed was not available (28), and had other resources available (27) such as private health insurance.

The amount and quality of the technical assistance being provided by IHS management staff to the Tribal Health Systems can be considered as an evaluative measure and can assist IHS Areas in their overall administration of these programs. Responses to these issues follow.

TRIBAL SATISFACTION TECHNICAL ASSISTANCE AMOUNT: Percent Satisfaction of Tribal Health System Managers with Amount of Technical Assistance Provided by IHS Staff, (N=450)

		PERCEPTION OF AMOUNT OF TECHNICAL ASSISTANCE FROM IHS (In Percent)		
TYPE OF RESPONDENT	Number	Mostly Satisfied	Partially Satisfied	Not Satisfied
All Respondents*	450*	28.7	46.9	24.4
Tribal Governing Body	252	29.4	46.8	23.8
Tribal Health System Management	198	27.8	47.0	25.2

* excludes 89 respondents who either did not identify their position or did not respond to this question.

TRIBAL SATISFACTION, TECHNICAL ASSISTANCE QUALITY: Percent Satisfaction of Tribal Health Systems Managers with the Quality of Technical Assistance Provided by IHS Staff, (N=447)

		PERCEPTION OF QUALITY OF TECHNICAL ASSISTANCE FROM IHS (In Percent)		
TYPE OF RESPONDENT	Number	Mostly Satisfied	Partially Satisfied	Not Satisfied
All Respondents*	447*	32.4	43.2	24.4
Tribal Governing Body	252	32.9	40.4	26.6
Tribal Health System Management	195	31.8	46.7	21.5

* excludes 92 respondents who did not either identify their position or respond to this question.

It can be seen that the responses from the Tribal Governing Body members and Tribal Health System managers track very closely. Approximately 75% of the respondents are satisified at least partially with both the amount and the quality of the technical assistance being provided to their programs by IHS managers. When analyzing the reported dissatisfaction, it is clear that there may be areas for improvement in the provision of technical assistance.

Tribal management respondents were requested to identify additional technical assistance they would like. These responses were jointly categorized and summarized by the Steering Committee members and Project Staff. The results are shown below.

Additional Technical Assistance Respondents Would Like	Group Represented by Respondent: Tribal Governing Body	Tribal Management	Unknown	Total
Management	23	21	7	51
Program Development/Review:				
Alcoholism	2	0	1	3
Environmental Health	8	6	0	14
Substance Abuse	2	3	0	5
General	33	24	1	58
Clinical/Professional Staff Issues	23	17	2	42
Health Care Issues/Concerns	8	12	4	24
Contracting	9	10	2	21
Funding	6	8	1	15
638	3	10	1	14
Reporting	5	4	0	9
Alternate Resource	3	3	0	6
Information Systems	0	6	0	6
Legislation	1	3	0	4
Indirect Cost	0	1	0	1
Other	20	19	4	43

The responses relating to the quantity and quality of IHS technical assistance being provided (Questions 12 and 13 of the Tribal Perception instrument) were analyzed further by IHS Area. There were no responses from the Albuquerque Area. IHS Areas identified by respondents as providing the most satisfactory amount of technical assistance were Alaska (43.2%) and Nashville (42%). The IHS Areas that had the highest percentages in which the amount of technical assistance was perceived as not satisfactory were California (38.9%), Oklahoma (37.5%), Billings (36%) and Aberdeen (35.9%).

Weights were assigned to each of the responses relative to the amount and quality of the IHS technical assistance to develop a scoring mechanism. A score of 5 was given to a response of Mostly Satisfied, a score of 3 for Partially Satisfied and a score of 1 for Not Satisfied. Mean scores were then calculated for all responses and summarized by IHS area. An overall mean score of 3.09 for the amount of technical assistance and 3.16 for the quality of the technical assistance was derived for all respondents.

The Nashville, Navajo and Bemidji Areas have the highest mean scores for the amount of technical assistance provided with scores of 3.50, 3.50 and 3.36 respectively. The Alaska, Bemidji and Navajo Areas have the highest mean scores for the quality of technical assistance provided with scores of 3.54, 3.30 and 3.25 respectively.

IHS Area Management Perception

IHS Area Management Perception forms were distributed to Area Project Officers, Contract Officers, Tribal Project Officers and Contracts Project Liaison Officers. There were 176 perception instruments returned. Respondents could be identified only by IHS Area and whether they identified themselves as being in Tribal project management or contract management. Apparently, respondents only gave answers to those items that they believed to be appropriate, applicable or those which would preserve their anonimity. For example, an item on the form which was frequently not completed was whether they were an Area Tribal Project Officer or Contract Officer. There were 68 respondents who identified themselves as being in Tribal project management, 67 identifying themselves as being in contract management and 41 respondents left this item blank. Responses to the IHS Area Management Perception instrument can be seen in Tables 24-26, pages 105-110 of the Appendix.

If the respondent was a Project Officer, they were asked to estimate the total dollars for the contracts and grants for which they were responsible. The sum of these estimates reported by the 94 Project Officers responding to this item was $201,063,615. There were 96 persons who reported being responsible for an average of four contracts each. An average of 16 site visits per project per year were made by 117 Tribal project and contract staff who responded to this item. An average of 162 telephone contacts per project per year were reported by the 121 persons who responded to this item.

Respondents were asked to estimate the percent of time they function as a project officer.

Percent of Time Functioning as Project Officer

Percent of Time	Type of Respondent: Project Mgmt.	Contract Mgmt.	Not Ident.	Total	Percent
Over 75%	15	6	5	26	24.8
50%	10	1	0	11	10.5
25%	16	5	3	24	22.8
Less than 25%	17	16	11	44	41.9
N/A	5	32	12	49	
Blank	5	7	10	22	
TOTAL	68	67	41	176	100.0

Of the 105 persons who indicated the percentage of time they spent as Project Officer, 35% reported they spent half or more of their time and 65% reported they spent one-fourth or less of their time as a project officer. Of the 68 persons who identified themselves as being in Tribal project management, 43% reported spending half or more of their time and 57% reported spending one-fourth or less of their time as a project officer. Based on the data as reported in this study, there is a ratio of the equivalent of one full time project officer for each $4.5 million of contracts.

In response to the question, "Do other assigned duties interfere with your serving as a Project Officer, Contract Officer or Tribal Project Officer/Contracts Project Liaison Officer?", 36.5% of the 146 respondents checked Yes, 23.3% Partially and 41.1% checked No. Of the 86 respondents who believed that other duties were interfering with their functions in the 638 process, there were 60 who furnished reasons. These responses were summarized into like categories. Thirty-one indicated that the Project Officer duties are secondary to their principal job. The balance indicated insufficient work time or resources or other.

The question was asked of the IHS Area Managers, "How would you describe the IHS Area Office management of Tribal health contracts in your IHS Area?" The following is a percentage distribution of responses from the 166 respondents to this question.

Rating of IHS Area Management of Tribal Health Contracts	Percent Response
Outstanding	6.6
Very Good	29.5
Good	33.2
Fair	23.5
Poor	7.2

It was found that 85.7% of the respondents in the Bemidji Area and 60% in the Tucson Area gave a rating of outstanding or very good. Fair or poor ratings by respondents were found more often in the Aberdeen (66.7%), Oklahoma (57.2%) and California (53.9%) areas.

Weights were assigned to each of the responses relative to the perception of IHS management of Tribal Health Systems by IHS Area Managers to develop a scoring mechanism. A score of 5 was given to a response of Outstanding, 4 for Very Good, 3 for Good, 2 for Fair and a score of 1 for Poor. Mean scores were then calculated for all responses and summarized by IHS Area (Table 24, page 105 of Appendix). The national mean score was 3.00. The Bemidji Area had the highest mean score (4.10) with Oklahoma the lowest mean score (2.43).

IHS Area staff were asked if the number of project site visits being made was adequate. Of the 147 who responded, 38.1% said yes, 38.1% said no and 23.8% said they were not sure.

Presented below is a summary of responses to additional questions in the IHS Management Perception form.

Issue	Percent Positive Response
Familiar with P.L. 93-638 at least to some extent	99%
Have access to someone for answers to questions on P.L. 93-638 process	94%
Trained well enough to provide adequate technical assistance (TA) to projects	68%
Need at least some additional training and experience to provide adequate consultation and technical assistance	45%
Effectively serving all contractors and grantees	50%
Certified as Project Officer	54%
Need at least some additional knowledge of Tribal activities and services in Area	74%
Involved in all aspects of project which are appropriate for current position	74%
Receive adequate support from IHS Area and Headquarters to perform current role	64%
There is an effective working relationship between contracting and program offices	55%

Comparison of Tribal Managers and IHS Area Management Perception

Although beyond the scope of a descriptive analysis, a statistical analysis was conducted on the two independently obtained sets of managers' perceptions of Area Office functions that could be correlated. These functions were the Tribal health managers' perception of the quantity and quality of technical assistance provided by the IHS Area offices (questions 12 and 13 of the Tribal Perception form) and the IHS Area staff perception of the management of Tribal health contracts in their Area.

It was found that a significant positive association exists between these two sets of perceptions. To obtain a single score for Tribal managers' responses for each IHS area, mean scores were calculated for all the responses to the questions, "Are you satisfied with the amount of technical assistance provided by the IHS" and "Are you satisfied with the quality of technical assistance provided by the IHS". Presented below is a ranking of the area from which responses were obtained from the Tribal and IHS managers.

Comparison of Tribal Satisfaction with IHS Area Technical Assistance and IHS Area Managers' Assessment of the Area's Management of Tribal Health System Contracts in Descending Rank Order by IHS Area Based on Mean Scores

Tribal Managers' Responses			IHS Area Managers' Responses		
Rank	Area	Mean Score	Rank	Area	Mean Score
1	Alaska	3.43	1	Bemidji	4.10
2	Navajo	3.38	2.5	Navajo	3.60
3	Bemidji	3.33	2.5	Tucson	3.60
4	Nashville	3.15	4	Alaska	3.30
5	Tucson	3.00	5	Portland	3.10
6	Portland	2.80	6	Billings	3.00
7	California	2.78	7	Nashville	2.95
8	Billings	2.72	8	Phoenix	2.90
9	Phoenix	2.63	9	California	2.50
10	Aberdeen	2.55	9	Aberdeen	2.50
11	Oklahoma	2.43	10	Oklahoma	2.43
*	Albuquerque		*	Albuquerque	

* Less than 5 respondents

Tribal Responses	Weight	IHS Responses	Weight
Mostly Satisfied	5	Outstanding	5
		Very Good	4
Partially Satisfied	3	Good	3
		Fair	2
Not Satisfied	1	Poor	1

Source: Tables 23 and 26, pages 106 and 112 in Appendix

In those individual IHS Areas where Tribal Health Managers tended to be mostly satisfied with the quantity and quality of technical assistance from the Area Office, Area managers believed that the Area Office was doing an outstanding or very good job managing Tribal health contracts. In those individual IHS Areas where the Tribal health managers were less satisfied with the quantity and quality of technical assistance from the Area Office, more of the Area managers believed that the Area Office was doing less than a good job.

IV. CONCLUSIONS

With considerable project staff time invested, responses of 86% reporting on Profile data and 55% on Site Criteria were obtained. If it is considered desirable for the IHS to continue to monitor any of the issues examined in this study in a uniform manner, dedicated staff resources for coordination, training and technical assistance will be required for two or three additional annual cycles to assure "institutionalization".

In order to develop the capability for Tribal management and IHS Area offices to monitor the efficiency and effectiveness of these programs, there is considerable evidence that there is a need for uniform definitions and guidance in classifying cost, personnel, services and routine reporting of these items.

The Tribal Health Systems have been extremely effective in obtaining supplemental resources to provide health services to their people, particularly in the area of community health services.

For all Tribal Health Systems reporting in all IHS Areas, approximately 80% of the service population is estimated to be within one hour of inpatient, outpatient, dental and community health services for free or for a small fee to the patient. Considerably below the national average for accessibility are some of the service populations in the Alaska, Aberdeen, Albuquerque, California and Navajo areas.

Special programs for adolescent care, nursing home services, health education, community care for the aged and podiatry were most often reported as not available.

Approximately 90% of the Criteria issues which are most subject to external review (those associated with accreditation and financial management) were found to be most frequently present in the Tribal Health Systems. All six inpatient medical programs operated by Tribal Health Systems that were operating during FY 1985 were reported to be accredited by JCAH or HCFA.

The Criteria document used in this study appears to be a reliable instrument, based on the paired results of the self-administered Criteria and the Criteria applied by the IHS Area representatives.

About 75% of the Tribal managers reported to be partially to fully satisfied with the quantity and quality of technical assistance being provided by the IHS and about 80% were satisfied with the overall operation of their Tribal Health System.

Approximately 70% of IHS Area staff reported a belief that their Area was doing a good, very good or outstanding job of managing Tribal health projects. In those few Areas where overall the Area staff reported a relatively low opinion of how the Area was managing these projects, the underlying problem(s) needs to be identified and constructively addressed.

IV. CONCLUSIONS (Cont'd.)

Based on the amount of time reported in the project management process and the dollar value of the contracts being managed, it appears that dollar volume alone is an inadequate basis for staffing this function.

The high response rates from both the Tribal and IHS managers on their perceptions were extremely helpful in identifying requirements and contributed to the overall description of these Tribal Health Systems. The correlation between the independent IHS and Tribal management perceptions as to IHS Area office services is an indicator which suggests general agreement on the quality and quantity aspects of this process.

V. RECOMMENDATIONS

Based on the findings of this study and the discussions of the Steering Committee and project staff, it is recommended that:

1) IHS and Tribal managers finalize the development of an on-going capability for routinely monitoring the efficiency, effectiveness and acceptability of services being provided by Tribal Health Systems. Staff resources will be required to:

   a) assure a uniform accounting and reporting system for Tribal Health Systems;
   b) assure an on-going, on-site program review based on negotiated administrative/management effectiveness criteria;
   c) assure an on-going process for monitoring Tribal Health System manager satisfaction of the IHS Area office services, and patient satisfaction with the Tribal Health System services;
   d) institute routine training of IHS and Tribal health staff on the implementation of the systems identified;
   e) assure the routine provision of technical assistance to Tribal Health Systems which will address the issues for improvement or further development that have been jointly identified through this process.

2) Concurrent with development of on-going capability for monitoring Tribal Health Systems, IHS initiate and apply this same process to health systems being operated directly by IHS.

3) Criteria used to establish the number of IHS project officers required be expanded to include: size and complexity of the program; number of Health System sites; degree of sophistication of fiscal management systems; and the experience of Tribes in the 638 contracting process. These expanded criteria need to be examined to determine if the number of project officers required needs to be modified.

4) In those instances where the Area staff collectively reported a relatively low opinion of how the Area is managing these Tribal Health Systems, the underlying issues be identified and constructively addressed.

5) Each IHS Area review the results of the criteria applications to Tribal Health Systems in their Area for identification of needs for technical assistance that are common throughout their Area. These common issues for technical assistance may be addressed efficiently through group training or processes.

6) An independent, routine evaluation process needs to be initiated and institutionalized which provides to the IHS Director and the Council of Associate and Area Directors with an overview assessment, and recommendations on the relative effectiveness and efficiency with which the IHS is implementing the P.L. 93-638 process.

7) A documentation and assessment of the patient's current health status be included in the future design of health care systems. It is recognized that the only true measure of effectiveness of a Health System is the relative change in patient's health status, including risk of illness, as a result of interacting with the services of that System.

APPENDIX

GLOSSARY

The following are acronyms used in the Descriptive Analysis of Tribal Health Systems.

CHA	Community Health Aide
CHN	Community Health Nurse
DHHS	Department of Health & Human Services
EMS	Emergency Medical Services
FTE	Full Time Equivalent
FY	Fiscal Year
HCFA	Health Care Financing Administration
HRSA	Health Resources & Services Administration
IHS	Indian Health Service
JCAH	Joint Commission for Accreditation of Hospitals
JCOHA	Joint Commission for Osteopathic Hospital Accreditation
NCAI	National Congress of American Indians
NIHB	National Indian Health Board
NTCA	National Tribal Chairmen's Association
OASPE	Office of Assistant Secretary for Planning & Evaluation
OHPD	Office of Health Program Development
OHP	Office of Health Programs
OPEL	Office of Planning, Evaluation & Legislation
PCP	Primary Care Provider
RAM	Resource Allocation Methodology
RRM	Resource Requirements Methodology
SU	Service Unit
TA	Technical Assistance
THEC	Tribal Health Evaluation Coordinator
THS	Tribal Health System

The following are definitions of terms as used in the Descriptive Analysis of Tribal Health Systems.

Accessability - As used in this project is limited to geographic distance from established health services and defined specifically as within one hour commuting distance by land transportation.

Accrual Basis - An accounting method which charges and accumulates costs to the organization within that time period for which the obligation for the cost is created.

Administration and Other Support Costs - Tribal or service unit administrative or executive direction costs for the management of Tribal Health Systems, includes indirect costs.

Administrative Positions - Includes those positions allocated for administrative support or executive direction (e.g., finance, personnel, clerical) not elsewhere identified with a specific health service activity.

GLOSSARY (cont'd)

Area - A defined geographic region for IHS administration purposes. Each Area Office administers several service units.

Availability - The existence of established health services within one hour commuting distance by land transportation for free or for a small fee to the patient.

Award Instrument - A written legal obligation negotiated between the Indian Health Service and a Tribal Health System under the authority of P.L. 93-638 the Buy Indian contracting process.

Community Health - Services provided in the community such as aging program, alcoholism, CHR generalist, Community Health Nursing, Drug Abuse, Environmental Health, Health Education, Home Health, Meal Program for the Elderly, Mental Health (separate program), Nursing Home, Outreach and Referral, Social Services, Transportation (non-emergency).

Community Health Aide (CHA) - The primary provider of health services in the Alaska Area, located at the village level. CHA's are chosen by the village council and educated to provide: a wide range of preventive health services, serve as the initial responder in emergencies, examine the ill, report their symptoms to the physician, carry out the treatment recommended, instruct the family in giving nursing care and conduct ongoing health education in the villages.

Community Health Component - An organizational element which is providing direct community health services, is distinctly identified on the Tribal Health System organizational chart, and has a separately identified manager, staff and budget.

Community Health Representatives (CHR) - Indians selected, employed, and supervised by their tribes and trained to provide specific health care services at the community level.

Contract Project Liaison Officer (CPLO) - Person who interfaces for the federal government providing technical assistance to the Tribal Health System in the pre-award stages of the 638 contracting process.

Contract Services - Services provided through a contractual agreement between a Tribal Health System and a non-IHS organization.

Costs - All accrued dollars for costs incurred to provide health and health related care for the period October 1, 1986 to September 30, 1986.

Dental Services - All types of dental services provided including prevention, diagnosis and treatment of diseases of the oral cavity and restoration of oral health. Two or more types of dental services may be provided during a dental visit.

Dental Visits - An encounter with a dental provider during which one or more dental services are provided.

GLOSSARY (cont'd)

Direct Services - Services provided directly by Tribal Health System employees.

Emergency Medical Service (EMS) - Emergency medical care and transportation of IHS eligible patients to and from appropriate health centers or providers.

Full Time Equivalent (FTE) - 2,080 hours of available productive staff time per year without consideration for leave or training equals one full-time equivalent. No individual can exceed one full-time equivalent. A person working half-time would be listed as .5 FTE.

"FY 1985" - The reporting period for this project is October 1, 1984 through September 30, 1985.

Indian Tribe - Any Indian tribe, band, nation, group, Pueblo, rancheria, or community, including any Alaska Native village or group, or regional or village corporation. A tribe may be federally recognized, State-recognized, or self-recognized and/or federally terminated. In the context of the Federal-Indian relationship, tribes must be federally recognized in order to be eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

Indirect Costs - Costs associated with all activities other than the direct provision of services.

Inpatient Services - Medical, obstetric, pediatric, surgical or other health services provided while admitted in a health care facility.

Medicaid - The state-federal program that provides medical benefits for certain low income persons in need of medical care.

Medical Facility - Inpatient - A facility that admits patients at least over night and provides room and board concurrent with diagnostic, therapeutic or rehabilitative services.

Medical Facility - Outpatient - A facility designed to provide preventive, diagnostic, therapeutic or rehabilitative services to individuals who do not require hospitalization or institutionalization.

Medicare - The federal health insurance program for people 65 years of age and over, people eligible for social security disability payments for more than 2 years, and people with end-stage renal disease, regardless of income.

GLOSSARY (cont'd)

Outpatient Services - Services received on an ambulatory basis at a hospital or other health facility without being admitted to the facility. Services are provided by PCP, CHA, Optometrists and Audiologists, in the following areas: Acute Episodic Medical Care, Adolescent care (separate program), Adult Periodic Screening, Audiology, Child Periodic Screening, Crippled Children, EMS, Family Planning, Health Education (separate program), Management of Chronic Medical Problems, Optometry, Physical Therapy, Podiatry, Prenatal Care, Public Health Nutrition, Well Adult Care, Well Baby Care, Well Child Care, WIC Program, Women's Health Care.

Physician Specialist - A board certified or board eligible physician who limits his/her practice to a specific branch of medicine; e.g., pediatrics, geriatrics, obstetrics.

Primary Care - Routine health care, including examinations, immunization, prenatal and well-child care, first aid, etc.

Primary Care Providers (PCP) - A specific type of health professional (physician, community health medic, physician assistant, nurse practitioner or nurse mid-wife) who provides preventive, diagnostic, therapeutic or rehabilitative services and has been professionally trained and licensed or certified to provide such service.

Program Office - A defined geographic region for IHS administration purposes analgous to Area offices however dependent upon an adjacent Area office for one or more support services; e.g., finance or personnel. Each Program Office administers several service units.

Project Officer - The federal government's representative on contracts, grants, cooperative or other agreements with the reciprocals of these agreements.

Provider - An individual who provides directly to a patient a specific element of preventive, diagnostic, therapeutic or rehabilitative care. This individual is usually specifically trained for this function.

Public Law 93-638 Indian Self-Determination and Education Assistance Act - This act required the Secretary, if so requested by a Indian tribe, to enter into a contract with any tribal organization of that tribe "to carry out any of is functions, authorities, and responsibilities" under the Transfer Act (P.L. 83-568).

Section 106(h) of the Act requires the Secretary to fund contracts entered into under section 103(a) at a level which is "no less" that the Secretary would have provided for the direct operation of the programs for the contract period. Section 104 authorized the Secretary to make grants to any Indian tribe or tribal organization for various health related purpose.

GLOSSARY (cont'd)

Reservation - Any Federally recognized Indian Tribe's reservation, Pueblo, or colony, including former Indian lands in Oklahoma and Alaska Native regions.

Service - A face-to-face contact between an individual and a provider of health care services who exercises independent judgment in the provision of health services to the individual. In addition, a telephone call of two hours or longer where a specific service is provided for an individual may be counted as one service.

Service Population - Persons identified to be eligible for IHS services and others not eligible for IHS services, but determined eligible by the specific Tribal Health System.

638 Contract - Contracts between Indian tribes or tribal organizations and Federal agencies (i.e., IHS and BIA), under which tribes assume planning, operation, and administration of programs and services for Indians from the Federal Government. Authorized by the Indian Self-Determination and Education Assistance Act of 1975 (Public Law 93-638).

Technical Assistance - Assistance provided by an IHS representative in the planning design, operations, monitoring and evaluation of Tribal Health Systems or their components.

Technical Project Officer - Health discipline specific representative of the federal government on contracts, grants, cooperative or other agreements with the reciprocals of these agreements.

Third Party Payers - Any organization other than Indian Health Service or Tribal Health System that pays or insures health or medical expenses.

Transportation (non-emergency) - Routine medical transportation of IHS eligible patients to and from appropriate health centers or providers.

Tribal Governing Body - An administrative organizational unit of a Tribe which has overall management responsibilities for Tribal activities.

Tribal Health Program - Components of tribal health system which may include one or more of the following units: inpatient, outpatient, dental or community health.

Tribal Health System - The entire health system that is operated by a particular tribe, band, group or Alaskan Native village or corporation regardless of the number of sites or funding sources.

Tribal Health System Management - Those individuals responsible for administering and directing the health system activities of Tribes.

Tribal Leader - A duly elected person who represents an Indian population and has been delegated the administrative authority to legally represent the Tribe.

Descriptive Analysis of Tribal Health Systems, FY 1985

Table 1: PROFILES RECEIVED - Distribution of Tribal Health Systems Included in Project[1] by IHS Area

IHS Area	Total From Master List[2]	Profiles Received	Percent Response	For Those Received Percent with Complete Information[3]
ALL AREAS	174	150	86.2	90.7
Aberdeen	17	16	94.1	93.7
Alaska	18	18	100.0	100.0
Albuquerque	3	2	66.7	100.0
Bemidji	29	29	100.0	100.0
Billings	7	7	100.0	100.0
California	26	13	50.0	100.0
Nashville	16	16	100.0	100.0
Navajo	3	3	100.0	100.0
Oklahoma	8	5	62.5	100.0
Phoenix	23	17	73.9	88.2
Portland	22	22	100.0	50.0
Tucson	2	2	100.0	100.0

1/ Tribal Health Systems with only alcoholism and/or Community Health Representative (CHR) programs are excluded from this report.
2/ Master list of all Tribal Health Systems within the scope of this project was furnished by IHS Area Offices.
3/ Those Tribal Health Systems provided complete information on staff, services, costs and/or population.

Descriptive Analysis of Tribal Health Systems, FY 1985

Table 2: TYPE OF AWARD INSTRUMENT - Type of Contractual Award Instrument by IHS Area

IHS Areas	Number of Health Systems Reporting	Total Award Instruments	TYPE OF AWARD INSTRUMENT		
			P. L. 93-638	Buy Indian	Grant
All Areas	150	232	208 1/	10	14
Aberdeen	16	41	34	1	6
Alaska	18	21	16	2	3
Albuquerque	2	3	3	0	0
Bemidji	29	37	36	1	0
Billings	7	7	6	1	0
California	13	15	12	1	2
Nashville	16	16	16	0	0
Navajo	3	4	1	1	2
Oklahoma	5	23	22	0	1
Phoenix	17	31	30	1	0
Portland	22	29	27	2	0
Tucson	2	5	5	0	0

1/ Includes one negotiated contract under standard procurement processes.

Table 3: YEARS OF IHS FUNDING - Number of Years Tribal Health Systems have been Funded Under P.L. 93-638, Buy Indian Contracts or Grants

	Number of Health Systems Reporting		Years of Funding					
			Less Than 3 Years		3-5 Years		Over 6 Years	
IHS Areas	Number	Percent	Number	Percent	Number	Percent	Number	Percent
All Areas	147 1/	100.0	14	9.5	21	14.3	112	76.2
Aberdeen	16	100.0	1	6.3	1	6.3	14	87.5
Alaska	18	100.0	2	11.1	1	5.6	15	83.3
Albuquerque	2	100.0	0	0.0	1	50.0	1	50.0
Bemidji	29	100.0	0	0.0	3	10.3	26	89.7
Billings	7	100.0	0	0.0	0	0.0	7	100.0
California	13	100.0	2	15.4	5	38.5	6	46.2
Nashville	16	100.0	4	25.0	2	12.5	10	62.5
Navajo	3	100.0	0	0.0	1	33.3	2	66.7
Oklahoma	5	100.0	1	20.0	0	0.0	4	80.0
Phoenix	17	100.0	1	5.9	5	29.4	11	64.7
Portland	19	100.0	3	15.8	1	5.3	15	78.9
Tucson	2	100.0	0	0.0	1	50.0	1	50.0

1/ Excludes 3 programs that did not report data for this item.

Table 4: REPORTED SERVICE POPULATION - Distribution of Reported Indian and Non-Indian Service Population Aggregated for Tribal Health Systems by IHS Area

IHS Area	Number of Health Systems Reporting	Tribal Reported Service Population					
		Total		American Indian/ Alaskan Native		Other 1/	
		Number	Percent	Number	Percent	Number	Percent
All Areas	148 2/	686,800	100.0	651,715	94.9	35,085	5.1
Aberdeen	16	70,468	100.0	68,092	96.6	2,376	3.4
Alaska	18	98,221	100.0	79,903	81.4	18,318	18.6
Albuquerque	2	4,095	100.0	3,595	87.8	500	12.2
Bemidji	29	56,546	100.0	55,040	97.3	1,506	2.7
Billings	7	39,252	100.0	39,252	100.0	0	0.0
California	13	31,562	100.0	25,939	82.2	5,623	17.8
Nashville	16	33,073	100.0	32,938	99.6	135	0.4
Navajo	3	109,885	100.0	109,885	100.0	0	0.0
Oklahoma	5	137,560	100.0	136,060	98.9	1,500	1.1
Phoenix	16	47,117	100.0	43,644	92.6	3,473	7.3
Portland	21	40,384	100.0	38,730	95.9	1,654	4.1
Tucson	2	18,637	100.0	18,637	100.0	0	0.0

1/ Includes non-Indians served by health system on a fee for service or any other basis.

2/ Excludes 2 programs that did not report data for this item.

Table 5: SOURCE OF POPULATION DATA - Distribution of Reported Source of Population Data by IHS Area

IHS Area	Source of Population Data						
	Total Programs	Projected from 1980 Census	Patient Registration	APC Reports	BIA	Other 1/	No Report
Percent 2/							
All Areas	150	31.3	24.0	6.7	18.7	47.3	5.3
Aberdeen	16	18.8	25.0	18.8	37.5	56.3	0.0
Alaska	18	55.5	11.1	0.0	11.1	61.1	5.6
Albuquerque	2	50.0	0.0	0.0	0.0	50.0	0.0
Bemidji	29	37.9	31.0	0.0	17.2	27.6	0.0
Billings	7	0.0	28.6	0.0	14.3	71.4	0.0
California	13	53.8	38.5	15.4	30.8	15.4	0.0
Nashville	16	18.8	18.8	6.3	6.3	38.9	12.5
Navajo	3	100.0	33.3	0.0	33.3	0.0	0.0
Oklahoma	5	20.0	20.0	0.0	20.0	60.0	0.0
Phoenix	17	41.2	23.5	11.8	17.6	52.9	11.8
Portland	22	4.5	18.2	9.1	18.2	68.2	13.6
Tucson	2	0.0	50.0	0.0	0.0	50.0	0.0

1/Predominantly Tribal enrollment.
2/Percent of Tribes reporting source adds to greater than 100.0% since some Tribes reported using more than one source.

The question was asked of IHS Area Managers, "Please indicate any training you feel you need to perform your duties. (Check as many as are appropriate.)" Specific categories were provided. The percent of the 166 persons who checked each of the categories is shown below.

Categories of Training	Percent
Contract & Procurement	41.6
Fiscal Management	39.8
Funding Sources	36.1
Project Officer Roles	33.1
Legislative Process	32.5
Personnel	25.9
Clinic Management	24.7
Organizational Team Building	24.7
Public Relations	19.3
Other	13.9
None	8.4

The question was asked of the IHS Area Management respondents, "What are your specific recommendations for improving the IHS Area Office Management of Tribal Health contracts in your IHS Area? All responses to this open-ended question were categorized and summarized as follows:

Recommendations for Improving the
IHS Area Office Management of Tribal Health Contracts

Categorized Responses (N=119)	Number Responses
Increase resources committed to 638 management	43
Increase available time for P.O.	9
Increase P.O. primary responsibility	16
Increase P.O. staffing	18
Improve teamwork and/or communications	39
Improve Area Office management	34
Increase training for project officer	29
Properly apply regulations	13
Increase accountability	8
Other	12