A Dialogue about Ideas for Renewing the Indian Healthcare System

What is this about and why should you be interested?

Preliminaries

We want to talk with you about the condition of Indian healthcare. This dialogue with you is not intended as formal consultation, which will become essential if plans to reform our system are later proposed. Rather, we want to open a wide-ranging discussion with you by sharing our views about the state of our health care system and some potential ideas for renewing it for the future.

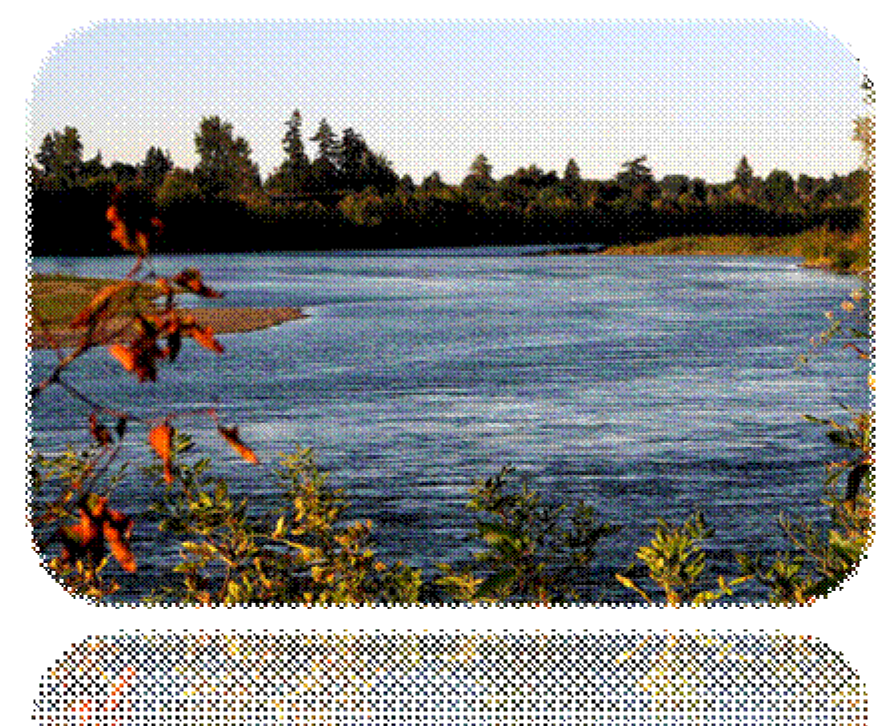
We've been listening!

Image courtesy of Candace Head, Chokecherry Studio

WE WANT TO TALK WITH YOU – NOT TO YOU.

We've heard about our healthcare system from Tribes, customers, community members, doctors, nurses and many others. We want to talk about what we heard and discuss some ideas with you.

Stress on our healthcare system is not unique



Forces acting over decades are inexorably shaping America's healthcare landscape. Wide-ranging forces such as demographic trends (aging and sedentary living habits), expanding medical technology and practice, and fundamental economic forces generated by rising prices are driving healthcare change across the board, including change in our system.

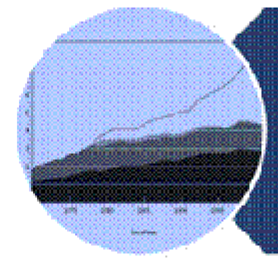
At age 53, the Indian healthcare system is due for a "check-up"

Symptoms	What signs do we observe?
Diagnosis	What is the explanation?
Forecast	What is the natural course of progression?
Options	What are some ideas for change?

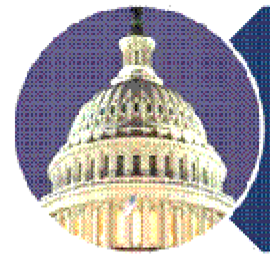
What signs do we observe when we examine our healthcare system?

Step 1
Symptoms

Encouraging Signs



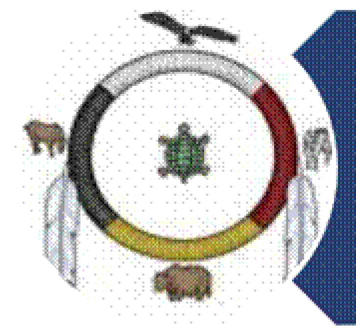
Accomplished a steady and gradual expansion of services



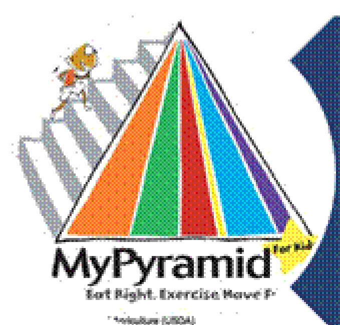
Has political support – consistent but small budget increases

Concentrated in Indian country where few health care alternatives exist

Encouraging Signs



Allies modern medicine with traditional native values about health

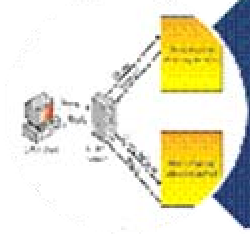


Comprehensive scope – combines individual medical care, community, and public health services

Contributed to remarkable advances in Indian health status

Encouraging Signs

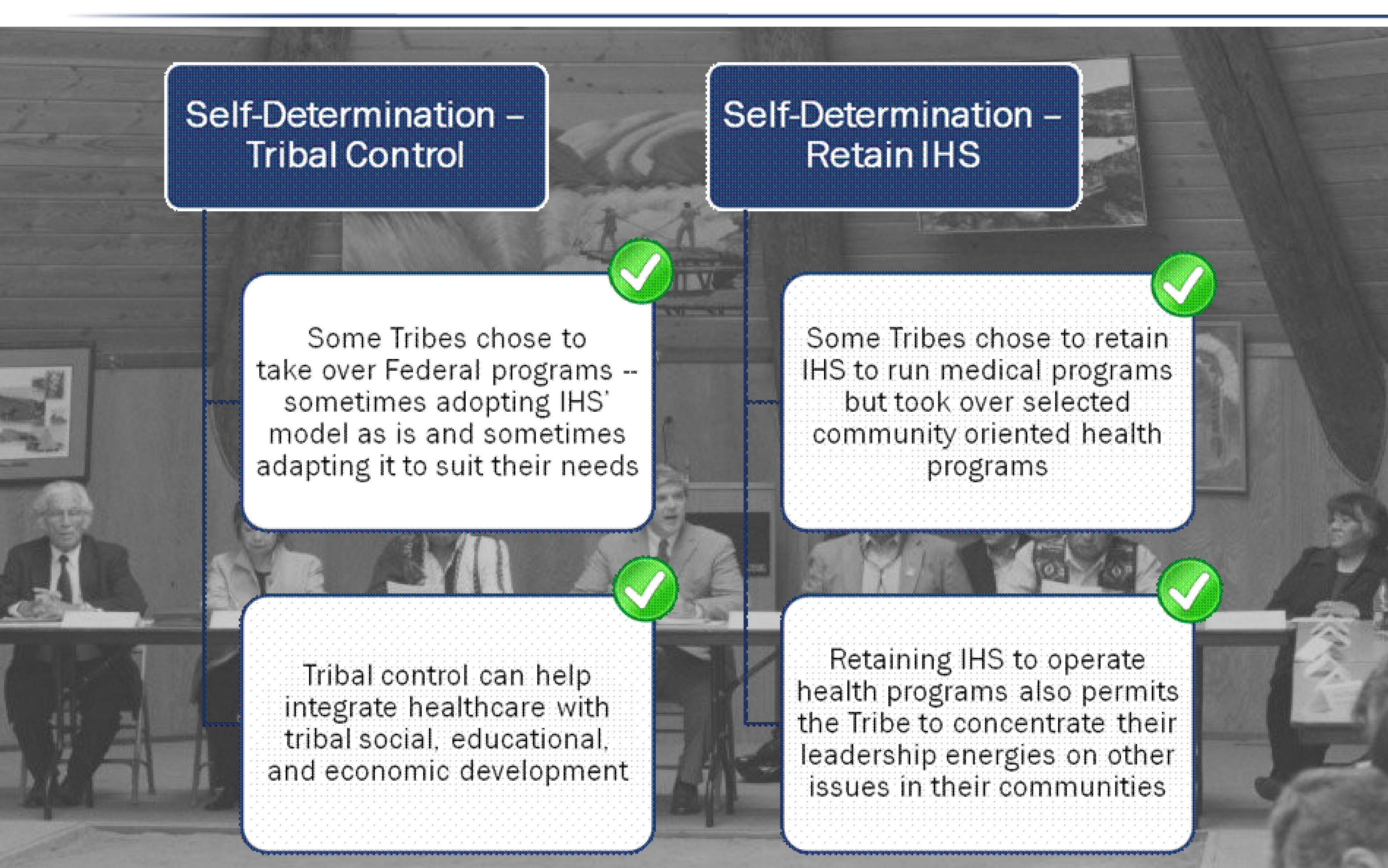
Fully accredited programs that combine local control with consolidated support.



New technology increasing access in areas of Indian Country

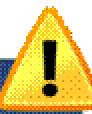
A dedicated workforce – largely AI/AN

Encouraging Signs

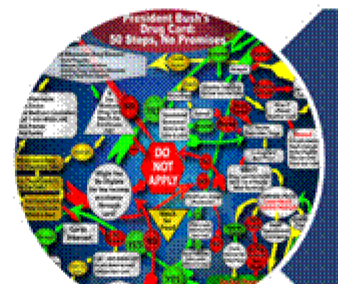


Troubling Signs

Sites run out of funds resulting in cut backs and risk of intermittent shutdowns



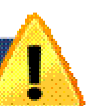
Rising denials for CHS payments



Medically necessary services are restricted, deferred or unavailable

Troubling Signs

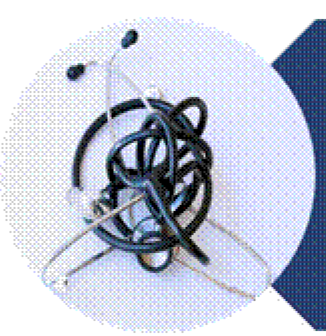
Excessive backlogs and long waiting lists



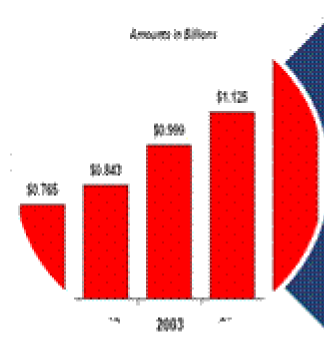
Insufficient capacity (facilities, staffing) - sometimes mismatched to needs

Un-portable benefits, unevenly available, doubts about fairness and equity

Troubling Signs



Chronically high vacancy rates, stress in the workforce, burn-out, some discouragement

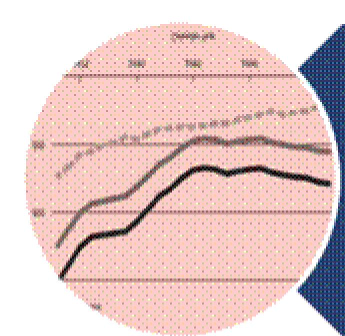


Rising tension with private sector partners - referrals without compensation

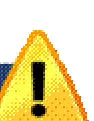
Patients, who are not members of the local Tribe, are sometimes excluded due to funding shortfall

Troubling Signs

Unhealthy lifestyles, poor diet, obesity, inadequate exercise



Disparities still exist despite decades of health improvements



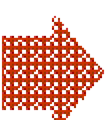
The AIAN health status gap remains stubbornly unclosed

What Causes these Symptoms?

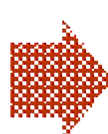
Step 2
DIAGNOSIS

Historically Low Funding

Indian health care funding falls short of other Federal healthcare spending benchmarks



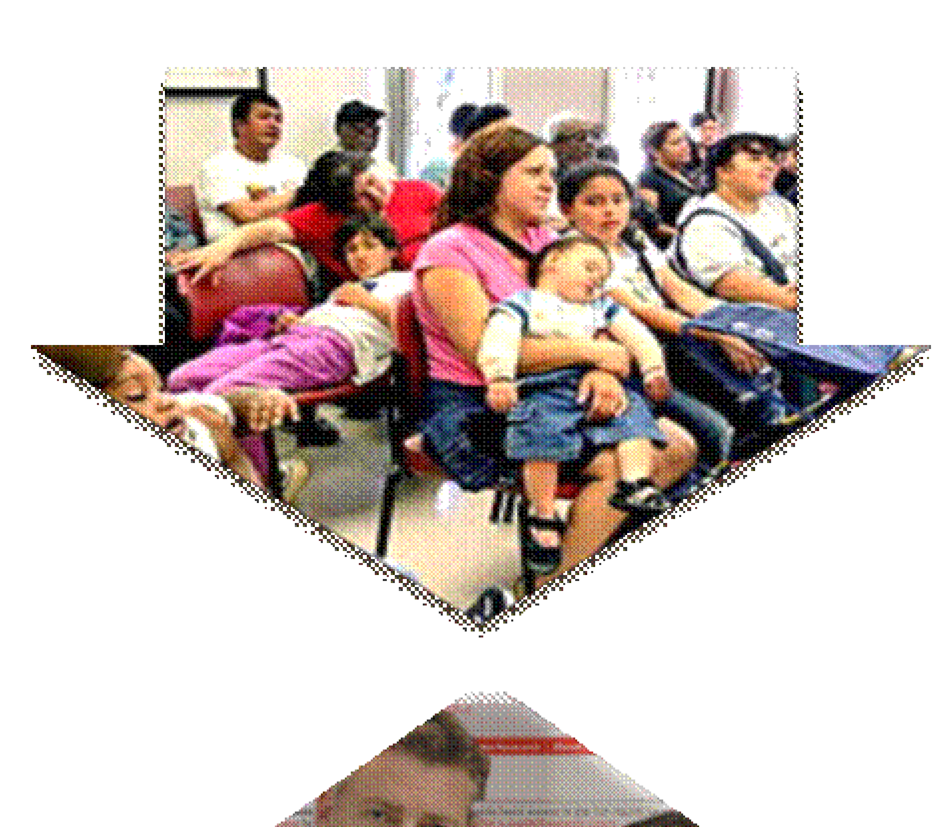
Erosion of buying power from rising healthcare prices (inflation) has counteracted modest IHS budget increases.



Our system is not the sole source of healthcare for some Indian people, but the extent that other care fills in the gap is unclear.

Demand Exceeds Supply

4 million people claim some degree AIAN ancestry. 1.5 million presently obtain some services from IHS. The huge pool of potentially eligible people creates open ended demand on our system, while limited resources restrict the services that can be provided.



Underlying Economic Forces

Escalating healthcare costs	• Costs rise faster that funding available.
Federal budget imbalance	• Bleak budget prospects • Reductions or cuts are not out of the question
Shortage of professions	• Shortages in medical professions is chronic

Configuration & Business Model

In a geographically dispersed system, small sites take a double hit

- Lack business leverage from other healthcare providers
- Fixed costs, relatively few patients
- Are some sites unsustainable?

Our organizational configuration has changed little in 50 years

- Historical restraints on reconfiguration
- We tend to look within traditional geographic and organization spheres for solutions rather than across and among them

Business model needs an update

- Some capacity is mismatched to needs
- A more integrated network could enhance leverage and share infrastructure costs

Product-Line Fit

Uneven

Rates of chronic conditions are rising . Our model is less effective resolving chronic conditions linked to poverty, behavior, poor diet, and alcohol/substance abuse.

Rising costs of advanced specialty care consumes ever more $ that would otherwise expand other services

Uneven services creates hardships, provokes criticism, undermines continuity of care, and generates tension in the patient-provider relationship.

Expectation versus Reality

EXPECTATION:
We want IHS to fulfill historic Federal commitments to Indian people.

REALITY:
Services are limited by funds appropriated. An imbalance of expectations and resources exists.

EXPECTATION:
We want needed services in small communities, on Indian lands, and in remote places.

REALITY:
Services are not economically feasible or medically appropriate in all places at all times.

EXPECTATION:
We want advanced care including high-technology services

REALITY:
High priced services often exceed our means and are not always more effective

Forecasting Where Our Healthcare System is Headed

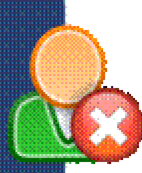
Step 3
PROGNOSIS

The Forecast?

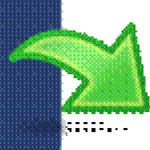
Many features of our model function well and will continue producing successes.

Other features are sub-optimal – prevailing conditions are different now.

Some features of our model are shaped by external forces and tied to legal authorities. Our means to alter external conditions is limited.



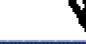
But there are some ideas to address internal problems to sustain and enhance our system.



Forecast for Supply?

BUDGET

- Proposals to rapidly grow the IHS budget have not met a lot of success. Continuing constraints on future budgets is probable.



Are there any ways to increase supply in our system?

REVENUE

- Improve billing and higher reimbursement rates
- Co-pays to individuals
- Focus on billable services

EXTERNAL

- Maximize use of external medical services.
- Increase alliances with external healthcare systems

Forecast for Demand?

DIRECT

- Reform statutory eligibility definitions
- Unify IHS' secondary eligibility rules
- Consider whether sites determine eligibility
- Individual means testing

Are there ways to manage rising demand on our system?

INDIRECT

- Service caps (#, duration, $)
- Self-rationing (wait lists, etc.)
- Cost sharing and co-pays
- Sliding fee scales

OTHER

- Services become more diluted
- About 54% of needs are met compared to a Federal Employees Health Plan benchmark

Business Model Forecast?

Evolution!

Dispersal Impacts

Cost trade-offs that are characteristic of dispersed sites can be partially mitigated, but not entirely eliminated

Mismatched Capacity

Mismatches can be converted to better use (e.g., convert underused inpatient capacity to expand ambulatory services)

In-Network Referral

Already present in places, a interconnected network could provide a broader range of services more efficiently

Pooled Infrastructure

Dispersed sites can gain leverage and reduce costs by sharing infrastructure and support systems. Technology makes it possible.

Forecast for Our Product-Line?

Trade-Offs!

Services

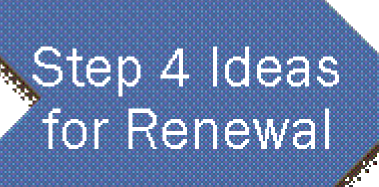
Costly treatments for chronic conditions will further restrict funds for other services. Balancing prevention (broad yield in the future) versus acute urgent care (narrow yield immediately) is a challenge

Personal - Public

Our model provides services to individuals and also public health and environmental programs for Indian communities. We face choices about allocating limited resources among these competing needs.

Limited Assurance

By law, IHS services are provided to the extent allowed by available funds. Under present authorities, all necessary services can NOT be guaranteed to individuals.



Ideas for Ways to Renew Our System

Guiding Principles for the Ideas

Securing a healthcare system for Indian people that fulfils our mission and goals

Strengthening our core model – a community oriented primary care system

Transform but not diminish services

Equalizing access to healthcare services

Seeking consultation on policies that affect Indian people

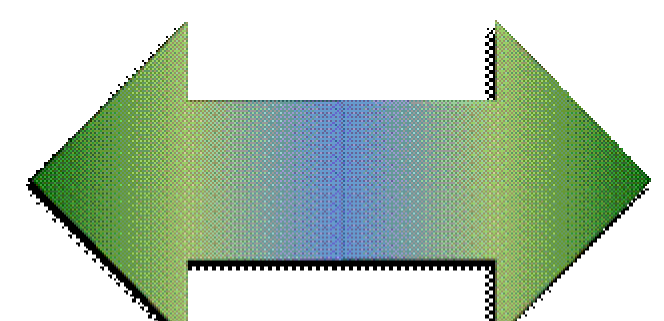
Honoring sovereign tribal choice

Honor Self-Determination

Both tribal and federal sites experience the conditions that we have discussed, often in tandem. Self-Determination law recognizes that tribally-operated sites may respond to these conditions differently than the IHS may respond. We encourage all tribes to fully consider ideas for renewal. Participation by tribal partners in renewing our system is welcomed but not required.

A Range of Approaches to Renewal

LOCAL

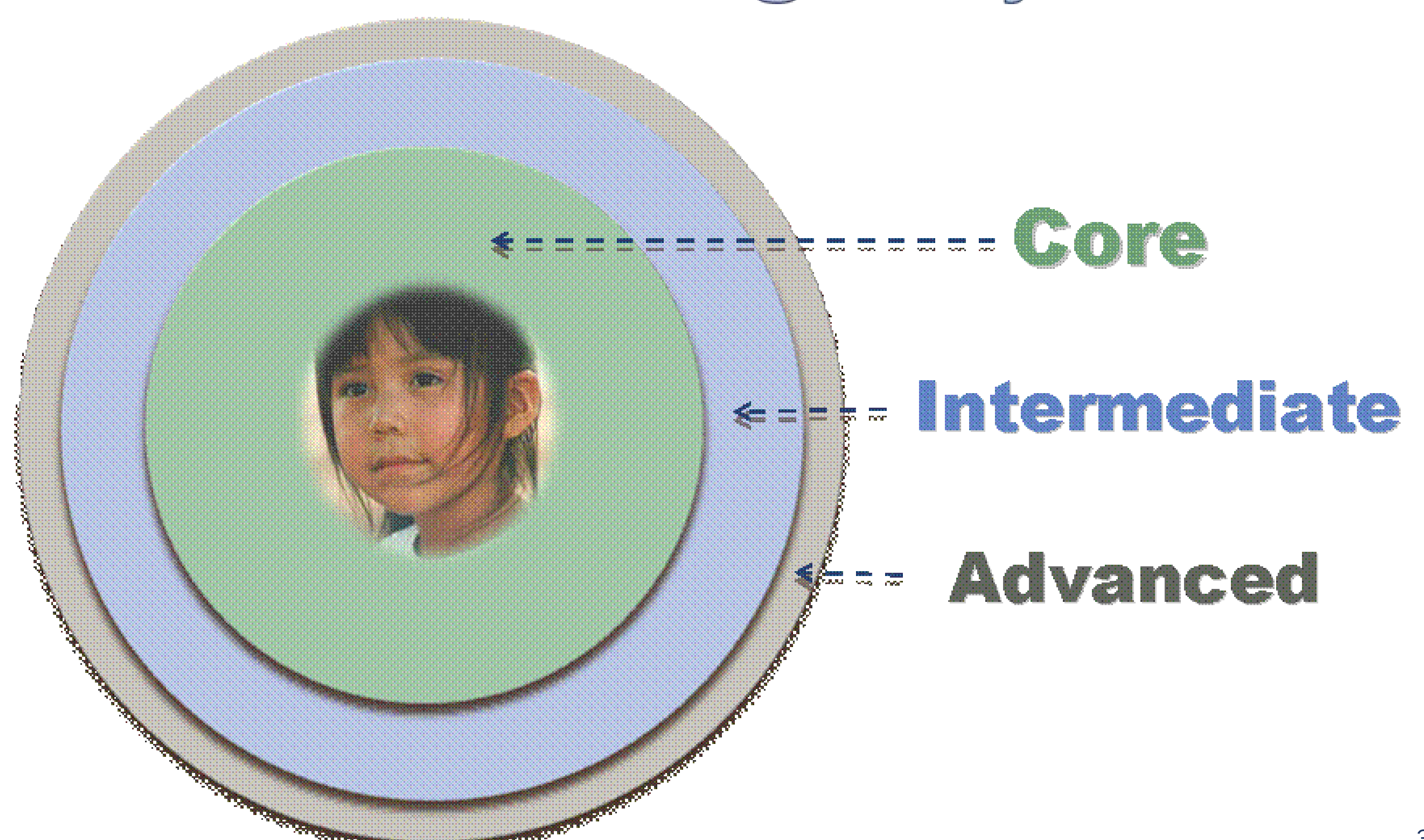


NATIONAL

- Local in scope
- Immediate, many already underway
- Focus on improving local operations
- Ex: Chronic Care Initiative

- National in scope
- Long-term
- System-wide focus
- Preliminary ideas
- Includes tribal consultation

Key Idea: 3 Dimensions of Care Surrounding Every Patient



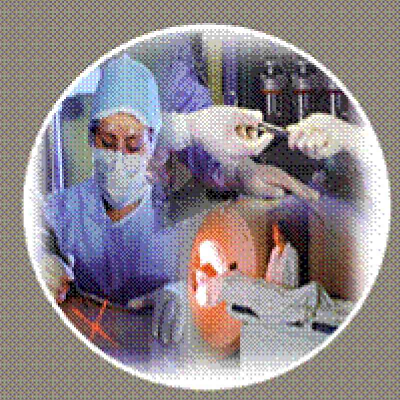
3 Layer Service Package

I – Core Primary Services

- Routine, ambulatory, screening, diagnostic and treatment services, basic preventive care, covered medications, some dental services, and some mental health and substance abuse services. Tier I list also includes PHN, CHR, EHS, SFC.

II – Intermediate Services

- Hospital and inpatient professional services, more advanced ambulatory screening, diagnostic and treatment services, vision, hearing, PT, orthopedic, and both non-complex ambulatory and inpatient surgery.



III – Advanced Services

- Complex and highly specialized diagnostic, surgical, and treatment services. These include transplants and other sophisticated surgery and treatments.

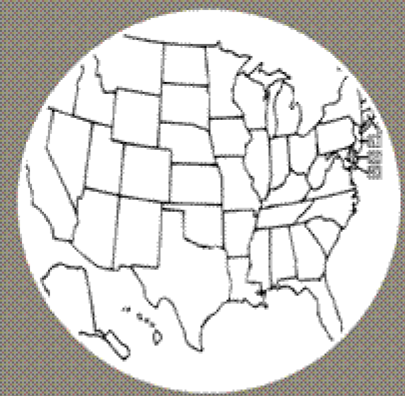
3 Layer Delivery System

I – Core Primary Sites

- A community based ambulatory clinic open Monday thru Friday and staffed with a team that may include physicians, nurse practitioners, mid-level providers, public health staff, and primary care diagnostic and treatment support capabilities.

II – Network of Intermediate Sites

- A hospital with essential inpatient services (not complex) that is open 24/7 and has urgent care capability. Some will have surgery. Staffed with a range of providers necessary for inpatient and more comprehensive ambulatory capabilities.



III – Purchased Advanced Services

- Complex and highly specialized diagnostic, surgical, and treatment services would be purchased typically, except as already may be available in some IHS medical centers.

Expand Services by Conversions

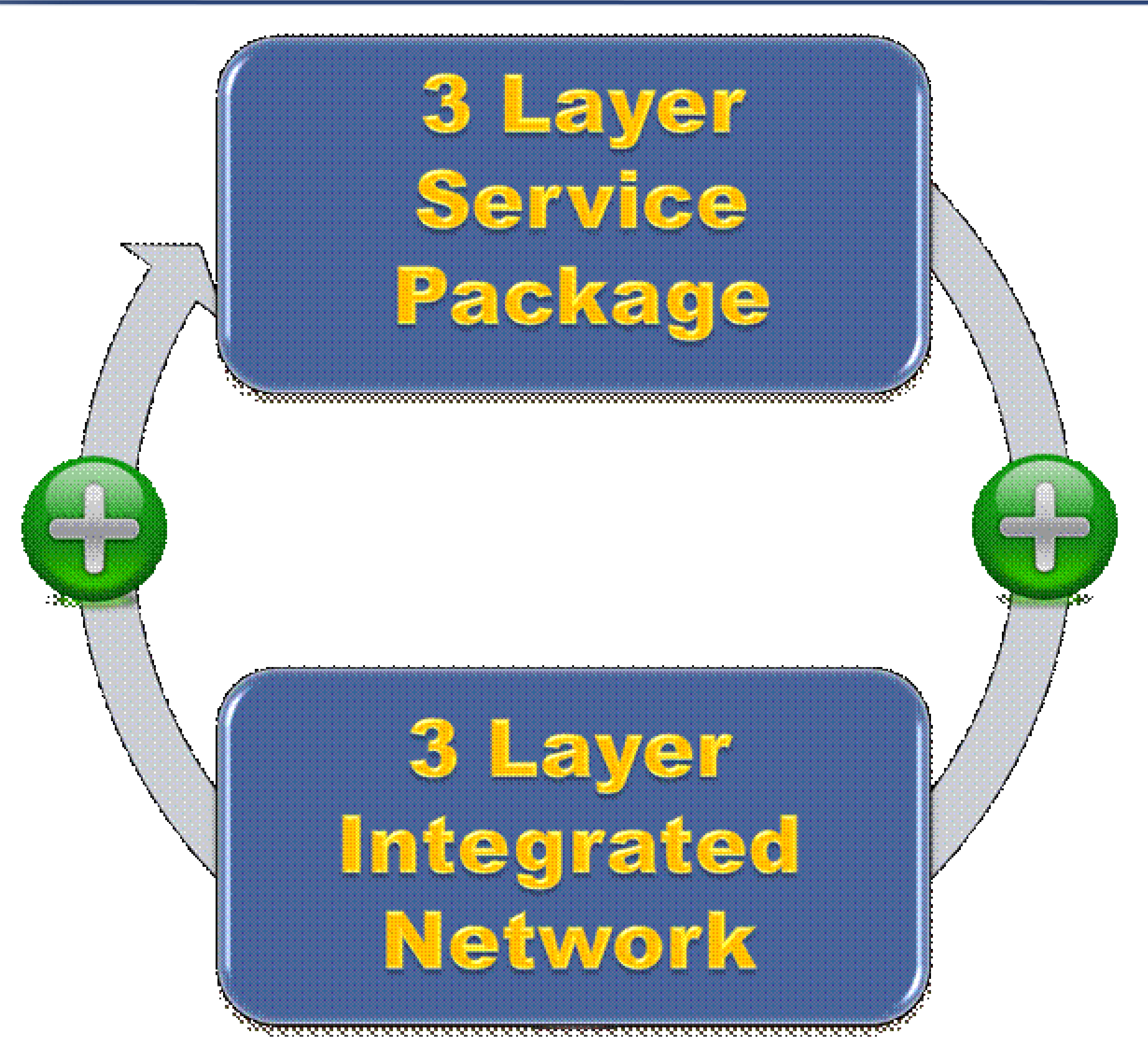
Under Used Inpatient

- Mismatched capacity
- 24/7 staffing is costly
- Uncompetitive cost
- Expensive to maintain accreditation

Expanded Ambulatory

- More services
- More efficient use of limited resources
- In-network referral
- Recruitment/retention is easier
- Better for health

More Cost Efficient, Better Quality



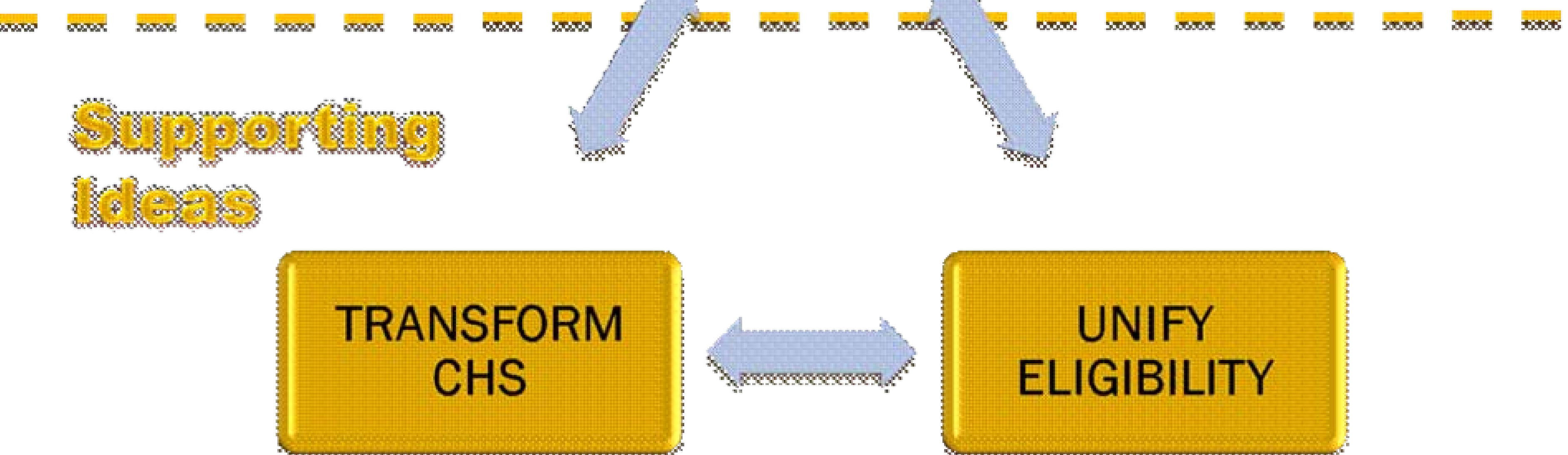
Some Issues to Consider

TIMING	• Transformation is a long term process.
FACILITIES THRESHOLDS	• Population thresholds and cluster groups for referral
HFCPS	• Does Health Facilities Construction Priority System align?
RESOURCE FORMULA	• Do budget IHS categories and allocation formula align?
REIMBURSEMENT	• Need in-network referral reimbursement mechanism.
CONVERSION COSTS	• Cost to transform facilities
INFRASTRUCTURE	• Forecast investments in EHR, beneficiary ID and transport

Supporting Ideas

Primary Idea

3 Dimensions of Service and Delivery



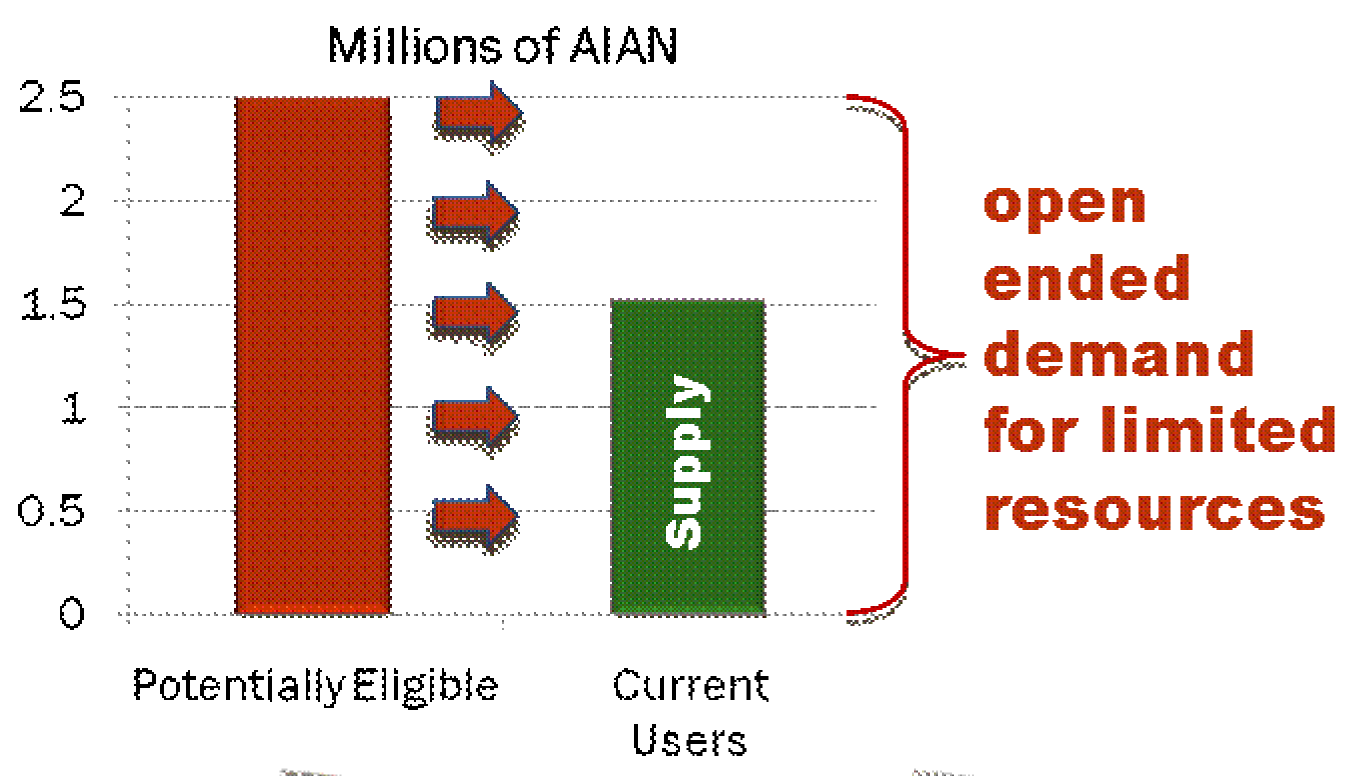
Align CHS with 3 Layer Concept

Align Medical Priorities	Unify CHS and Direct Eligibility	Align Resource Management
Align CHS medical priorities with the service package to promote better health outcomes.	Unify CHS and Direct eligibility rules to promote a continuum of care and uniform access.	Align CHS policy and funding within a mutually supporting network.

CHS – Some Issues to Consider

ALIGNING CHS PRIORITIES	• Implications of 3-layer model on CHS medical priority list.
INTEGRATING SERVICES	• Extent CHS policies and practices need adapting to fit.
ELIGIBILITY	• How many people would be affected?
BUDGET	• $ impact is potentially large. Need a forecast.
MANAGEMENT OPTIONS	• Extent that CHS management practices need adapting to fit.

Should eligibility be reconsidered?



Statutory eligibility – "member or descendent of a federally recognized Tribe"

4 million people claim AIAN ancestry – e.g. open ended demand

Only the Congress and Tribes can directly address statutory eligibility

Secondary Eligibility Rules

- Withdraw 1987 published rules still under moratorium
- Clarify and align secondary eligibility rules and IHS open door policy
- Seek uniform eligibility for CHS and Direct services

Clarify and align secondary eligibility rules

Some Questions

ELIGIBILITY #s	• How many AIAN would be affected by unifying eligibility rules?
OVERLAY	• Are rules aligned with the layered approach to services?
UNIFY	• Which path to uniform eligibility is preferable – CHS, Direct, other?
EXISTING USERS	• Should existing users be grandfathered?
REBOUND	• If sites individually restrict eligibility, such persons would impact other sites of the system

No Instant Gratification

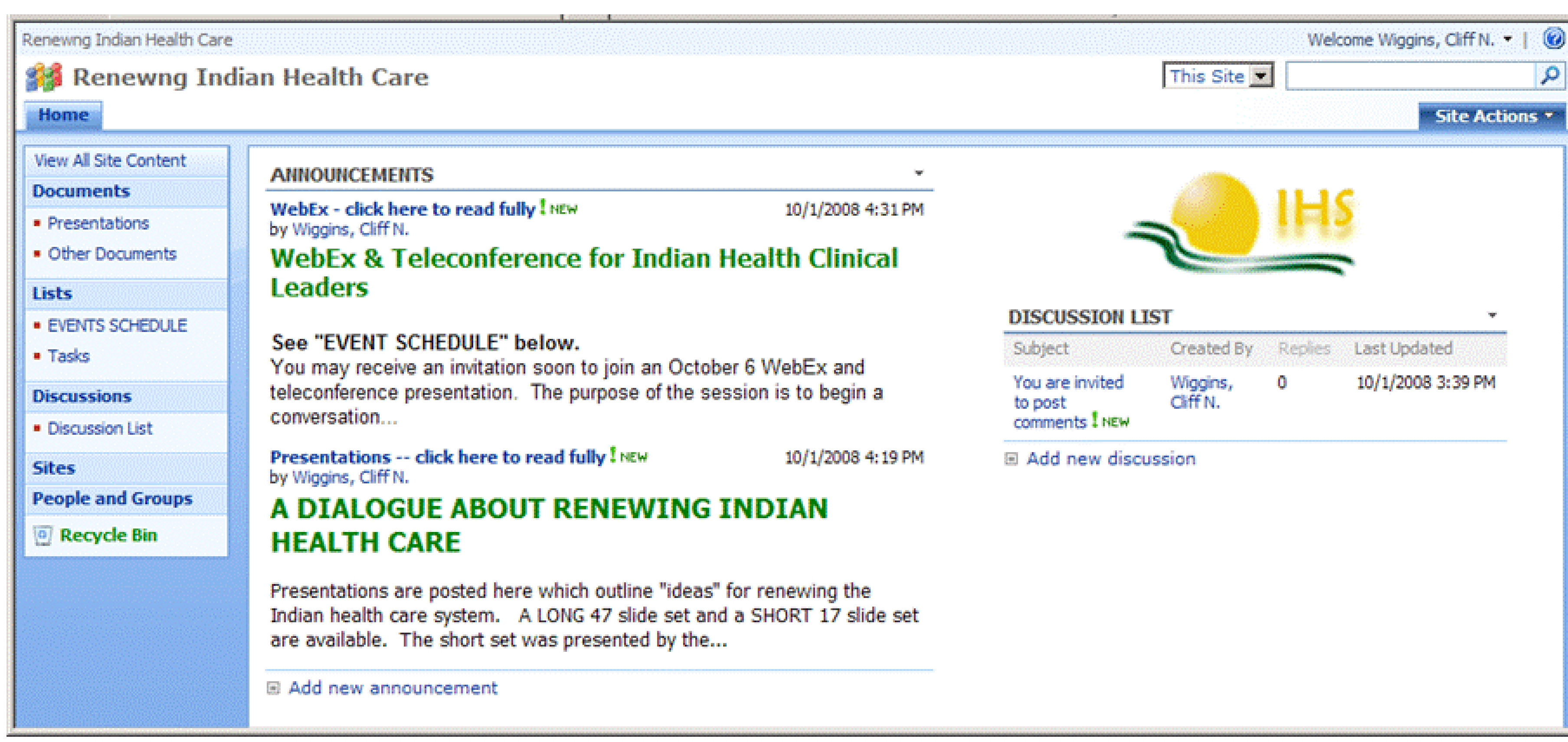
Our ideas are not a quick fix. Renewal can not be fully accomplished next year, in the following year, or even in the year after. This path is a long one! We can not see all the twists and turns along the way. But we think this path leads in the right direction..

Why Renew Our System?

We must secure and improve Indian healthcare, not only for this generation, but for generations to come!

Presentations and other material are available from this "intranet" site:

http://workgroups.ihs.gov/sites/Renew



Thank you for considering these ideas. Let us begin a dialogue on ways to renew our health care system.