Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MANAGEMENT ISSUES IN THE COMMUNITY HEALTH REPRESENTATIVE PROGRAM

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EXECUTIVE SUMMARY

PURPOSE

This report describes management issues in the Community Health Representative (CHR) program.

BACKGROUND

The CHR program is based on the concept that indigenous community members, trained in the basic skills of health care provision, disease control, and prevention, can successfully effect change in community acceptance and utilization of health care resources. The CHR program is governed by the Indian Health Care Improvement Act of 1988. In Fiscal Year (FY) 1992, the Indian Health Service (IHS), within the Public Health Service (PHS), spent $39 million for 1,544 CHRs in 260 programs. The program is funded through contracts, grants, or cooperative agreements based on the Indian Self-Determination and Education Assistant Act (P.L. 93-638), hereafter referred to as 638.

In 1983, Congress mandated that IHS establish guidelines, goals, and clear evaluation standards for the CHR program. The IHS produced guidelines and goals for the program which are written in Chapter 16 of the Indian Health Manual. They also developed two management tools: the Scope of Work (SOW), for planning purposes, and the CHR Information System II (CHRIS II), for reporting.

Although Chapter 16 states that tribal CHR programs will be evaluated on a triennial basis, IHS has neither developed evaluation criteria nor conducted a national evaluation of the program.

We contacted 403 people involved with the program at the national, area, and local levels to obtain information about factors which make CHR programs strong. See our report entitled "Revitalizing the CHR Program" (OEI-05-01070). During the course of obtaining that information, we discovered selected management issues that are described in this report.

SCOPE AND METHODOLOGY

Our intent in this study was to identify factors that make CHR programs strong, factors which IHS and tribes could use to manage and evaluate the program. During the course of the study, certain management issues arose that we believe are important; this report describes those issues.

Our companion report entitled "Revitalizing the CHR Program" (OEI-05-91-01070) describes the factors that the 403 respondents for this study said make individual CHR

programs effective, and why they make programs effective. It also describes how the factors might be used to judge the effectiveness of a CHR program.

FINDINGS

MOST RESPONDENTS ARE NOT FAMILIAR WITH THE GOAL AND OBJECTIVES OF THE CHR PROGRAM.

Except for area CHR coordinators, respondents who knew the CHR program were not familiar with its national goal or objectives.

THERE IS WIDESPREAD DISAGREEMENT ABOUT THE APPROPRIATE ROLE FOR CHRs.

Although respondents agree that CHRs should be a part of the health care system, there are widely varying opinions about how this integration should occur. Respondents say that if there is not consensus on a role for CHRs, the program will be less effective.

TRANSPORT IS A MAJOR UNRESOLVED ISSUE IN THE CHR PROGRAM.

Compared to other services CHRs could provide, transport is a disproportionately large CHR activity. Respondents disagree on whether CHRs should be transporting clients. Many see it as a needed service as well as what tribes want CHRs to do.

THE SOW AND CHRIS II HAVE LIMITED USEFULNESS.

We question the usefulness of the SOW as a planning tool, and the CHRIS II as both a management tool and reporting system. Analysis of CHRIS II data raises questions about its accuracy and reliability. Respondents also voiced mixed opinions on the usefulness of the SOW and CHRIS II.

RECOMMENDATIONS

THE PHS, TOGETHER WITH TRIBES, SHOULD RE-EXAMINE THE CHR PROGRAM TO DETERMINE ITS FUTURE DIRECTION.

The PHS, and tribes, should consider the following options in determining the future direction of the CHR program: retain it in its current form, revise it to become a transportation program, or abolish it if it is no longer needed.

IF A CONSENSUS IS REACHED TO REVISE OR ABOLISH THE PROGRAM, PHS SHOULD DEVELOP THE APPROPRIATE LEGISLATIVE PROPOSALS TO DO SO.

IF IT REMAINS AS A BROAD-BASED HEALTH CARE PROGRAM, PHS SHOULD DEVELOP A MULTI-FACETED NATIONAL STRATEGY TO REVITALIZE THE CHR PROGRAM.

This strategy should include: (1) a clarification of the national goal and objectives, (2) a revised national policy on transport, (3) development of performance indicators, (4) improvement of the SOW and CHRIS II, (5) development of technical assistance and training plans, and (6) periodic program evaluation.

COMMENTS

The Assistant Secretary for Planning and Evaluation and PHS commented on the report. Both concurred with the findings and recommendation, and PHS described steps that IHS has initiated to revitalize the CHR program. We made some editorial changes in the report based on technical comments from ASPE. The full text of the comments is in Appendix D.

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INTRODUCTION

PURPOSE

We conducted this study to identify factors which make Community Health Representative (CHR) programs strong, factors which could be used in the future to plan, monitor, and evaluate these programs. This report describes management issues that arose in the course of the study.

BACKGROUND

Program History

In 1968, under the 1921 Snyder Act (25 U.S.C. 13), Congress established the CHR program within IHS. The program was intended to provide outreach health care services for American Indian and Alaska Native tribal governments and organizations. It is based on the concept that indigenous community members, trained in the basic skills of health care provision, disease control, and prevention, can successfully effect change in community acceptance and utilization of health care resources. A CHR is "a tribal or Native community-based, well-trained, medically-guided, health care provider, who may include traditional Native concepts in his/her work."[1]

The program is currently governed by the Indian Health Care Improvement Act Amendments of 1988. In Fiscal Year (FY) 1992, the Indian Health Service (IHS), within the Public Health Service (PHS), spent $39 million for 1,544 CHRs in 260 programs throughout the continental United States and Alaska. Currently, IHS spends about $1 million of this amount on training for CHRs, including funding a national training officer and a number of training facilities.

The CHR program is funded through contracts, grants or cooperative agreement arrangements with Native or tribal governments and organizations based on the Indian Self-Determination and Education Assistance Act (P.L. 93-638), hereafter referred to as 638. The IHS is increasingly using 638 contracts as a mechanism to provide health services to Indian people. Under them, tribes are delegated responsibility for administering programs, and have great latitude in designing and operating them. The IHS sets basic parameters and guidelines, and is responsible for management and oversight of the national CHR program; however in terms of the day-to-day operation of individual programs, IHS assumes more of a consultation and technical assistance role.

The program grew quickly from 1968 to 1980. At that time, however, Congress grew concerned that the budget for the program could not be adequately justified. Program activities had not been clearly documented and monitored by IHS, and programs varied widely across tribes. Congress grew concerned about a lack of program goals and objectives and an adequate reporting system, and reports that the CHR program was

little more than a "jobs" or employment program for reservations. In FY 1981 and 1982, Congress began to reduce the number of CHR positions, and in FY 1983 the program came close to being eliminated. Although the program ultimately survived, Congress cut 513 slots from a peak of 2,293. This decline continued until FY 1990, when Congress slowly began to increase slots to the 1,544 of today.

Program Administration

In 1983, Congress mandated that IHS establish guidelines, goals, and clear evaluation standards for the CHR program. In response, IHS established the position of a national CHR program director and developed program goals, objectives and guidelines which are written in Chapter 16 of the Indian Health Manual.

Individual CHR contracts are administered by the 12 IHS area offices. The national CHR program director, in the Office of Health Programs under the Special Initiatives Branch, has no direct line authority over these area offices or staff. In more of a consultation or technical assistance role, that office develops and implements management standards and tools, plans training, and conducts program reviews.

In each area office, a CHR coordinator is the primary contact with the national program director and the one area staff person with direct responsibility for CHR programs. Project officers also have certain program and fiscal responsibilities in connection with monitoring contracts, including CHR contracts, and facilitating the interaction between tribal CHR programs and the service unit or area health care programs. Most CHR coordinators and project officers juggle CHR duties with other responsibilities.

The IHS uses two important management tools in the CHR program. The Scope of Work (SOW) is a form tribes may use to plan their CHR programs. The CHR Information System II, or CHRIS II, is a reporting system based on the SOW. Although not required to use either the SOW and CHRIS II, at present most of the tribes are doing so.

Chapter 16 states, "Tribal programs will be evaluated on a triennial basis, through the use of a nationally developed instrument, with tribal consultation and concurrence."[2] To date, however, IHS has neither developed national evaluation criteria or tools, nor conducted a national evaluation of the program.

SCOPE AND METHODOLOGY

Our intent in this study was to identify factors that make CHR programs strong, factors that IHS - and tribes - could use in the future as a basis to manage and evaluate the program. During the course of the study, certain management issues arose that we believe are important. This report describes these issues. Our companion report entitled "Revitalizing the CHR Program" (OEI-05-91-01070) describes the factors that respondents said make CHR programs strong.

As background for the study, we conducted a review of literature: legislation and regulations on the CHR program, the Indian Self Determination Act, and the Indian Health Care Improvement Act; Chapter 16 of the IHS manual; annual reports, CHRIS II reports and other documents related to the CHR program; and reports on Indian health. We also spoke with persons in the Office of Management and Budget, and the Office of the Assistant Secretary for Planning and Evaluation in the Department of Health and Human Services (HHS).

Data collection took place in three phases. As this chart shows, we contacted over 400 respondents for the study.

Respondents	Phase 1	Phase 2	Phase 3	Total
National	6	23		29
Area	22	30	10	62
Local	16	58	25	99
CHRs	32	161	20	213
Total	76	272	55	403

Phase One: In November and December 1991, we visited 2 of the 12 IHS area offices and 5 CHR programs, chosen in collaboration with IHS area coordinators to represent a variety of types of programs. We talked with over 75 respondents: people involved in creating the program; IHS staff in area offices; and people in CHR programs and service units. We also held focus groups with area CHR coordinators and CHRs and talked to the national training officer and persons from the National Association of CHRs.

We asked respondents, "What makes a CHR program strong (effective)?" We found that their responses could be grouped into four broad categories, or:

Factors that Influence the Effectiveness of CHR Programs

Factor 1 Agreement on the role of the CHR
Factor 2 Integration into the health care system
Factor 3 Tribal support and direction
Factor 4 IHS support and direction

Phase Two: In February, March, and April 1992, we contacted an additional 272 respondents to learn their perceptions about these four factors: how important are they, and why?; if a factor is not present in a CHR program, is the program weakened?; and, what can IHS do to strengthen or promote these factors?

- At the national level, we talked to Congressional staff, people in the Office of the Assistant Secretary for Health in the Public Health Service, and IHS Headquarters staff.

- At the area level, we chose five IHS area offices (Oklahoma City, Oklahoma; Aberdeen, South Dakota; Window Rock, Arizona, Navajo Nation; Portland, Oregon; and Nashville, Tennessee) which are diverse in terms of geography, program sizes and types, and together represent half of the 1,544 CHRs nationwide. We talked to area directors, CHR coordinators, and other health care professionals in these offices.
- For respondents at the local, or program, level, we chose three CHR programs in each of these five areas (15 total). They were programs that had more than two CHRs, represented a geographic and programmatic mix, and agreed to participate in the study. We spoke by telephone with the tribal health directors, CHR supervisors, service unit directors, and health care professionals at these programs. We also contacted 161 CHRs. One of the 15 tribal officials we contacted responded to our inquiries.

- We visited a third IHS area office and three other CHR programs in connection with a review conducted by the national CHR program director. We also talked to tribal health directors at a conference.

Phase Three: In April 1992, using a case study approach, we visited two CHR programs in two IHS areas, to apply these factors in a "real life" situation. We chose the programs in collaboration with the national program director, the CHR coordinator in each area, and the tribes themselves. We contacted 55 respondents in this phase.

This study was conducted in accordance with the *Interim Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

FINDINGS

MOST RESPONDENTS ARE NOT FAMILIAR WITH THE GOAL AND OBJECTIVES OF THE CHR PROGRAM.

In 1983, IHS developed a goal, objectives and guidelines for the CHR program which are written in Chapter 16 of the Indian Health Manual.[3]

CHR Program Goal

"The CHR Program was implemented to improve the health knowledge, attitudes and practices of Indian people by promoting, supporting, and assisting the IHS in delivering a total health care program. The efforts of CHR program staff have produced an American Indian and Alaska Native health service delivery system, which provides for follow-up and continued contact with the health care delivery system at the community level, thereby meeting the most basic needs of the American Indian and Alaska Native population."

"The goal of the CHR Program is to address health care needs through the provision of community-oriented primary care services, including traditional Native concepts in multiple settings, utilizing community-based, well-trained, medically-guided health care workers."

The 14 program objectives are mainly a listing of possible services such as home health care, transport, language interpreter and health education. Other objectives include activities such as development of an annual program plan, assurance of the availability of appropriate IHS medical guidance to the CHR program, and compliance with the CHR data collection plan.

Two-thirds of the local respondents in our study, and 40 percent of those from IHS area offices, said they are not familiar with the goal and objectives of the CHR program. This includes 2 of the 5 area directors, 9 of the 11 tribal health directors, 4 of the 8 service unit directors, and 8 of the 12 public health nurses. In contrast, area CHR coordinators not only know the goal and objectives but emphasize that they help direct and assist CHR programs: "Chapter 16 has been very handy. It is a guidepost or a guideline overall, something for us to work with."

THERE IS WIDESPREAD DISAGREEMENT ABOUT THE APPROPRIATE ROLE FOR CHRs.

In reviewing contracts, observing CHR programs, and talking to respondents, we found that there are many different, and sometimes conflicting, opinions about what CHRs should do. We found that a CHR can be an animal control officer, dental assistant, janitor, billing clerk, data entry clerk, or appointment clerk in a clinic. Some people said that tribal officials want CHRs primarily to transport or do "domestic" work: cutting

wood, making meals, or taking out garbage. At one program, we both observed and were told that medical staff sometimes expect CHRs to act as "go-fers."

Respondents say that CHRs should play a role in their tribe's health care system, but there is no clear or consistent view of that role.

We asked national, area, and local respondents to explain how they define an "effective" program. Whether they mentioned CHRs providing outreach and advocacy, access to care, or delivering health services, respondents clearly believe that a CHR program should be part of the tribe's health care system. However, few offered specifics about exactly what activities CHRs should undertake. Comments were vague and varied: CHRs should be "health care workers," they should work closely with a health care professional (especially public health nurses), or, a "team approach" is important.

The CHR responses to questions reveal that they feel strongly that the program must be linked with the health care system. However, they also disagree on the specifics of how this should occur. For example, almost 60 percent ranked "working as a team with medical staff" as the most important factor to make a CHR program strong. A strong majority think that there should be referrals between CHRs and medical staff (88 percent), CHRs should be included in meetings with medical staff (65 percent), and medical staff should regard CHRs as competent (87 percent). Yet, CHRs disagree on whether they should be "the eyes and ears of the community" or assistants to health care professionals, and on whether they should work closely with or independently from health care professionals.

Respondents say that if people do not agree on the role, CHRs may be less effective.

According to respondents, confusion or disagreement about what CHRs are supposed to be doing can limit their effectiveness. Some said that CHRs, often "perceived as the answer to everyone's problems," are pulled in different directions and asked to do inappropriate things until they "burn out." Others said that CHRs can become unfocused and confused about what they should do, which can lower morale. The CHR services may become fragmented and chaotic, lacking cohesiveness or continuity with other health care services. Finally, some people said specifically that without a clearly defined role for CHRs, a program could become focused solely on transport.

TRANSPORT IS A MAJOR UNRESOLVED ISSUE IN THE CHR PROGRAM.

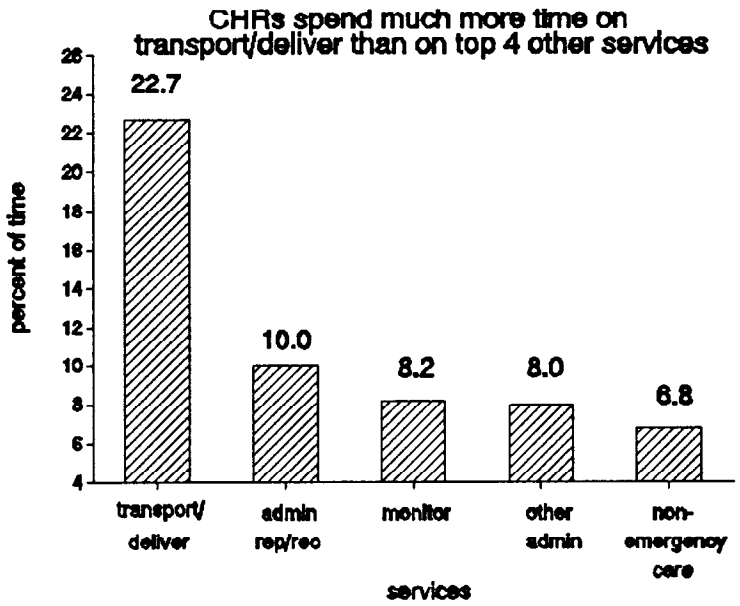
We did not set out in this study to specifically address the issue of transport as a CHR role. However we quickly found that the subject arose repeatedly as we talked to respondents and visited programs.

Historically, transport has been a major activity for CHRs, and transport, including the delivery of medications, remains an allowable CHR service today. Chapter 16 sets forth certain boundaries governing it. Transport shall be "within the local community to/from an IHS or tribal hospital or clinic for routine, non-emergency problems, to a patient

without other means of transportation, when necessary."[4] Transport "includes waiting for a patient...to finish treatment."[5] Chapter 16 also states that programs must have a tribally developed transportation policy, although there is no further explanation of exactly what this means.

Transport is a disproportionately large CHR activity.

An analysis of the FY 1991 CHRIS II report (see Appendix A) reveals that as a proportion of their total time (service hours plus travel hours), CHRs recorded almost a quarter of their time in "transport/deliver." As the chart below shows, this is more than twice the proportion of time recorded for each of the four next highest services.



At 8 of the 10 programs we visited, we observed that transport was a major, if not the primary, CHR activity. When we asked people - CHRs, their supervisors, and many others - to describe what CHRs did, they talked about transport. The transport they described included delivering medications and commodities, and taking patients to clinics, dialysis facilities, hospitals far away for delivery of babies, or funerals.

Even at a program where there is a written transportation policy, it didn't appear to be enforced, since most of the CHRs were heavily involved in transport. At another program, where transport is clearly discouraged as a CHR activity, the CHRs said that they still feel pressured on occasion to provide it.

Opinions of the CHRs at these programs about transport differed. Some seemed satisfied with a transport role. Others "feel torn because we aren't sure whether or not we should be transporting people." Still others seemed ambivalent, recognizing a need for transport but wanting to do more. Some mentioned that because they were so involved in transporting, they could not use many of the skills they learned in training - which they regretted.

Analysis of the CHRIS II reports at one of the case study sites showed 70 percent of CHR time as transport; other reports and CHR logs confirmed this. (In fact, the logs themselves are called "transportation verification forms.") At the other case study site, CHR logs showed that in 9 workdays, 2 CHRs transported almost 40 people and delivered medications to 26; the only other activity noted in the logs was 5 home visits. Also, the CHR supervisor's narrative report to the tribe talked only of transport.

Respondents disagree on whether transport is a desirable or legitimate CHR activity. Many believe that it should be better defined, or limited.

These quotes from respondents illustrate the range of opinions about transport in the CHR program:

> "Transportation is a basic need and CHRs should be providing it."
>
> "Transport is an important service, but it is inappropriate for CHRs to be doing this."
> "If CHRs are viewed as transporters, they are less effective and less involved in other activities. Transport is not an optimal use of their skills and services."
>
> "Access to health care is essential, but it should be provided by IHS. It is inefficient for CHRs to spend a great deal of their time driving people around."

The CHRs we surveyed seem to view transport as an integral duty. They made specific comments to us about the need for more government cars, higher mileage reimbursement, and money for auto insurance, comments which in and of themselves would seem to indicate that transport is a significant activity for them. Yet they also seem to want limits; three-quarters strongly favor a tribal, written, transportation policy that "clearly describes what kind of transportation CHRs are and are not allowed to provide."

Respondents other than CHRs said that problems can arise if the role of transport in a program is not clearly defined, or limited. This comment sums up what can happen: "People have expectations for a ride from CHRs, so CHRs comply and therefore activities in other areas are diminished and everybody is confused about the goals of the program."

There are many reasons why transport is a major CHR activity.

The main reason that transport may be the primary activity at many CHR programs is because this is what tribes expect and want CHRs to do. During a focus group, we asked respondents what they thought tribes wanted CHRs to do. The first answer was "transport." Elsewhere we heard: "Tribal people don't know the role of the CHR. They think of it as transport." Some CHRs told us that if they refuse to transport people, there may be complaints to tribal officials, placing them in an awkward position since they depend on those officials for their jobs.

There are several other reasons, which we both heard about and saw for ourselves, why transport may still be a major CHR activity:

- At many reservations that cover huge areas or are remote from health care facilities, the need for transport is great.
- Many families no longer accept responsibility for taking relatives to the doctor as they did in the past.
- On some reservations, there is an increased need for transport to dialysis facilities, which are often hours away.
- Health professionals sometimes take advantage of CHRs as "go-fers" to bring patients to clinic or deliver medications.
- Tribes have not sought or used other resources (contract health care, for example) to provide transportation.

THE SOW AND CHRIS II HAVE LIMITED USEFULNESS.

In recent years, IHS has developed two important management tools for the CHR program. The SOW is a document tribes can use to plan their CHR programs. The CHRIS II is a reporting system based on the SOW. Although many tribes are apparently now submitting the SOW and CHRIS II, they are not required to use them; they may submit narrative reports instead.

The SOW provides a framework for tribes to plan their CHR programs. Appendix B contains a copy of the SOW form. It is comprised of a combination of service categories (e.g. health education, case management) and health areas (e.g. diabetes, cancer), which together provide a matrix of 240 different categories into which projected CHR activities can be placed.

The CHRs report their activities in CHRIS II using the SOW matrix of health areas and services, as well as client age and gender, time spent on each service, place of service, and number of clients served per service. They report activities for 1 week (consecutive days) each month.

According to the IHS 1990 annual report on the CHR program, "CHRIS II is currently providing valuable data to (1) assist tribal programs and area offices evaluate CHR performance and (2) provide the national CHR program office the pertinent data to prepare reports to Congress and others, as well as to justify the annual budget appropriation."[6]

The most important concept behind CHRIS II is that the activities reported for a CHR program, and the amount of time spent in them, should generally match those projected in the SOW.

As management tools, the SOW and CHRIS II appear to have minimal impact on how tribes run their CHR programs.

For a number of years, the national program director and area CHR coordinators have encouraged tribes to use the SOW and CHRIS II to manage their CHR programs, and a national Mangement Applications Guide is now being developed to move tribes in this direction. Tribal CHR program managers should be comparing CHRIS II reports with the SOW and redirecting CHR activities when necessary to make sure that CHRs are doing what the tribe projected. However, these respondents say that many tribes are not yet using the SOW and CHRIS II in this way.

A copy of two CHRIS II summary reports for 1991 is in Appendix A. After analyzing these reports, we also believe that tribes are not using the SOW and CHRIS II to manage programs. Furthermore, we think the data also show that tribes are not directing their CHRs to provide health care services directed at specific health problems. For example:

- In 1991, CHRs recorded almost 40 percent of their service time in training and a variety of administrative services, and 17 percent in "trans/del." They recorded only 43 percent in specific health care services (e.g. case management, health education, and monitoring) to consumers.

- Also in 1991, CHRs recorded over half of their service hours in the health areas of "not applicable," "other general medical," and "unknown." Also, the percent of service time recorded in "not applicable" rose from 12 percent in 1990 to 31 percent in 1991.

- Overall, CHRs recorded only 10 percent of their service hours. combined, in the health areas of substance abuse, diabetes, and cancer. Respondents commonly told us these were the most serious health problems in their communities, and they are well documented in the literature as significant Indian health problems.

We are also concerned that, as management tools, the SOW and CHRIS II are too heavily focused on activities. They do not reflect the quality, effectiveness, and impact of CHR services.

Analysis of CHRIS II data also raises questions related to accuracy and reliability.

The development of the SOW and CHRIS II has been a process of continuous attempts at improvement by IHS. The forms have been refined and simplified over time, and training on their use has been conducted for many program directors, supervisors and CHRs. However, IHS is aware that problems remain. In the year-end FY 1990 report on the CHR program, IHS recommended that training of CHRs on using CHRIS II be improved, and the language for the "other general medical" and "not applicable" categories be refined to reduce the amount of time reported in them and to increase

reporting in other, more specific, areas. In addition, IHS will spend over $135,000 this fiscal year on quality control for national CHRIS II data.

The two summary reports in Appendix A contain breakdowns of service time, number served, and number of activities by health area and service. Some of the numbers, in particular, raise questions about the accuracy and reliability of the data.

- The number of persons served in 1991 was 4,258,665.
- The CHRs spent 17 percent of their service time on the **service** "trans/del" (transporting people and delivering medications).
- The CHRs spent over half (56 percent) of their service time in the non-specific **health areas** "other general medical," "not applicable," and "unknown."
- The CHRs spent 33 percent of their service time on administrative **services** ("admin rep/rec," "pt clerical," "meetings," "other admin").

First, the data do not give us an unduplicated count of how many people the CHR program served in 1991. The 4.2 million figure is not only inaccurate but misleading; it is clearly not an unduplicated count, since the entire American Indian/Alaska Native population in the United States is only 1.5 million. Furthermore, IHS uses this figure to calculate the average cost **per person served**, by dividing the amount funded for the program by the total number served. This means that this cost figure is also misleading because it counts a "person" more than once.

Next, the proportion of time reported for "trans/del," at 17 percent, strikes us as low, since transport appears to be such a major CHR activity. Or, is the definition of the category in CHRIS II inaccurate in terms of the kinds of transportation that CHRs actually provide?

Next we ask whether the large proportion of service time reported in non-specific health areas, particularly "not-applicable" at 31 percent, accurately depicts what CHRs are doing. Are the other, specific, categories, such as case management and monitoring, not meaningful in terms of what CHRs actually do, and if so, why are they there? Or is it that CHRs are not filling out their reports accurately because the categories are confusing or unclear, or because the reporting process is too complicated?

As for the data reported in the services categories, our first observation is that many of the categories are not services but activities - for example, training, record-keeping and reporting, and meetings. This gives a misleading picture, then, of the time CHRs spend providing services to consumers. Secondly, the large amount of time reported in these categories raises the same questions about accuracy that we explained relative to the health areas.

Finally, we are curious about the relatively large proportion of time devoted to reports/recordkeeping - at 12 percent, the second highest, after transport/deliver. We wonder whether this could be an unintended result of how the CHRIS II reporting system works; that is, CHRs could be reporting the time they spend filling out CHRIS II reports, which is time they do not spend during the other 3 weeks of the month. If so, this figure is also an unreliable reflection of how CHRs are spending their time.

MANY AREA AND LOCAL RESPONDENTS ARE SOMEWHAT FAMILIAR WITH THE SOW AND CHRIS II. OPINION IS MIXED ON THEIR USEFULNESS.

Two-thirds of the area and local respondents are familiar to some extent with the SOW or CHRIS II. People generally see the SOW as useful for providing guidelines or direction for CHR programs. However, they have some criticisms of CHRIS II: (1) reports are far too detailed and burdensome to complete; (2) the data in CHRIS II are misleading, inaccurate or inflated; (3) CHRIS II provides only a general or partially accurate picture of what CHRs are doing; and, most of all, (4) CHRIS II does not reflect the quality, effectiveness, or outcome of services.

Some people commented also that both the SOW and CHRIS II are "only as good as the people filling them out," or that they will only really be effective if tribes actively use them to manage their CHR programs.

Area CHR coordinators, who work most closely with tribes, find both tools useful but also identify problems. They appreciate the SOW as a tool for defining clear and specific expectations for CHR programs but see a number of problems: some programs refuse to use the SOW; people who fill it out do not understand it; some programs have projected such small percentages over so many categories that "it is impossible for them to really be workable;" and CHRs feel that the SOW has been imposed on them without their input and therefore does not really define what they are doing. One person said also that it is very important to give clear instructions on the SOW to tribes, and good examples to follow.

As for CHRIS II, area CHR coordinators see it as a necessary accountability mechanism but also have concerns: it "does not tell the story" since it contains data for only 1 week per month; there is no mechanism to ensure that the forms are filled out accurately; and, many tribal people do not value the information, so do not use it to manage their programs.

RECOMMENDATIONS

When discussing what makes CHR programs strong, many respondents for this study also raised deeper questions about the purpose and the management of the program. Their comments, combined with our own observations at 10 programs, revealed some fundamental problems at the heart of this program - a poor understanding of goals and objectives, confusion and disagreement about the appropriate role of CHRs, especially transport, and questions about the usefulness of certain management tools. Unless PHS takes steps to address these concerns, we would have difficulty supporting the continuation of the CHR program in its current form.

THE PHS, TOGETHER WITH TRIBES, SHOULD THOROUGHLY RE-EXAMINE THE CHR PROGRAM TO DETERMINE ITS FUTURE DIRECTION.

Such an examination should take into account legislative intent, health care needs, and current program practices and results. It should consider the following options:

- Retain the program as a broad-based health care program, if they conclude that this is the greatest need;
- revise the program to become primarily a transport program, if they conclude that transport is the greatest need;
- abolish the program, if they conclude that it is no longer needed to meet Indian health care needs.

IF A CONSENSUS IS REACHED TO REVISE OR ABOLISH THE PROGRAM, PHS SHOULD DEVELOP THE APPROPRIATE LEGISLATIVE PROPOSALS TO DO SO.

IF IT REMAINS AS A BROAD-BASED HEALTH CARE PROGRAM, PHS SHOULD DEVELOP A MULTI-FACETED NATIONAL STRATEGY TO REVITALIZE THE CHR PROGRAM.

If PHS, together with tribes, decides that the CHR program should continue, and should provide a wide variety of health care services, PHS should develop a broad national strategy to address the problems described in this report. The following elements should be included in such a strategy.

Clarify the national goal and objectives of the CHR program.

The CHR program should be sharply focused and strategically geared to results. A clearly defined framework, including goals and objectives, is needed for PHS and tribes to effectively focus resources and management efforts on the program. We suggest that PHS and tribes develop a consensus on the goal and objectives of the CHR program.

They should consider: how CHR programs can be linked to other Indian health care programs; what are and are not appropriate CHR activities; whether the program should focus as a priority on specific health care problems or populations; and what outcomes or measures of effectiveness should be established.

Then PHS should publish the goal and objectives in Chapter 16 and disseminate them widely to tribes. The goal and objectives should serve as a basis for providing technical assistance and developing and refining management tools for the program.

If transport remains an allowable CHR activity, develop a clear national policy which governs it.

As described in this report, most respondents for this study have only a general notion of what the CHR program should be and what are appropriate CHR activities. Nationally, transport appears to be a major CHR role. We question whether PHS should be funding a program which is heavily transport, whether it is appropriate for CHRs to be providing transport, and whether over $1 million annually should be spent on training CHRs who are mainly transporters. Furthermore, given morbidity and mortality statistics on Indian health, it seems clear that much more than transport is needed.

At the same time, we recognize that transport may be a legitimate need for some tribes, and that PHS and tribes may therefore decide that, to some degree, transport should be an allowable CHR activity. In this case, we recommend that the role of transport in the CHR program be carefully and clearly defined, and that a national policy be developed in accordance with it; the policy should then be issued by the Director of IHS.

We also suggest that PHS and tribes explore other sources of funding for transportation, including contract health care, Medicaid, or others, so that CHRs can devote their time to activities more directly related to health care.

Develop performance indicators.

The Chief Financial Officers Act requires the development of performance indicators, and in response, IHS is now developing performance indicators for some programs. In addition, as part of the reauthorization of the Indian Health Care Improvement Act, Congress recently established voluntary targets for decreasing death and disease rates for Native Americans, in light of concerns for increased accountability and effectiveness in Indian health care programs. We recommend that performance indicators be developed for the CHR program which are consistent with a revised program goal, and that the indicators be published in Chapter 16.

Improve the SOW and CHRIS II.

Issues of accountability and oversight relative to IHS programs are particularly timely as the regulations for P.L. 93-638 are being finalized and the relationship of the Federal Government and tribes is being re-examined in this light. The Inspector General has

gone on record in support of the inclusion of data collection requirements in these regulations.

We have described a number of shortcomings causing us to question the usefulness of the SOW and CHRIS II as management tools for this program. We recommend that they be improved: based on a revised program goal, simplified, made to capture what CHRs actually do, and include measures of effectiveness besides strictly number of activities - beginning with an unduplicated count of people served. This is especially important because we understand that IHS may replicate CHRIS II, or a similar reporting system, in other programs. If so, every effort should be made to develop as accurate and useful a reporting system as possible.

In order to assure effective oversight and technical assistance for this program, we also believe that tribes should be required to submit the SOW and CHRIS II reports. These are still optional, and some tribes continue to submit narratives instead.

Develop technical assistance and training plans.

Under P.L. 93-638, the role of IHS is shifting away from direct service provider towards consultation and technical assistance to tribes. It is becoming increasingly important for IHS to work cooperatively with tribes to share knowledge and expertise so that they can run their 638 programs effectively. We recommend the development of a more strategic plan for providing technical assistance and training for the CHR program, based on a more clearly defined goal and objectives. In terms of training, specifically, we believe that training should be closely related to what CHRs are actually doing, and that it should be focused most heavily on CHRs whose primary role is providing health care services of some sort rather than transport.

Develop an evaluation tool and conduct periodic evaluations.

As noted in the Background, IHS has not yet developed the evaluation criteria for this program mandated by Congress in 1983. The national CHR program has never been evaluated, nor are formal evaluations conducted of individual programs. We recommend that such evaluation criteria and tools be developed and applied in periodic evaluations of both the national program and individual programs.

. . .

We suggest that PHS use the information in our report entitled "Revitalizing the CHR Program " in connection with this recommendation. It describes a number of factors which respondents said should be present in strong CHR programs. Together, we believe these factors provide a solid framework for developing a strategy to plan, manage, and evaluate CHR programs.

COMMENTS

The Assistant Secretary for Planning and Evaluation (ASPE) and PHS commented on the report. The full text of their comments is in Appendix D.

The ASPE agreed with us that more attention should be paid to the CHR program and believes that our report provides IHS with an approach to re-examine it. Based on technical comments they made on the text, we made some editorial changes in the report.

The PHS concurred with our findings and recommendation to revitalize the program and described steps that IHS has initiated to address the problems described in the report. In addition to developing an action plan, they noted that the IHS strategy to revitalize the program will take into account the factors described in our companion report "Revitalizing the Community Health Representative Program," factors found to influence the effectiveness of CHR programs.

We thank ASPE and PHS for their comments.

APPENDIX A

CHR REPORT NO. 1
TIME SPENT, NUMBER SERVED, NUMBER of ACTIVITIES by HEALTH AREA

ALL AREAS
257 Program Codes
AREAS: ALL
For the 52 weeks of the fiscal year ending 9/91
(made JAN 08, 1992)

HEALTH AREA	SERVICE HOURS		TRAVEL HOURS		NUMBER SERVED		NUMBER OF ACTIV	
TOTAL	1,837,490	100%	401,921	100%	4,258,665	100%	1,957,374	100%
1 DIABETES	148,927	8%	55,598	14%	377,704	9%	237,416	12%
2 CANCER	16,595	1%	6,367	2%	26,124	1%	19,812	1%
3 HYPERTENSION	61,290	3%	20,579	5%	259,168	6%	134,293	7%
4 AIDS	6,848	0%	1,136	0%	40,866	1%	4,732	0%
5 COMMUNICABLE DIS	26,813	1%	8,383	2%	143,551	3%	77,208	4%
6 SUBSTANCE ABUSE	21,690	1%	5,121	1%	51,108	1%	24,636	1%
7 COMMUNITY INJ CTRL	18,312	1%	3,905	1%	67,432	2%	15,354	1%
8 PROMOTION, PREVEN	136,312	7%	27,108	7%	654,683	15%	140,570	7%
91 OTHER GEN MED	323,777	18%	98,968	25%	886,116	21%	416,348	21%
92 DENTAL	39,705	2%	11,853	3%	168,022	4%	46,894	2%
93 GERONTOLOGICAL	127,197	7%	39,534	10%	341,550	8%	194,486	10%
94 MCH	130,919	7%	38,389	10%	399,876	9%	207,712	11%
95 MENTAL	18,670	1%	4,855	1%	38,263	1%	26,060	1%
96 ENVIRONMENTAL	61,735	3%	15,271	4%	343,469	8%	44,767	2%
NOT APPLICABLE	572,044	31%	45,036	11%	290,198	7%	282,256	14%
UNKNOWN	126,656	7%	19,817	5%	170,535	4%	84,830	4%

CHR REPORT NO. 2
TIME SPENT, NUMBER SERVED, NUMBER of ACTIVITIES by SERVICE

SERVICE	SERVICE HOURS		TRAVEL HOURS		NUMBER SERVED		NUMBER OF ACTIV	
TOTAL	1,837,490	100%	401,921	100%	4,258,665	100%	1,957,374	100%
1 HEALTH ED	101,162	6%	12,358	3%	563,854	13%	134,197	7%
2 CASE FIND	80,293	4%	13,286	3%	472,447	11%	120,237	6%
3 CASE MANAGE	116,478	6%	18,507	5%	367,986	9%	214,051	11%
4 MONITOR	135,961	7%	46,892	12%	376,247	9%	298,694	15%
5 EMERGENCY CARE	20,089	1%	3,688	1%	20,072	0%	11,658	1%
6 NON-EMERGENCY CARE	126,242	7%	25,648	6%	389,125	9%	220,432	11%
7 HOMEMAKER SERVICE	29,879	2%	4,093	1%	46,233	1%	29,778	2%
8 TRANS/DEL	315,950	17%	193,060	48%	616,578	14%	414,960	21%
9 INTERPRET	17,562	1%	1,677	0%	99,101	2%	28,141	1%
10 ENVIRONMENT	51,318	3%	12,388	3%	323,211	8%	31,425	2%
11 ADMIN REP/REC	225,290	12%	8,952	2%	124,409	3%	134,127	7%
12 PT. CLERICAL	126,774	7%	3,814	1%	321,880	8%	84,592	4%
13 MEETINGS	84,284	5%	14,562	4%	199,898	5%	35,985	2%
14 TRAINING	117,746	6%	13,212	3%	19,313	0%	25,797	1%
15 OTHER ADMIN	168,552	9%	11,614	3%	110,145	3%	83,963	4%
16 OTHER SERVICES	115,125	6%	16,755	4%	200,244	5%	84,086	4%
UNKNOWN	4,786	0%	1,416	0%	7,920	0%	5,251	0%

APPENDIX B

INDIAN HEALTH SERVICE
CHR PROGRAM
SCOPE OF WORK MATRIX

H E A L T H A R E A

FY: _____ TRIBE: _____ CHR FUNDS: _____ CONTRACT #: _____ EFFECTIVE DATE: _____ PROG. CODE: __-__-__-____ SERVICE	1. DIABETES	2. CANCER	3. HYPERTENSION/CARDIO	4. HIV/ARC/AIDS	5. COMMUNICABLE DISEASE	6. ALCOHOL/SUBSTANCE ABUSE	7. COMMUNITY INJURY CONTROL	8. HP/DP	91. OTHER GENERAL MEDICAL	92. DENTAL	93. GERONTOLOGICAL	94. MATERNAL/CHILD HEALTH	95. MENTAL HEALTH	96. NON-SPECIFIC	TOTAL
1. HEALTH EDUCATION															
2. CASE FIND/SCREEN															
3. CASE MANAGEMENT															
4. MONITOR PATIENT															
5. EMERGENCY CARE															
6. PATIENT CARE															
7. HOMEMAKER SERVICES															
8. TRANSPORT PATIENT															
9. INTERPRET/TRANSLATE															
10. OTH PATIENT SERVICES															
11. ENVIRONMENTAL SERVICES															
12. ADMIN./MANAGEMENT															
13. OBTAIN TRAINING															
TOTAL															

% OF TIME NUMBER OF CHRs FUNCTION

APPENDIX C

ENDNOTES

1. *Indian Health Manual, 3-16.2B*
2. *Indian Health Manual, 3-16.13C*
3. *Indian Health Manual, 3-16.5A*
4. *Indian Health Manual, 3-16.5B3*
5. *Indian Health Manual, 3-16.9D4f*
6. *Indian Health Service, Community Health Representative Program; Annual Report for Fiscal Year 1990, p. 1.*

APPENDIX D

AGENCY COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Memorandum

Date MAR 24 1993

From Acting Assistant Secretary for Health

Subject Office of Inspector General (OIG) Draft Reports "Management Issues in the Community Health Representative (CHR) Program," and "Revitalizing the CHR Program"

To Acting Inspector General, OS

Attached are the Public Health Service comments on the subject draft reports. We concur with the recommendation to thoroughly re-examine the CHR program and determine its future direction. The Indian Health Service has begun activities to revitalize the program. The attached comments discuss the actions planned or taken to develop a national strategy to revitalize the CHR program.

Audrey F. Manley

Audrey F. Manley, M.D., M.P.H.

Attachment

PUBLIC HEALTH SERVICE (PHS) COMMENTS ON THE OFFICE OF INSPECTOR GENERAL (OIG) DRAFT REPORTS "MANAGEMENT ISSUES IN THE COMMUNITY HEALTH REPRESENTATIVE PROGRAM," OEI-05-91-01071, AND "REVITALIZING THE COMMUNITY HEALTH REPRESENTATIVE PROGRAM," OEI-05-91-01070

General Comments

The OIG reports on the Community Health Representative (CHR) program provide valuable information. They highlight problems that the Indian Health Service (IHS) is aware of and is working actively to resolve. The reports also supported PHS efforts to implement long-range initiatives in collaboration with the IHS Headquarters East and the Tucson-based Office of Health Programs Research and Development.

The IHS, in order to determine if Area Office CHR programs are meeting the intent of Congress and program objectives, will utilize an evaluation methodology developed by the Oklahoma City Area Office. The Oklahoma Area Office's CHR annual program assessment is comprised of a standardized table of scores that are derived from a comparison of the scope of work and data in the CHR Information System II (CHRIS II) records. Using this methodology, the Oklahoma Area Office has performed annual evaluations to compare the progress of individual CHR programs between Fiscal Years (FY) 1990 and 1991. Because of the satisfactory results obtained in the Oklahoma Area Office, a version of this management tool will be distributed to the other Area Offices.

In addition, IHS is developing outcome and quality oriented evaluations for the CHR program. The evaluations will be based on "Healthy People 2000" objectives, the patient care component of the Resource and Patient Management System, and data contained in CHRIS II.

OIG Recommendation

The PHS, together with Tribes, should thoroughly re-examine the CHR program to determine its future direction. If a consensus is reached to revise the program, PHS should develop the appropriate legislative proposals to do so. If it remains as a broad-based health care program, PHS should develop a multifaceted national strategy to revitalize the CHR program.

PHS Comments

We concur and will initiate actions to revitalize the program. IHS has begun activities in this regard. The Area Office CHR Coordinators met with IHS Headquarters staff the week of October 26, 1992, and drafted an action plan to revitalize the

CHR program. This draft action plan was presented to the Board of Directors of the National Association of CHRs. The purposes of this presentation were to (1) brief Board members on the goals and objectives of the draft action plan, and (2) seek Board member comments on, criticisms of, and suggested improvements to the draft action plan.

The IHS' FY 1993 activities to revitalize the CHR program will culminate in a national IHS/CHR Tribal Partnership Conference which is tentatively scheduled for late September 1993. It is expected that this conference will be attended by IHS executives and managers, tribal leaders, CHRs, and consumers. At this conference, IHS intends to summarize the findings and recommendations contained in the OIG reports. Position papers on the "national goal and objectives of the CHR program" and "role of the CHR" will be presented also.

In developing a national strategy for revitalizing the CHR program, IHS will carefully consider the factors, identified in the OIG reports, that influence the effectiveness of CHR programs. IHS acknowledges that:

- The role of the CHR must be well-defined and understood by tribal governments, community members, and the IHS health care team.
- A community-based health care outreach program should work closely with the health care professionals serving the respective communities. Therefore, CHRs must be integrated into the health care system.
- The CHR program is a community-based, tribally-operated program that can only be effective with full tribal support and direction.
- IHS support and direction is important to make a strong CHR program.

The national strategy will address the factors mentioned above.

DEC 1 1992

TO: Bryan B. Mitchell
Principal Deputy Inspector General

FROM: Assistant Secretary for
Planning and Evaluation

SUBJECT: OIG Draft Reports: Management Issues in the Community Health Representative Program," OEI-05-01071 and "Revitalizing the Community Health Representative Program," OEI-05-91-01070

The draft reports on the IHS Community Health Representative Program present compelling evidence that more attention should be paid to this program. Your findings are dramatic and the proposed elements of a revitalization strategy provide a thoughtful framework for further action. The clearest indication that the program could be strengthened is the finding that the majority of local respondents are not familiar with its goals and objectives. Your examination of the SOW and CHRIS II reports calls into question the usefulness of these instruments as management tools. In addition, the lack of integration of CHRs into Native American primary care systems is particularly problematic. This report provides IHS with an approach to begin examination of the program.

We have the following specific comments.

- The reports document that transportation is an important component of CHR responsibilities. There exist large, unexplained discrepancies, however, between different sources of information on the proportion of the CHR's time which is devoted to transportation services. It is not clear that revision of the program to become primarily a transport program is actually a reasonable option to be considered by IHS, based on these preliminary findings.

- "Tribal support and direction" is listed as one of the four key factors influencing CHR program effectiveness. However, as noted on page 4 of the "Management Issues" report, only one of 15 surveyed tribal members responded to IHS inquiries. This report would be strengthened by an increased effort to include tribal input as an integral component of your evaluative process.

- It would be helpful to clarify how information was gathered from the 403 respondents. When you "talked to" respondents, was a questionnaire used, or were these free flowing conversations? Was a standard set of questions used to base the contacts?

- How were the four factors that most influence the effectiveness of CHR programs developed? Were respondents presented with a list of factors created by your staff? Were they elicited through focus groups? Many perspectives were represented in the comments: a statistical breakdown of the commentary would clarify the agreement on various elements and assertions.

- The organization of the papers is somewhat confusing. It is not clear which report should be read first, and the reader often finds it necessary to consult one document in order to fully understand some of the points made in the other. It might be preferable to consolidate the reports into a single document, with the methods, findings and recommendations clearly organized.

- Your case studies indicate that the information presented in written documents was sometimes contradicted by your observations. Did you ask any of the respondents to address the apparent discrepancy between the written materials and your observations on elements A and D of Factor 1?

- References to the presence or absence of tribal health plans in the "Revitalizing" report are confusing and should be clarified. The discussion of Factor 2, Element D, on page 10 states that "as mentioned under Factor 1, Element A, we found no plan." The referenced section on Factor 1, Element A does not mention this finding, however, and even states on page 7 that "Both sites were rich in documentation." In the summary section following the individual discussions of the elements, at the bottom of page 8, there is also an indirect reference to "the absence of documents (like a tribal health plan)."

Martin H. Gerry