

University of New Mexico  
**UNM Digital Repository**

---

Native Health Database Full Text

Health Sciences Center Archives and Special  
Collections

---

1979

# The Indian Health Service Planning Process, An Indepth Study and Evaluation

Indian Health Service, Portland Area.

AS. Ham

Follow this and additional works at: <https://digitalrepository.unm.edu/nhd>

---

## Recommended Citation

Ham AS. Indian Health Service planning process, an in-depth study and evaluation. Indian Health Service, Staff Office of Planning, Evaluation and Research, Rockville, MD 20857 (E-06). 1979

This Article is brought to you for free and open access by the Health Sciences Center Archives and Special Collections at UNM Digital Repository. It has been accepted for inclusion in Native Health Database Full Text by an authorized administrator of UNM Digital Repository. For more information, please contact [disc@unm.edu](mailto:disc@unm.edu).

9701354

"THE INDIAN HEALTH SERVICE PLANNING PROCESS,  
AN INDEPTH STUDY AND EVALUATION"

Prepared By:

Alan S. Ham  
Evaluation Coordinator

Portland Area Indian Health Service  
Contract #248-77-0132

Northwest Portland Area Indian Health Board  
Terminal Sales Building  
1220 S. W. Morrison, Rm. 510  
Portland, Oregon 97205

January 31, 1979

## FOREWORD

My sincere thanks go to the many health planners, Indian Health Service personnel and program staff who assisted me in this study. Special thanks goes to my Project Officer Ron Gilbert, Assistant Area Director for Quality Assurance, and to the Project Consultant, Quentin D. Clarkson, PhD. Also, I acknowledge with special appreciation, Felicia S. Hodge, NPAIHB Executive Director and Dan H. Peterson, NPAIHB Researcher for their many hours devoted toward assisting me in the study, design, analysis and editing the final study results. In addition, I would like to thank Loretta Seaman for designing the cover page of this report.

Study results of this evaluation are to be distributed to the Northwest Indian tribes, Service Unit Health Boards, Northwest Service Units, the Portland Area Indian Health Service Office and Headquarters Office of the Indian Health Service, Rockville, Maryland. All requests for further information regarding the study should be directed to the Northwest Portland Area Indian Health Board, 1220 S. W. Morrison, Room 510, Portland, Oregon 97205. Telephone number: (503) 228-4185.

TABLE OF CONTENTS

	<u>Page(s)</u>
I. SUMMARY OF FINDINGS . . . . .	1
II. PURPOSE/INTRODUCTION . . . . .	2-9
III. EVALUATION METHODOLOGY . . . . .	10-24
IV. PLANNING PROCESS OVERVIEW . . . . .	25-39
V. EVALUATION FINDINGS . . . . .	40-59
VI. RECOMMENDATIONS . . . . .	60-63

The following Appendices are found immediately after the report narrative.

- Appendix A: Glossary of Definitions used in the report
- Appendix B: Maps of the Portland Area Service Units
- Appendix C: An Example of A Service Unit Emphasis Plan
- Appendix D: Bibliography
- Appendix E: Justification For Rating System
  - By Service Unit
  - Portland Area Office
  - Indian Health Service Headquarters
- Appendix F: Indian Health Service Administrative Structure
  - Organizational Charts

Listing of Illustrations Found in this Report

		<u>Page(s)</u>
Illustration A:	Planning Components	12
Illustration B:	"Universal" Planning Model	13
Illustration C:	Planning Approaches	20
Illustration D:	Rating System for IHS Plans	22
Illustration E:	Evaluation Methodology	24
Illustration F:	Flow of IHS Planning Documents	39

Miscellaneous Charts, Tables and Matrixes

- Diagram of IHS Appropriations	41
- Table Contrasting IHS Planning to Allocative Planning	43
- Matrix Comparing Service Unit Planning to the "Universal" Planning Model	46-47
- Chart Comparing Planning at the Service Units with IHS guidelines for Planning	51-54

I. SUMMARY OF FINDINGS

## SUMMARY OF FINDINGS

In studying the Indian Health Service (IHS) planning process in the Pacific Northwest, this report contains these findings:

1. The IHS planning process is tied directly to predetermined resource availability which severely limits planning objectivity.
2. The IHS planning process is ill-defined and fails to demonstrate, over time, whether or not the health status of Northwest Indians is being appreciably upgraded.
3. The existing IHS data system is geared to providing top level monitoring (input oriented) and does not provide tribes with necessary data for long-range planning.
4. IHS planning is oriented to identifying symptoms rather than causes, and is based on services provided rather than seeking to ameliorate the health problems identified in the assessments of the total population served.
5. Indian input into the planning process is limited due to a lack of consumer knowledge, interest, and participation in the process.

II. PURPOSE/INTRODUCTION



## PURPOSE

The purpose of this study is to evaluate the Indian Health Service planning process. To achieve this goal, the following objectives were formulated:

1. To assess evidence of real and ongoing planning within the Indian Health Service.
2. To identify the purpose of plans.
3. To identify the discrepancies between actual IHS plans and a comprehensive planning model.

Recognizing there are many possible planning systems and approaches that are used in the Indian Health Service, it was decided to look primarily at the Service Unit Program Plans, the Portland Area Office Operations Plans and the Indian Health Service Headquarters Major Initiative Tracking System. These documents were used as the basis of our study because they were the most readily available and reliable for establishing an overview of the Indian Health Service planning process. These three systems generally form the basis for Indian Health Service planning at the Portland Area level. Lack of time prohibited extensive review of other planning systems such as the Resource Allocation Criteria, tribal specific health planning and the political process itself.

## INTRODUCTION

Before any evaluation of a planning process can begin, the word "planning" should be defined. Planning may be defined as a devised method for making or doing something to achieve a stated goal. It may also be defined as a means of introducing social change in a desired way. Without plans, uncertainty arises in the decision making process. This often leads to haphazard "on-the-spot" choices which are crisis-oriented in nature.

The planning process of a department, organization or system is an important and essential step in achieving stated goals. Thus, periodic assessment of any or all components of an existing planning process is desirable. Evaluation has been proven to be a very efficient means of pinpointing problems and recommending corrective action.

The major emphasis of all evaluation studies is to compare the results of actions with the goals they are intended to achieve. For the evaluation to be meaningful, it should be based on measurable standards rather than general impressions. A sound method of evaluation is crucial in any planning process, because as conditions change, goals and priorities must change accordingly.

It appears that, at the present time, significant change is taking place in the relationship between the Indians and the Indian Health Service. In the past, this relationship has tended to be one way --

an active provider and passive consumer. Previous studies have indicated that Indians often feel alienated in the existing structure of the Indian Health Service health care. Insufficient information on the IHS health delivery system and a misunderstanding as to the impact of this system has been voiced by Indians over the course of this evaluation. However, it also appears that Indian tribes are beginning to ask, "What is the Indian Health Service?" "How does it function?" "Where does the Indian fit into this system to make it more responsive to him?"

Increasing Indian participation in the planning process may be a large task, but with the passage of P.L. 94-437, (the Indian Health Care Improvement Act) and P.L. 93-638, (the Indian Self-Determination and Education Act), Indian communities, governmental organizations, health boards and the Indian Health Service are undertaking a major effort to communicate with each other as to problem areas that exist from the tribal, or "grass roots" levels to top-level management. Efforts to strengthen the bridge between the Indian Health Service and the Indian consumer to insure equal participation in planning for the delivery of health care service should be an ongoing process and should be strengthened. This will take a major effort not only on the tribe's part, but also on the part of the Indian Health Service. At the same time, awareness among health professionals to better understand the Indian culture and to tailor health services to Indian needs is desirable. In turn, tribes need to be made aware of restrictions and regulations placed on the Indian Health Service by the Federal Government.

Interest among the Northwest Indian tribes in the area of health planning is also in evidence. A recognition that planning can be useful for upgrading the delivery of health services as well as serve as a useful tool for documenting recurring and newly identified health needs is beginning to grow. The tribes of Washington, Oregon and Idaho in many cases have health needs different from those of other tribal communities across the country, thus these needs must be identified and planned for accordingly.

In that the Pacific Northwest does not have an IHS Indian hospital, and has a widely dispersed population, there is increased and almost total reliance upon community hospitals, reimbursed through Contract Health Services. Secondly, it is apparent that, differing levels of sophistication exist between Northwest Indian tribes in the area of planning. Yet it is clear that tribal involvement in the delivery of health programs and health planning is increased and will continue to increase in the coming years.

The responsibility of planning for the health services to Northwest Indians is found in all three Indian Health Service administrative levels. The Headquarters of Indian Health Service in Rockville, Maryland, is responsible for national planning of health services for all Indians. The Area Office, in this case, Portland, develops Area plans based on determined needs at the Service Unit level within its geographically designated area. As listed on page 7, the Portland Area has twelve Service Units under its jurisdiction. At each Service Unit, there is employed a Service Unit Director (SUD) who is responsible for the delivery of

IHS health services to tribes in his/her respective area. This responsibility is primarily for direct care (clinics and field health) and indirect services (contract services) purchased from local care providers for the tribes located within that area.

PORTLAND AREA IHS SERVICE UNITS

State of WASHINGTON

NORTHWEST WASHINGTON SERVICE UNIT

Tribes served:

Lummi  
Nooksack  
Swinomish  
Upper Skagit

WELLPINIT SERVICE UNIT

Tribes served:

Kalispel  
Spokane

COLVILLE SERVICE UNIT

Tribes served:

Colville

YAKIMA SERVICE UNIT

Tribes served:

Yakima

PUGET SOUND SERVICE UNIT

Tribes served:

Nisqually  
Squaxin Island  
Skokomish  
Port Gamble/Klallam  
Suquamish  
Puyallup  
Tulalip  
Muckleshoot  
Sauk-Suiattle

TAHOLAH SERVICE UNIT

Tribes served:

Quinault  
Chehalis  
Hoh  
Shoalwater

NEAH BAY SERVICE UNIT

Tribes served:

Makah  
Quileute  
Lower Elwha  
Jamestown/Clallam

State of OREGON

WARM SPRINGS SERVICE UNIT

Tribes served:

Warm Springs  
Burns-Paiute

UMATILLA SERVICE UNIT

Tribes served:

Umatilla

CHEMAWA SERVICE UNIT

Tribes served:

Siletz

State of IDAHO

FORT HALL SERVICE UNIT

Tribes served:

Shoshone-Bannock

NORTHERN IDAHO SERVICE UNIT

Tribes served:

Nez Perce  
Kootenai  
Coeur d'Alene

In closing, it should also be stated that the Indian Health Service is only one of many agencies within the Department of Health, Education and Welfare required to abide by federal rules and regulations. Therefore, if overall success in planning is to occur, efforts must be department-wide.

The recipient of this contract, the Northwest Portland Area Indian Health Board, is a federally recognized non-profit health advisory board serving as a voice for some thirty-three (33) federally recognized tribes in the tri-state area of Washington, Oregon and Idaho. Because it is the only organization of its kind in the Pacific Northwest, the Northwest Portland Area Indian Health Board has developed several functions and avenues of service as a health advisory board to provide direct assistance to the Indian population it represents.

The major function of the Board is to act in an advisory capacity to the Portland Area Indian Health Service on all health related matters. An excellent method of accomplishing this function is by way of evaluation studies, objectively recommending courses of action to modify events in order to reach stated goals.

With these facts in mind, the Northwest Portland Area Indian Health Board has elected under the direction of the member Tribal Board of Directors, to pursue an evaluation of the Portland Area Indian Health Service planning process. It is hoped that this evaluation will result in a clearer understanding of the processes involved in planning and will also provide documentation to Northwest tribes on the current planning methodologies employed by the Portland Area Indian Health Service, and the IHS as a whole. Finally, it is hoped that the recommendations made will bring positive improvements in the Indian Health Service planning process as

Indian Health Service pursues its goal of upgrading the health status of Indians and Alaska Natives to the highest possible level.



III. EVALUATION METHODOLOGY

1. Formulation of a Planning Model
2. Analysis of Planning Process
3. Definition and Evaluation of IHS Planning Process

## METHODOLOGY

This evaluation of the Indian Health Service planning process, as undertaken by the Northwest Portland Area Indian Health Board Evaluation Coordinator, was conducted during the period: December 1, 1977 to January 31, 1979. The methodology used in undertaking the study can be shown as consisting of three major areas:

1. Formulation of a planning model upon which to base evaluation results;
  2. Analysis of the existing system of health planning used at three major administrative levels of the Indian Health Service;
  3. Definition and Evaluation of the Indian Health Service planning process.
1. Formulation of a Planning Model as a Tool to Compare with IHS Planning:

In initiating this evaluation of the Indian Health Service planning process, it became apparent that a comprehensive and easily understood planning model should be developed. Such a model was necessary because different levels of planning expertise existed among Service Units in the Portland area and the existing process was extensively complex. Also, planning can be, for the most part, an ill-defined process involving many different methods of approach utilizing complex jargon. By developing an evaluation model, a more logical appraisal of the IHS planning process could be made.

The model would provide a visual overview of the Indian Health Service planning process, in terms that would be both understandable and meaningful to the Indian Health Service and Northwest Indian tribes. From this model a rating system would be developed from which actual planning success at all three administrative levels was to be measured. In designing such a model, two areas of emphasis were needed.

First, the evaluator studied the organizational structure of the Indian Health Service at all three administrative levels. This step included extensive review of available publications on the Indian Health Service planning process. (Listings of specific information collected can be found in the bibliography.) In addition, interviews were held with the key Portland Area Indian Health Service staff responsible for the planning of health services to tribes under their jurisdiction. These initial interviews focused primarily on the organizational structure of health planning in the Portland Area, responsibilities for planning at the Headquarters, Area Office, and Service Unit level, and standard criteria used in developing health plans. (The administrative structure of the IHS is outlined in appendix F.)

Following the initial review of Indian Health Service documents and interviews, the evaluator analyzed all possible planning systems that could be used as evaluation tools in analyzing the Indian Health Service Planning process. After analyzing various planning methodologies, it was clear there was four universal planning components generally employed by all planners. Viewed very simplistically, all planning generally consists of a needs assessment, a planning design phase, implementation procedures, and a followup or evaluation phase.

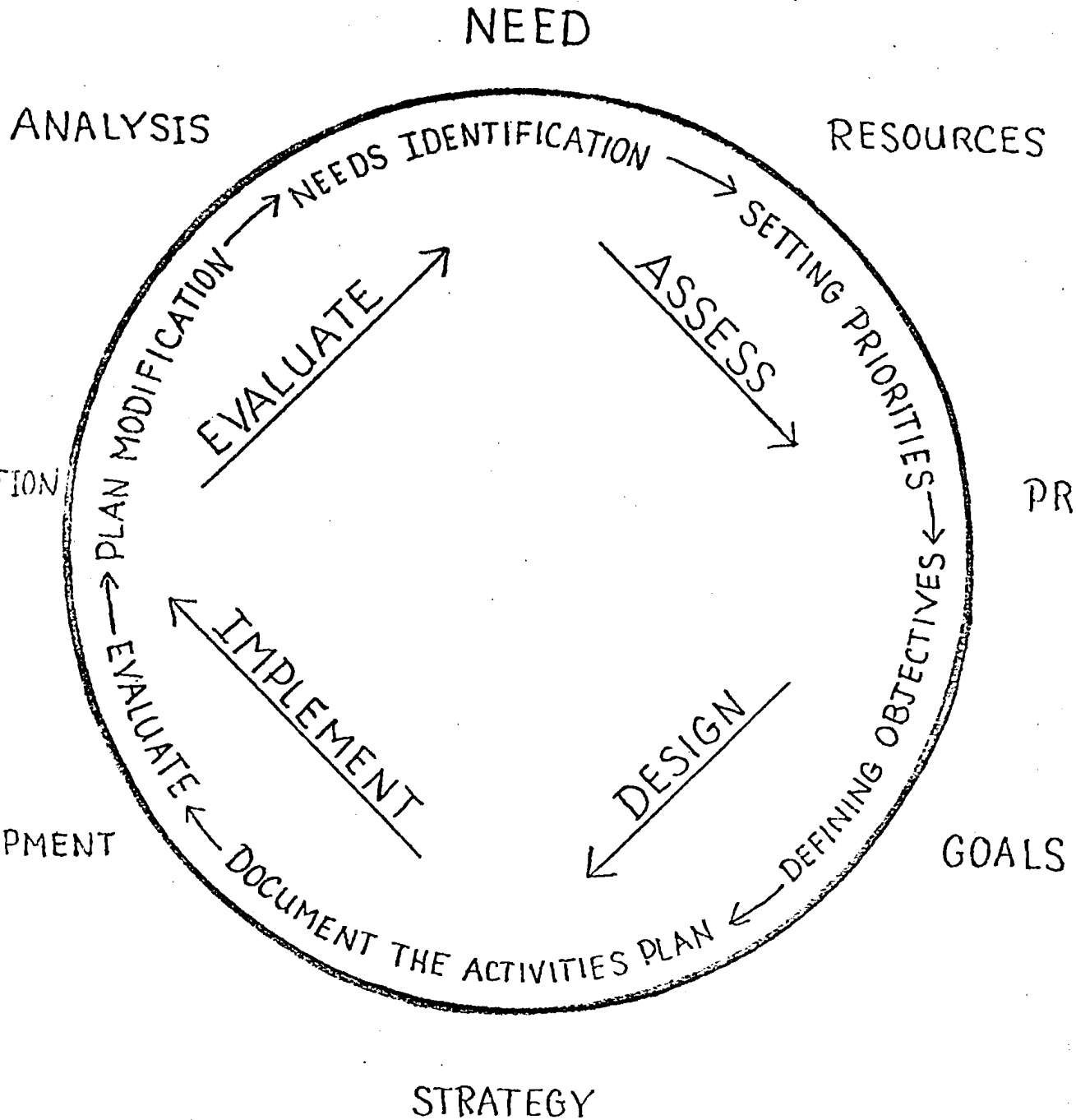
Simple definition of these terms (as taken from Webster's dictionary) are as follows: NEED: "A condition requiring supply or relief"; DESIGN: "To create, fashion, execute or construct something according to a plan"; IMPLEMENTATION: "To give practical effect to something by ensuring actual fulfillment by concrete measures"; EVALUATE: "To examine or judge something".

In terms of a planning process, these words would mean:

Illustration A - Planning Components:

- I. NEED                   - Who is affected and to what degree?  
                                  What is the possible/probable cause?  
                                  What is the situation and areas of concern? What is the stated goal for setting of priorities?
- II. DESIGN               - What alternative solutions are possible?  
                                  What is the best way to document the problem and write up a plan of action considering cost and impact the solution will have?
- III. IMPLEMENTATION - Determine the actual tasks required to reach the goal. Program activities, work assignments and milestones are begun.
- IV. EVALUATION       - Did we do what we said we would? Reassessment of the situation begins with phase I to receive feedback and to design implementation plan to correct problem areas and/or new areas of concern.

# PLANNING



Theoretically, every planning process should have these four components, and the process should be ongoing and cyclical. Identification of need is a continuous process from which all subsequent actions are determined. Needs or problems can be identified by the community at large, or through research. Upon identification of need, all possible approaches to solving the problem are considered during the design phase. The best method of solving the problem is determined based on existing resources, manpower, environmental constraints, and community input as to the most economical, and effective way of solving a predetermined need. Ultimately, a plan is designed, written up, and reviewed by the organizations that will undertake the actions, and the support of the community which the action affects is enlisted. This support should be documented. Goals and objectives are then set from which activities are developed to reach the objectives as stated.

The implementation phase of planning involves actually building into a plan a methodology for solving the identified problem. Included in the implementation plan will be the timeframe for carrying out the action or activities planned, responsibility or delegation of authority for carrying out stated actions, and a plan for financial control of the resources to be spent in undertaking the action as planned.

The evaluation phase of planning involves building into the plan an ongoing method of review of the actions being undertaken. Evaluation in effect asks "Are we doing what we said we would do?" Evaluation is important in that it assures that the interventions being used will reach the stated objectives. Evaluation can help to identify other needs that exist but might not have been evident during the

time the problem was originally identified, or to redefine the problem more precisely. It is also the best means of ensuring that the actions being undertaken are done as cost/effectively as possible, and that the community being affected by the actions has a chance to provide input during the actual carrying out of the plan. Evaluation allows continuous review or "feedback" on how well the identified problem is being solved.

Out of these findings on how planning should be effected, a "universal" model was developed (as shown in Illustrations A and B on the preceeding pages) using the four basic planning components previously discussed.

The "universal" planning model as established is the major evaluation tool used throughout this report. From this model, the Indian Health Service planning process was analyzed. Areas of responsibility in the categories of need, design, implementation and evaluation were assessed. In addition, problem areas were analyzed by focusing on weakness and strength in the need, design, implementation and evaluation phases of the Indian Health Service planning process. Findings from this analysis are discussed later in this report.

## 2. Analysis of the Existing Indian Health Service Planning Process

The second major step in evaluating the Indian Health Service planning process involved field work at all three Indian Health Service administrative levels (Headquarters, Area Office, and Service Units), and a review of 1977-78 health plans. During the first eight months of the evaluation, on-site visits were conducted at all Portland Area Service Units. Interviews were held primarily with key individuals (identified by Service Unit Directors) responsible for planning at the Service Unit level.

The rationale behind this field work was to observe the Indian Health Service planning process first-hand from the "grass roots" up, the goal being to define the Indian Health Service planning process and to assess problem areas. This was achieved by viewing the actual process of planning at Service Unit, Area Office, and Headquarters level in terms of our universal planning components. Field work centered around observing the actual setting of health objectives and implementation of those objectives at all three IHS administrative levels so as to provide an insight into the weaknesses and strengths in the overall Indian Health Service planning process.

The initial step in this analysis involved collection of Service Unit emphasis plans, the Portland Area OPS plans, and Headquarters MITS plans for fiscal years 1977 and 1978. These documents, as listed below, constitute the major planning documents at each respective level.

MAJOR IHS PLANNING DOCUMENTS:

I. SERVICE UNIT PLANS:

Developed primarily by the Service Unit Director and professional staff, or in some cases, a task force team, the "plans" are a report on the year-end activities and a method of defining activities for the coming year. Areas of concerns represent major Service Unit problems. Priority areas are emphasized in a chapter called the Emphasis Plan, complete with milestones or plans of action to be undertaken which the Service Unit has determined can be carried out within existing resources. Yearly Area Office reviews of these plans are carried out by assigned teams of Indian Health Service Area Office Personnel, as part of the annual Service Unit support reviews.



## II. OPERATIONAL PLANNING SYSTEM (OPS) PLANS:

Developed at the Area Office level, the OPS plans incorporate Service Unit Emphasis Plans into area-wide concerns. OPS plans may include (or exclude) Service Unit objectives (emphasis areas), but for the most part include objectives imposed on areas by the Headquarters level. These OPS plans are submitted to the Headquarters level, with quarterly progress reports required throughout the year.

## III. MAJOR INITIATIVE TRACKING SYSTEM (MITS) PLANS:

At the Headquarters level, all OPS plans are incorporated into MITS plans, which often include additional national objectives as determined by the Health Service Administration, imposed on IHS Headquarters. The MITS plans include a nationwide plan by "objectives" which point to concerns the Indian Health Service plans to address over the next 18 months.

During the months of July, August and September of 1977, all twelve Portland Area Service Units were visited by the evaluation coordinator conducting this study. Prior to each visit, the existing Service Unit program plans were reviewed. In some cases, the plans had to be collected during the "on-site" visit. Because some Service Units had greater expertise in health planning, it was necessary for the evaluator to be aware of both the special needs and levels of expertise evident among the Service Unit areas.

Major emphasis of the on-site visits was to analyze the Indian Health Service planning process at the community level on a comparative basis, with our previously discussed "universal planning concepts"

in mind. It was hoped that this kind of approach would be the best means of identifying problem areas or "gaps" in the existing planning process.

Throughout the field visits, interviews were held with Service Unit Directors, tribal health board members, and other tribal members. Questions during these interviews centered around how needs are identified, whose responsibility it is for designing Service Unit plans, how planning objectives were set, and how existing plans are being implemented and evaluated.

Other areas discussed included the documentation of health needs, the population enumerators used in planning, community or tribal input into the planning process, Area Office and Headquarters monitoring of Service Unit plans, and problems encountered in the development of plans. (Findings from these interviews are discussed in the chapter on the Indian Health Service Planning Process - chapter IV.)

Following this fieldwork, the planning process was examined from an Area Office and Headquarter's perspective. Meetings with the Indian Health Service staff at the Portland Area Office and at Headquarters in Rockville, Maryland focused on how planning is accomplished at these levels.

At the Area Office level, the evaluation focused primarily on monitoring of Service Unit plans, and how Service Unit program plans were incorporated into the Operational Planning System (as previously discussed). Of importance here was the levels of communications maintained between the Area Office and Service Units, the responsibility for monitoring Service Unit planning, especially as monitoring related to actual implementation and evaluation of plans.

Meeting at the Headquarters level focused on the integration of identified needs at the Service Unit level into agency-wide objectives as evidenced in the MITS plans. Communication between the Area Office and Headquarters level were also addressed. The final emphasis of field work at Rockville, Maryland centered around how plans at the community or tribal level are financed, prioritized, and translated into system-wide plans of action for meeting the stated IHS goal: "to improve the health status of American Indians and Alaskan Natives to the highest possible level".

### 3. Definition and Evaluation of the IHS Planning Process

The last major step in evaluating the IHS planning process involved defining the existing system of IHS planning, and evaluating the overall performance of the system, identifying problems and making recommendations for improvement. This was accomplished through several different methods.

First, because the concept of IHS planning is for the most part very complex, it was necessary to define the overall system. Defining the system afforded the evaluator an opportunity to get a "handle" on something quite complex. After the system has been defined, agency-wide problem areas and the impact these system-wide problems have on the overall planning process is determined.

Defining a given system of planning involves ascertaining the approach an organization or individual takes in doing planning. There are many possible approaches to planning. These can vary from no planning to total planning of every action undertaken. Yet it is clear that whatever approach is undertaken, it should be the

appropriate approach for the purposes of the planning activity.

Although there is a myriad of possible approaches to planning, generally all approaches can be said to fall into one of four major categories:

ILLUSTRATION C: PLANNING APPROACHES

<u>No Planning:</u>	Do nothing, hope the problem will disappear. No one participates in planning - let nature take its course.
<u>Minimal Planning or the process of Muddling through:</u>	Apply obvious remedies to undesirable situations as they become intolerable. Improve present problems in a haphazard manner, being more concerned with political orientation than actual reaching of long-range goal. Token consumer group involvement.
<u>Allocative Planning:</u>	Letting available short-term resources and line item monies dictate planning priorities, no matter what reality says. Chances of reaching long term goals are minimal with this type of planning. Minimum involvement of consumers or providers.
<u>Problem - Solving Planning:</u>	Analyzing communities as systems including various affects on the people, environment, heredity, behavior and available services, etc., identify the problem. Design interventions and select them for effectiveness, compatibility with local culture, customs, goals, etc. Allocate resources accordingly. Involve affected consumers and providers of health services throughout the process. <sup>1/</sup>

Following an assessment of all planning documents and interviews at all administrative levels of IHS, a determination was made as to the planning approach that actually existed in the Indian Health Service. This finding and the impact this approach has on the planning process is discussed in this report in the "Evaluation Findings" section (Chapter V).

---

<sup>1/</sup> Blum, Henrik L., Planning for Health Development and Application of Social Change Theory, Human Studies Press: New York, 1974. P. 55-64.

In an effort to document the quality of planning compared to the "universal" model at the Service Unit, Area Office and Headquarters level, a simple rating system was developed. The central premise of this rating scheme was that the most effective planning should incorporate the four basic components found in planning: NEED, DESIGN, IMPLEMENTATION, and EVALUATION. It was apparent in reviewing the plans that although the planning process contains these components, the extent to which these elements were documented in the plans themselves was the only real indication of planning success or accomplishment that could be made by viewing the plans based on Needs Identification, Design, Implementation and Evaluation techniques used. For example, the plan might contain an excellent needs assessment phase. However, a weakness may exist in that population statistics are not cited or documented or the overall well being of the population is not addressed. This makes it impossible to plan to overcome the problems of the service population. Likewise, a plan might have within it a well defined implementation procedure. Yet if the plan lacks specific task assignments, (i.e., who will carry out the plan, or what resources are on-hand to accomplish the activities) assuming the entire planning process is weakened. The rating system mentioned above is seen in Illustration D. It contains specific ratings used for all three administrative levels of the Indian Health Service Plan, according to presence or absence of documented evidence of the four necessary planning elements.

The results of this rating are listed in this report under "Evaluation Findings".

ILLUSTRATION D

RATING SYSTEM FOR IHS PLANS

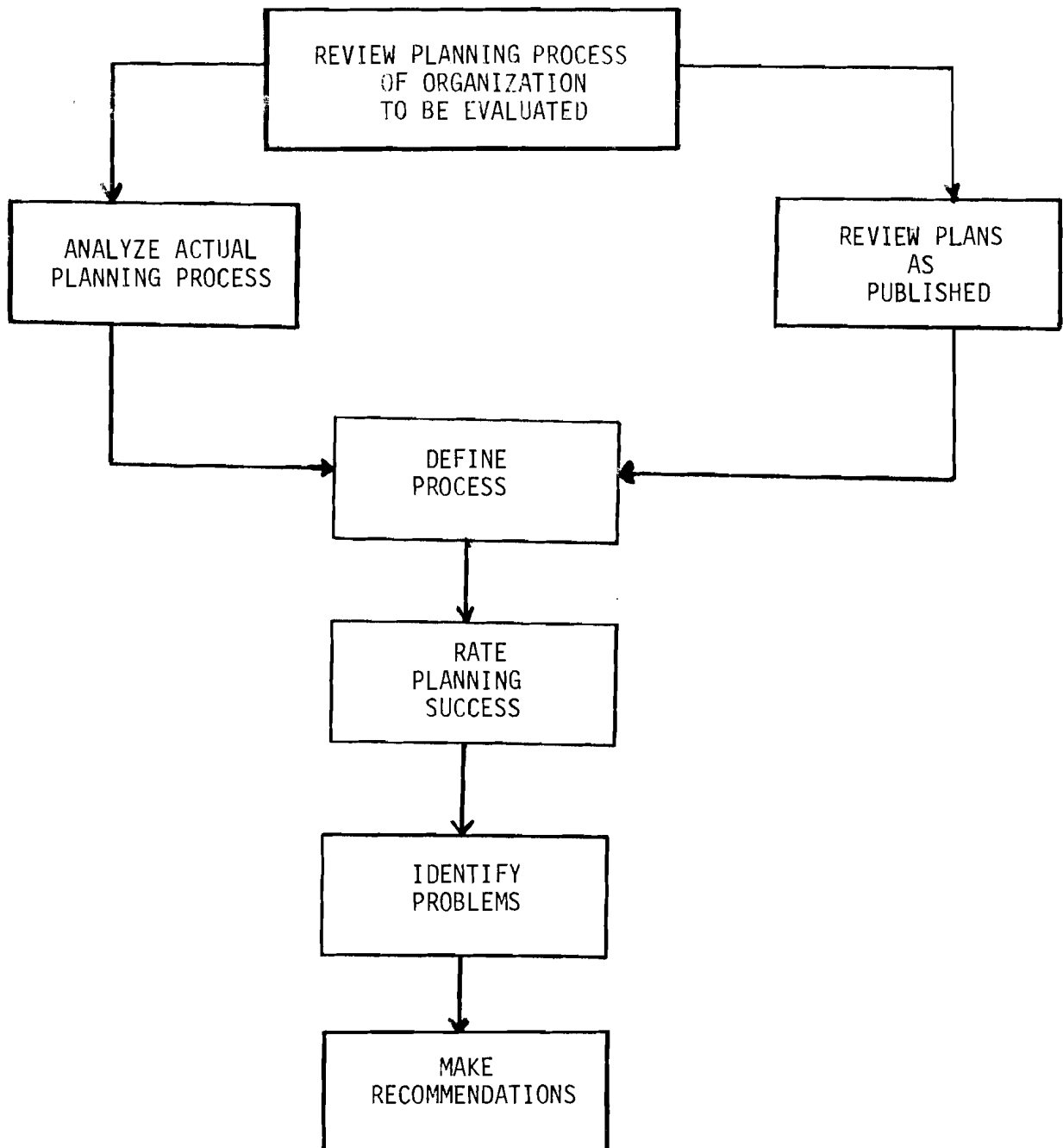
NEED	+	Well-done documented based on actual measurable data along with population figures of the area to be served.
	+ -	No documentation of statistics or records on the extent of the problem. Only provide subjective data.
	-	No basis of need, no population figure of service population, or statistics on major health problems.
DESIGN	+	Realistic goals and measurable objectives that are outcome oriented.
	+ -	Vague goals and objectives that are not measurable or outcome oriented.
	-	No statement of intent.
IMPLEMENTATION	+	Specific task and activities that are delegated to staff personnel. Documented work plans that are time-framed with specific dates which are to be implemented. Tasks and activities relate to resources, people and time.
	+ -	Tasks are documented but they don't relate to who is to implement them. No time-frames or resource allocation.
	-	No evidence of performing activities that were planned to be implemented.
EVALUATION	+	A stated quantitative measurement of outcome. Evidence that a real change in Indian health status has occurred. The plan utilizes measurement tools on an on-going basis.
	+ -	Informal review. Data based on subjective data.
	-	No examination of outcome documented or accounted for within the program plan.

Lastly, in order to analyze the IHS planning process and pinpoint major problem areas, the evaluator compared planning at the Service Unit level (as observed) with established IHS Guidelines for planning. These guidelines of planning were taken from the Indian Health Service manual and the San Carlos sample Tribal Health Plans as collected during the literature review at the beginning of the evaluation. What in effect is attempted here is to describe the actual planning process within the Indian Health Service as observed against an implied IHS standard for planning as reflected through these publications.

Although much of the description of the IHS planning process and problem areas identified are subjective judgements for the most part, they were generalized consensus of opinions that surfaced during field observations, interviews, and documents.

An illustration of the methodology which was used in evaluating the IHS planning system is as follows:

ILLUSTRATION E: EVALUATION METHODOLOGY





#### IV. PLANNING PROCESS OVERVIEW

1. Historical Overview of IHS Planning
2. An Overview of IHS Budgeting
3. The IHS Planning Process
  - Planning at the Service Unit Level
  - Planning at the Area Office Level
  - Planning at the Headquarters Level

1. HISTORICAL OVERVIEW OF IHS PLANNING

In reviewing the IHS health planning process, it is important to gain a perspective on how this planning system evolved. This is important not only so that historical problem areas can be identified but also to provide a clearer conception of the strengths and weaknesses of the Indian Health Service in the area of planning.

Although provision of health services to American Indians has existed in one form or another since the early 1800's, planning for the delivery of resources is a relatively new phenomenon. Many of the major health problems that currently beset Indians, and problems in the delivery of health services are clearly historical. Contemporary health problems such as high incidences of tuberculosis and otitis media, among others have existed for many decades. In turn, problems in the delivery of health services such as shortages in qualified health professionals to provide services, have been documented as problem areas as far back as the 1820's.

In providing an overview of planning for Indian Health Services, it is clear that determination of health need has always been the strong suit in the Indian Health Service planning process, and before its inception, in the Bureau of Indian Affairs. Major federally supported studies such as the Merian Survey of 1928, and the Public Health surveys of 1913 and 1928, do an excellent job of identifying Indian health needs. However, it is apparent that many of the health problems identified in these surveys still exist. Thus, over long periods of time, health problems long ago addressed have yet to be resolved.

Poor implementation of programs to resolve the problems identified, and lack of evaluation has caused many efforts to fall short.

Historically, the provision of health service to American Indians has always been a Federal responsibility. This responsibility can be traced back to clauses 2 and 6 of the Snyder Act of 1921 (25 USC 13), which states that the Bureau of Indian Affairs (under supervision of the Secretary of the Interior) shall direct, supervise, and expend such monies as congress may from time to time, appropriate for the benefit, care, and assistance of Indians throughout the United States. Federal control of Indian health programs has several obvious ramifications.

First, because the majority of the Indian population resides long distances from the seat of power (Washington, D.C.), communications often become very unstructured and difficult. A realization throughout this evaluation was that there is often an inability on the part of tribes to communicate their desires to Headquarters, and a misunderstanding of the Federal agency's perspective and role, in so far as planning was concerned.

Secondly, the simple fact that Indian health historically has been a federal concern ties the administration of Indian health programs to a cumbersome Federal structure. For example, the Indian health planning process is tied directly to the short-range nature of the federal budgeting system. The IHS planning process has also increased in complexity largely due to the fact that the Federal government now requires the use of data systems and increased reporting of tribal

activities in the administration of programs. In many cases, tribes may be unable to either understand or keep pace with numerous federal requirements. Often they have neither the manpower nor the resources to do so.

Thirdly, the provision of health services by the Federal Government has historically meant minimum involvement from the various states. Not until 1925, with the passage of the Social Security Act, did states begin to take an actual role in the provision of health services to American Indians. Therefore many of the problems that exist in documenting existing health resources, or working with states to assess local resources that might be used by Indians, are historically based.

The major impetus for Indian Health Service planning can be traced to the 1950's. At that time, the responsibility for health related services was placed in the Bureau of Indian Affairs (BIA) within the Department of Interior. The BIA built and operated hospitals and clinics which provided health services. However, the BIA health programs were continually plagued with problems, including severe understaffing and inadequate appropriations.

Although the BIA had to make progress during the 1930's, in the prevention and treatment of disease, Indian health continued to lag far behind identified need (as documented in the 1936 Public Health Survey of Indian Health). Early efforts to improve the delivery of health services, through planning, were undertaken, as far back as 1940.

By the mid-1950's, health services and the level of Indian health had deteriorated so severely that pressures began to mount for the

transfer of Indian health programs to the U.S. Public Health Service.

Argument in favor of the transfer included:

Public Health Service was more attractive to health professionals; therefore, placing Indian Health Services under the Public Health Service could ease staffing problems encountered by the Bureau of Indian Affairs.

Within the Public Health Service, the Indian Health Service would be under direct medical supervision, and thus be better able to understand the health needs of Indians and plan for services.<sup>2/</sup>

The Public Health Service with its medical expertise would be better able to explain its budget requests to Congress and thereby obtain more adequate appropriations than BIA.

Also, it was thought that the transfer would enable HEW health system resources to be made more available and responsive to Indian health problems.<sup>3/</sup>

In 1955, federal responsibility for health services to Indians were transferred to the newly created Division of Indian Health, under the Surgeon General of the U.S. Public Health Service, HEW. The Indian Health Service is presently a division of the U.S. Public Health Service in the Health Service Administration of the Department of Health, Edu-

---

<sup>2/</sup>US Senate, Committee on Interior and Insular Affairs, "Report on the Transfer Act", June 1954, Page 8.

<sup>3/</sup>US Surgeon General, HEW, "Report on Indian Health", 1957

cation and Welfare. The agency has grown rapidly since 1955. Tribal involvement in planning has generally occurred only in this decade.

Thus historically, the IHS planning process can be viewed as a system in which comprehensive planning is relatively recent. Although needs have been well-documented, the system as a whole can be viewed as an ill-defined one, in which program implementation has long been a problem.

## 2. OVERVIEW OF THE INDIAN HEALTH SERVICE BUDGET PROCESS

Much of the structure for Indian Health Service planning, as well as setting of health priorities, is tied directly to the Indian Health Service budgeting process. Briefly, this process can be seen as incremental one in which the Office of Management and Budget (OMB) negotiates with individual federal agencies (such as Indian Health Service) based on past allocations, to develop a mutually acceptable budget which is submitted to the Congress by the President of the United States. During these negotiations, the Indian Health Service budget is reviewed by the Health Services Administration, the U.S. Public Health Service and the Department of Health, Education, and Welfare based on past performance (primarily the previous three fiscal years) cost estimates for the upcoming year and historical allocation. Following this review, the Director of the Indian Health Service is called upon by Congress to give testimony to support the dollar amount requested. Congress may either approve, reduce, or add additional money to the President's request for Indian Health Service. Upon Congressional approval, the appropriation is broken down into line items which specify how the

money will be spent. Allocations are then made to the IHS Area Offices, which in turn dispense these funds to the Service Unit or tribal level.

Although it appears the Indian Health Service budgeting process is a very simplistic one, it should be emphasized that the budgeting process plays a major role on Indian Health Service planning. Briefly, the budgetary system impact the planning process in three ways:

1. Because the Indian Health Service budget process is "historical" in nature, (or based on the amount of money appropriated over past years) there is little impetus for long-range planning or changes in emphasis. Thus, planning exists in a limited time frame due to the fact the allocations may change the following year.
2. Because Indian Health Service programs are funded on an annual basis relative to past performance, the vast majority of money appropriated by Congress is used to support on-going programs. Thus, there is very little money left to deal with other health problems identified. Whether or not the plans are actually implemented after they have been written is variable to how much money is available. In many cases, annual allocations only keep pace with inflation or insure that existing programs continue.
3. A "historical" appropriation of funds (or funding based on last year's budget) are geared more on the amount received

the previous years, combined with political pressure, than on performance. Due to "historical" or incremental budgeting, programs often seem to develop a life of their own. Tribal communities many times may want to maintain the programs they have regardless of how successful these programs may be, fearing the loss of any replacement program. Thus, the impetus to evaluate plans is often lacking, on the part of tribes.



## THE IHS PLANNING PROCESS

The intent of the IHS planning documents is to direct the planning of health services for American Indians. No evidence could be found as to whether the plans actually assisted in the improvement of health for Indians. The desired outcomes were difficult to assess over the short time frame of the study. Such objectives can be ascertained only over a longer period. A review of the Area plans illustrates this point. The following synopsis of the Service Unit, Area Office and Headquarters plans is provided below to illustrate the contents, development and the flow of the documents.

### Planning viewed at the Service Unit level.

Planning at the Service Unit level is an ongoing process. Service Units have on the average, one year in which to produce a health plan and forward it to the Portland Area Office. The major planning document contained in the Service Unit plan is the "Emphasis" plan.

This plan generally contains within it: a) a problem statement, which indicates the impact of the problem; b) objectives, which states what the Service Unit hopes to accomplish in relation to the problem; c) action steps, which represent the alternatives on how the Service Unit will try to resolve the problem at their level of Indian Health Service; d) evaluation, which is basically looking to see if you did what you said you would do in your original problem statement.

The primary responsibility for drafting the Service Unit plan is

entrusted with the Service Unit Director (SUD). Normally, the SUD will receive support and/or input in developing this plan from one or more of the following sources:

- Service Unit staff personnel.
- A Service Unit planning "task force" made up of Service Unit staff and tribal leaders.
- The Service Unit tribal health board.

These groups are normally involved in documentation of health needs, and assessment of health problems. Information incorporated into the plans may also come from other sources such as Community Health Representatives (CHRs) tribal consumers, tribal health workers or by utilization of patient encounter statistics.

Service Unit emphasis plans usually contain a listing of objectives and activities or "milestones" to be implemented over the following one year period. The setting of actual health priorities at the Service Unit level varies. In a majority of cases, objectives were set by the Service Unit Director with staff input. Tribal input in 9 of 12 Service Units was viewed as "token" input, in which tribal health boards were consulted only after objectives had been set.

In viewing Portland Area Service Unit emphasis plans it becomes apparent that approximately one half of the 1977-78 plans contained an identical emphasis plan format which had been developed by the Area Office. (see Appendix) Standard formats were used primarily to expedite the process due to manpower shortage or time constraints.

Interviews at the Service Unit level indicated universal confusion among Service Unit staff as to the overall IHS planning process, and the impact the plans have upon submission to the Area Office. A common

complaint was that the planning process was ill-defined, and that poor communications existed between Service Units, the Area Office and with IHS Headquarters.

Field work at the Service Unit level indicated a considerable amount of frustration on the part of Service Unit staff to plan for health services. There was universal misunderstanding among tribal members as to how the process worked. Service Unit staff in a majority of cases had little idea as to how the plans were used upon completion. Turnover in staff, lack of resources and poor communication with the Area Office and tribes further complicates this process.

#### Planning viewed at the IHS-PAO level

The major planning document at the IHS Portland Area Office level is the Operational Planning System. Written yearly, this plan forms the major objectives for the area as a whole. The goal of the OPS plan is "to improve the health and assist Indians of the Northwest to assume the managerial responsibility for their health care program".

Operational planning objectives are statements of the most important projects that Area Directors and their area health boards intend to achieve over a single fiscal year. They also form the basis for evaluation performance for that year. Used also as a management control, the plans contain, in addition to several major objectives, projected cost estimates, justification, approaches to be used and implementation milestones. Quarterly reports submitted to IHS Headquarters are used to ensure progress is being made.

Responsibility for development of the OPS plan lies primarily with

the four major departments under the Indian Health Service Area Director: Office of the Director, Quality Assurance, Operations, and Planning and Evaluation.

Major OPS objectives are developed from Service Unit emphasis plans and suggestions received from the IHS Headquarters. Although our field notes verify this fact, for the most part, the OPS plans reflected the objectives 'suggested' from Headquarters. In fiscal year 1978, eight "major program emphasis areas" were distributed to all IHS Area Offices as areas to be considered in developing OPS Area plans for FY 1978. Of the seven Portland Area OPS objectives, four were taken directly from Headquarters directives. The remaining three OPS objectives were developed by the Portland Area Office staff to address needs they deemed relevant at that time. Thus, the OPS plans are written solely by Area Office staff, strongly considering Headquarter's suggestions for objectives. No structured input or review by Service Unit staff was found during this evaluation other than the submission of the Emphasis Plans. The impact or results of the Emphasis Plans have on the OPS plans was unclear -- the submission of an Emphasis Plan in no way guaranteed support or recognition of the Service Unit objectives in the OPS plans. Generally, the Service Units were unaware of the content of the OPS plan until its completion and submission to Headquarters. Once completed, the OPS plans remain unchanged until the following year's plans are drafted, which many times reflect the previous year's objectives. Evaluation of the plans consist solely of quarterly reports by the Area Office staff to Headquarters. Service Units have not, to date, been involved in any review or evaluation of the Area Office.

Thus, OPS plans are for the most part a separate planning system in

which the Area Office makes its own judgement as to area wide objectives. Normally these objectives are more influenced by Headquarters then by Service Unit plans.

Planning viewed at the IHS Headquarters level.

Although the planning document at the Headquarters level has been identified as the Major Initiative Tracking System (MITS), this document can be viewed more realistically as a tracking devise which allows HEW to monitor major initiatives (or objectives) set forth in its agencies. Written primarily by assigned personnel at the Headquarters level, the MITS document forms its objectives from HSA and HEW directives, with consideration of area wide OPS plans. The MITS covers a nation-wide plan by objectives which points to areas IHS will take action on.

Like the OPS plan, the MITS document is evaluated informally through a series of reports to HSA and HEW. No objective evaluation takes place by either the Area Offices or HSA/HEW. The MITS progress reports evidently provide enough information on the process and success of the objectives contained in MITS. Normally MITS documents contain objectives that are very broad in scope.

CONCLUSION

Planning at the Headquarters, Area Office and Service Unit level as described above is an autonomous process. Service Units develop Emphasis Plans and forward them to the Area Office. The responsibility for drafting the plans varies, but it is up to the Service Unit to implement the plans as it sees fit. Area Office monitoring is informal. The Area Office OPS plans reflect Headquarter's directives with informal

input from Service Units. MITS plans provide HEW with a method for tracking IHS agency performance.

Thus in effect, every planning document upon completion is submitted to the next highest administrative level. The path these planning documents follow is a combination of upward flow in the planning process with downward directions from HEW. (Once plans are submitted to the next highest agency, major objectives are determined for that level in the process).

This process is a very long and cumbersome one. It takes approximately two years for Service Unit plans to complete the cycle from the Service Unit level to the Department of Health, Education and Welfare. During such a lengthy period, needs and conditions may have changed. Thus in effect, the DHEW is addressing health needs that were documented two years in the past. In other cases health concerns in the plans may not reflect current HEW priorities and not be reflected in the MITS plan.

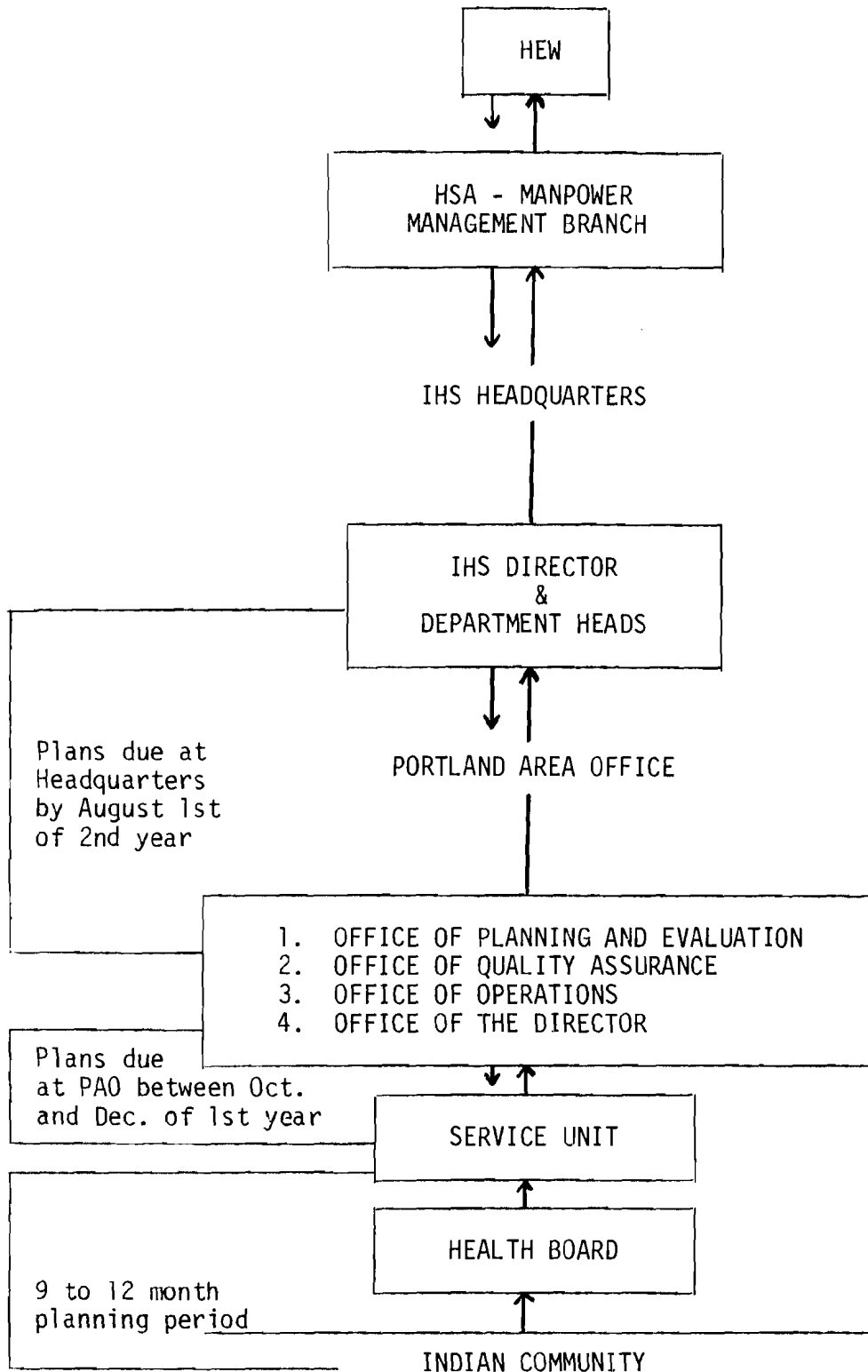
An excellent example to illustrate this contention is the IHS immunization initiative. The need to immunize Native Americans was well documented in public health surveys during the 1930's and 40's. Yet little was done in this area. Although immunization was mentioned in several Service Unit plans during the 1970's, few references can be found in the Portland Area plans on the need for immunizations, up until a determination had been made by the Department of Health, Education and Welfare to initiate such a program.

In this case an essential component of health services had been overlooked by the planning process, and it became necessary for HEW to initiate action on its own. HEW mandated a major initiative to undertake full scale immunizations at the tribal level.

The existing system has few direct mechanisms for immediate communication of need from the lowest to the highest level. It was also clear from field interviews that many tribal members and other individuals directly responsible for planning at the Service Unit clearly do not understand the roles that HSA, PHS, DHEW play in the overall planning process. Overall, there is no strategic flow of communications in the formal Indian Health Service planning process.

Because of the time involved in processing plans, and in view of the complex nature of the planning process, monitoring of the system is difficult. It may be next to impossible to expect HEW to address needs documented in the past, especially in consideration of the fact that departmental directives and new thrust in policy are continuous. Often it may be easier to file plans and forget about them than to act upon them. In reality the Service Units, OPS and MITS plans all look good on paper, yet they in no way reflect what is actually being done. A chart showing the flow of Service Unit, OPS and MITS plans is shown on the following page.

ILLUSTRATION F: FLOW OF IHS PLANNING DOCUMENTS





V. EVALUATION FINDINGS

- Summary
- Evaluation Techniques/Specific Findings  
(Specific findings are lettered A through F)

## SUMMARY

It has been the intent of this report up until this point to describe the evaluation methodology, and outline the actual process of planning in the Indian Health Service as it was observed through documents, field observations and interviews.

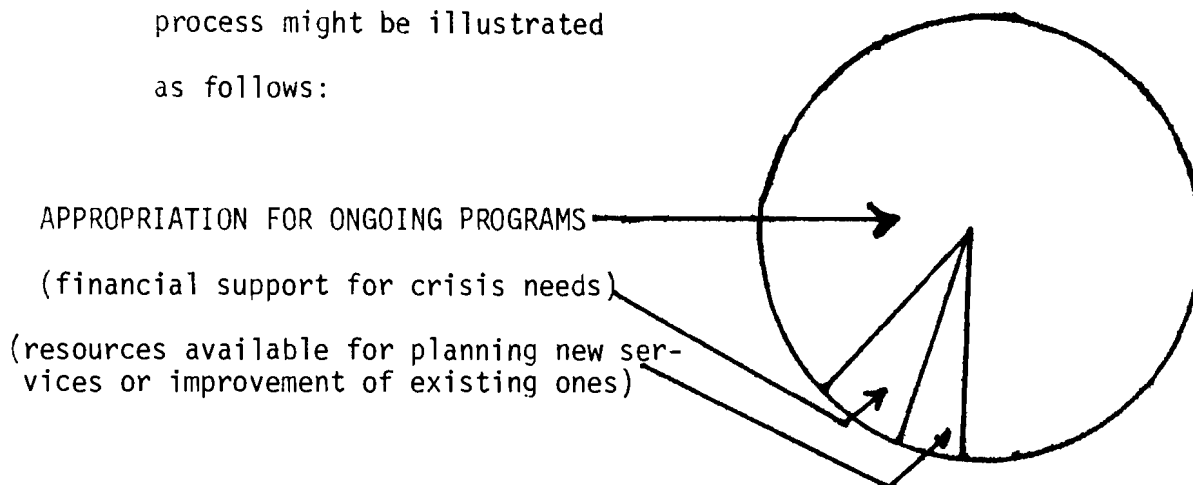
In identifying weakness that exist in the IHS planning, it is important to bear in mind that a myriad of administrative, budgetary and political factors have to be considered. Thus the evaluation findings will be limited to major system-wide problems identified over the course of this evaluation. The rationale behind these conclusions is documented after an initial statement of the problem.

Overall, this evaluation found two major weaknesses in the IHS planning process. First, the IHS planning process is based on budgetary allocations, not on need and secondly, there are few implementation or evaluation procedures built into the planning process.

- I. The IHS planning process can clearly be defined as an "allocative" planning process which is limited in impact due to the inherent nature of the IHS budgetary process. Long range planning is minimal at all levels. Planning at the tribal level often entails only a documentation of immediate or crisis need rather than a conscious long range effort to improve the health status of the local tribes. Because funding is limited, planning options are also limited. Graphically, resource limitations

and its impact on the planning process might be illustrated as follows:

IHS BUDGET APPROPRIATIONS



Throughout this evaluation, evidence was found that upon completion, IHS plans are used more as a proof that planning was undertaken than as a tool to improve the delivery of health services for Northwest Indians.

II. The IHS planning process generally does not build implementation or evaluation procedures into plans. This study found little evidence that submission of a health plan meant that the plan would in anyway be carried out. Implementation and evaluation components of the existing IHS planning process are informal in nature. As a result, it becomes difficult for the Area Office and Headquarters level to know whether or not Service Unit plans are being carried out. For the most part, the plans surveyed demonstrate that Northwest Service Units have the ability to assess health problems or needs. In addition, in a majority of cases, the plans contain well thought out plans of action or "milestones" for carrying out objectives. Yet seldom are responsibilities assigned for implementing these plans.