Conversation to Renew the Indian Healthcare System
Feedback and Comments from the
Indian Health Service/California Area Office

Organizational/Group Responses

April 15, 2009

Current Indian Healthcare System

1. Are you satisfied with the existing Indian healthcare services and delivery system?

California Rural Indian Health Board (CRIHB), Inc.: The universal response to this question by CRIHB Board members and meeting attendants was no. There were also some ideas about what was good about the current system that were offered. One generally held opinion was that it was good for the Area Director to meet with the CRIHB Board, TGCC and Program Directors committee. Providing advice and guidance to the California Area Office as well as learning from CAO staff about IHS concerns can be productive and appropriate. Over the past eight years, this type of dialogue has been too intermittent. There is a general feeling that the CAO has not always supported the rights of Tribes and Tribal Health Programs to work together and has not fully appreciated the added value that CRIHB brings to the Area in technical capacity, consensus building policy, advocacy, and added resources. The California Dental Center and the California Tribal Epidemiology Center are good examples of how collaboration can work. The "Dialogue to Renew the Indian Healthcare System" is another good example of how IHS can work productively with Tribes and tribal Organizations

Consolidated Tribal Health: No. We have no Indian hospital to refer to in CA. We are opposed to "building" an Indian hospital, but rather we (Indian Health Service) "contract" locally for hospital beds, out-patient care, etc. With the shortage of health providers now and projected for the future, "building" a new hospital will not solve the problem. It would be prudent to have financial arrangement at the local level for all in-patient, out-patient and specialty care. It would be better for the tribal patients and their families for visitation and support.

Karuk Tribe: Not totally

Northern Caucus – Annual Tribal Leaders' Consultation Conference:

- No
- American Indians and Alaskan Natives need to protect the rights of Tribes to select the type of healthcare delivery system that best meets the need of their local community; IHS needs to honor and support that decision
- Increase funding to support additional scholarships for physician and other licensed professional staff. Increase funding to support and "guarantee upon hire" the loan re-payment program. Increase the ability and/or provide assistance to programs to recruit physicians and professional staff

- A primary barrier for many/most isolated programs is the absence of adequate housing for professional staff
- Additional funding for a designated clinical pharmacist to implement a more integrated health care education and provide services for anti-coagulation, asthma, blood pressure treatment clinic, etc...
- Line item from IHS budget for pharmacy program
- Decrease/eliminate IHS charge for Commission Corp officers to be stationed at tribal sites
- Additional funding, HP/DP activities to programs for implementation of preventative activities for children i.e., to prevent obesity, chronic disease, behavioral health, special needs, substance abuse, nutritional, etc. Support for these activities would include funding for a health educator at tribal sites
- SAMHSA set aside for tribal health programs
- Provide funding to extend clinical practice to community prevention/intervention for tribal programs for cultural and spiritual well being
- Support for community youth and family programs
- YRTC aftercare programs within the community upon return from treatment centers
- Radiology – California area does not have a licensed area consultant to assist with Radiology needs. Establish mobile imaging units for radiology, mammogram, cardiovascular….. This could be implemented on a monthly rotation for facility or this could be provided at a centralized tribal intermediate care facility
- Mobile dental van services
- Dialysis services
- IHS/CAO needs to provide licensed consultant services in pharmacy, lab, third party billing, … to assist with program needs and issues
- Could IHS and/or tribal programs maintain a local area pool of staff available to assist with staff shortages? Temporary duty and/or on call – that could be utilized prior to using high cost locum companies. Tribes would absorb the cost for these shared resources

Southern Caucus – Annual Tribal Leaders' Consultation Conference: Indian Health Council, Inc. (IHC), is in favor of modifying the system. This could include adding a pharmacy line item. CHS funding currently covers pharmacy. IHS needs to look at innovative ways to "stretch" CHS funding. This could include flexibility in eligibility and also bringing CHS type services (specialty care) into clinics to bring the services to the rural population. IHC agrees with the United Indian Health Services in Arcata, that programs that are innovative with services should be rewarded and not penalized by IHS.

Facilities: IHS needs to support the Tribes in California with construction funding. This includes retiring debt on existing construction projects. Indian Health Council, Inc., and other clinics have increased the size and array of services offered at our clinics. There were no "staffing" funds added, even though there was an increase in square footage and services.

Health Information Technology: IHS needs to work with and fund all Indian clinics in California with their patient management systems and electronic health records projects. This means they need to acknowledge that Indian clinics are going to implement and use non-RPMS systems. These clinics need the assistance of IHS to implement GPRA reports and clinical production reports that will be accepted and verified by the appropriate federal agency.

United Indian Health Service (UIHS): UIHS is in support of community based clinics and community based prevention activities. The healthcare benefits package for Native Americans greatly varies from Area to Area. However, IHS's continued historical funding methodologies continue to penalize hundreds of thousands of Native peoples based upon their residence or tribal affiliation. Those Areas with hospitals and CHS are at a significant advantage to provide comprehensive healthcare over those IHS Areas which are CHS-dependent and those Areas that must divert health funds to pay construction and mortgages.

In order to survive and provide the essential basics of healthcare, California tribal health programs have had to be very creative in finding alternative sources of funding and inventing the most efficient and effective methods of providing health services. These programs should be rewarded by IHS and their practices incorporated throughout other IHS Areas. Instead, California tribal health programs are penalized by the "IHS' funding formula.

Facilities: IHS has failed the Tribes of California by not supporting the construction of healthcare facilities. IHS has not funded a single tribal clinic in the state of California. However, California Tribes have built themselves new clinics to increase healthcare space from approximately 200,000 square feet of grossly substandard space inappropriate for healthcare in 1991 to almost 900,000 square feet of "appropriate to excellent" space today. Unfortunately, in order to do so, Tribes have had to divert other funds, including their own, away from housing, education, and economic development needs in order to support the construction of health clinics. Additionally, many health programs are diverting critically short healthcare funds to pay for loans obtained to build and to equip clinics.

IHS has only recently provided limited funds from the Small Ambulatory Program (SAP) towards the construction of a few tribal clinic projects. The SAP provides the best financial option for Congress and IHS to assist in clinic construction in underserved areas. However, the SAP only provides limited funds for construction and no assistance whatsoever for staffing and personnel to tribal clinics. The SAP could assist clinics in small rural areas that often have no accessible healthcare services of any kind. Assisting Tribes in the construction of clinics and retiring mortgage debt should be IHS's highest facility priority, especially when Tribes are also incurring the ongoing debt of increased personnel and staffing costs.

IHS also fails in the revising of the Health Facilities Construction Priority System. Although the California tribal facilities were in such substandard condition in 1991, IHS did not include a single facility in its priority system and 18 years later IHS is still using the same list to select projects. The IHS bureaucracy continues to maintain the status quo of serving its own agenda by only funding large IHS facilities.

Staffing: IHS continues to fail in supporting Tribes in California that have made the huge financial sacrifice and commitment to build facilities in order to provide basic healthcare services. IHS is remiss in not advocating an increase in staffing funds to meet these efforts. The Joint Venture program provides one such opportunity. IHS should support cooperative agreements with Tribes in order to maximize the limited amount of federal funds to their full potential. Most Tribes would probably be grateful to receive even a partial staffing package to

support their construction efforts. This current feast or famine policy is very poor stewardship and very detrimental to California Tribes.

California programs are dramatically under-funded compared to other Areas. For example, when a California tribal health program was fortunate to receive a JV project, it increased its IHS-funded staff of 21 persons to a staff of 71. This is indicative of the under-funded staffing needs of California tribal health programs. California tribal health programs also find it hard to attract healthcare professionals due to their limited budgets.

Equipment: IHS fails to secure adequate equipment funds to support new tribal clinic construction. IHS should advocate for increased funding to the Tribal Equipment Program (TEP). At a minimum, with Tribes carrying the financial burden of constructing and staffing clinics, IHS should heavily advocate for no less than full equipment funding for new clinics.

#2. Do you think the existing Indian healthcare services and delivery system needs to change? If yes, please identify what things the Indian health system does "right" and/or could be better.

California Rural Indian Health Board (CRIHB), Inc.: Yes, the IHS system needs to change in spite of the fact that there are a number of things that the IHS does "right". The IHS is right to have more resources focused on health promotion and disease prevention that any known Managed Care Organization. The IHS rightly focuses on the provision on patient oriented primary care. The IHS has had an archaic electronic patient management system and electronic medical record system but great improvements have been made and the agency has been right to foster health information technology. The IHS has been right to engage Tribal Governments in the control of agency resources and to foster local control over the IHS funded delivery system. This is the IHS version of the "community focused care". The most collaborative form of "community focused care" is expressed though the Indian Self- Determination Act Contracting which directly assigns the responsibility for local program design and resource allocation in the hands of the clients themselves a process almost unique to the IHS.

Consolidated Tribal Health: Yes. There is not an equitable distribution of funds to the various I.H.S./tribal clinics. Dental programs are under-funded. Behavioral health programs are under-funded. We are not funded for the Three Director's Initiatives. We are not funded for electronic health records. We are not funded for telemedicine. We are under-funded for contract health service. We are attempting to provide care each day in all disciplines with a shortage of health providers. Indian Health Service should improve in three areas: (1) take an advocacy role with tribal health programs in our "problems" with the State of California….other States meet routinely each year in a formal " consultation process" with the Regional HHS Office. The I.H.S. Area Office should assist the Tribes in meeting with the State to develop an acceptable MOA. The Area Office and HHS should facilitate this process ASAP. Have CMS provide "Medicaid" payments directly to the Tribes, not through the 35 States! (2) There should be a formal annual strategic planning process between the Area Office and Tribes so we are in "sync" with each other as we move forward. Tribal health programs should be funded at an equal level as Indian Health Service clinics.

Karuk Tribe

What they do Right:

- Guidance with Federal Regulations (HIPAA, compliance)
- Outside of Accreditation IHS has maintained high standards for tribal health programs to adhere to, and these standards have made us successful
- A concern for Indian health and traditional values, and recognition that we are a separate, sovereign people. Prayer is offered up at the IHS meetings from local traditional people
- Indian people feel welcomed at their clinics; and believe that they are respected there; whether it is IHS or tribal program
- They have raised the Indian health care status up
- A good resource agency
- Many Indians are employed by IHS
- Provides benchmark of care throughout Indian health programs
- Excellent guidance and assistance in IT programs and EHR
- Advocates for Indian health care (Congress, government?)
- MOA with Medicaid is good, but some improvements needed

What they could do better:

- Conflicts between sovereignty and IHS authority (in running tribal programs). IHS sometime strong arms the tribal program, e.g., Indian beneficiaries, etc.
- Conflicting demands from IHS: Provide CHS services to everyone, but IHS only provides a limited amount of dollars that are unstretchable
- Communication stops when Tribes take their shares; a better working relationship is indicated
- As a health care provider, care should be available to Indian people. I learned at a CHS conference that Indians receiving care from service units must wait for long periods to receive care, e.g. surgery etc. California Indians have such limited funds that we may wait indefinitely for care or be denied at the beginning of the request. However, if it's approved in CA, the patient gets care fairly quickly
- LCSW would like to hire case managers to go into the home and develop treatment plans, but in the MOA with Medicaid, it's not a billable service, but outside the IHS MOA it is a billable service. These funds are needed to develop successful programs where we are independent of grants
- The formula for CHS dollars is off, unreasonable in that if we limit eligibility our funding will go down, but at the same time we don't have enough funds to help anyone. It's very limited even after selecting our levels of care
- We need a system to provide the health care needs of all Indian people
- Medication costs are extreme, how can this change?
- A surgery center for CA Indians is needed

Northern Caucus – Annual Tribal Leaders' Consultation Conference:

- Yes
- There needs to be some fair and equal method of allocation of federal funds in Areas with IHS hospitals and in Areas that are CHS dependent. For example, when hospitals are built

- IHS currently has a loan repayment program. During the recruiting and negotiation process, tribal programs are unable to guarantee that a physician will be eligible and/or funds available for the student loan repayment programs. IHS should make funding available for a "guaranteed" loan repayment program for tribal facilities. Classified as an underserved area needs to be lifted to allow all tribal program areas
- IHS currently has EHR implemented in federal facilities. IHS should provide more assistance and funding to tribal programs for both implementation and support cost and not charge tribal sites. IHS should support tribal sites that have chosen to implement another EHR system. This will reduce waiting times, more patients can be seen, increase program income and accountability for reporting GPRA measures
- Expand tribal program on-site services with additional resources to include programs that the available at other private and governmental programs (physical therapy, massage therapy, pre/post natal, acupuncture, etc…)
- Additional funding for equipment and capital purchases would improve services
- Study the disparity between federal facilities and tribal sites to include the scope of services provided at each level of care to include utilization vs. cost of inpatient and outpatient care regarding funding, staffing, services, and number of patients/visits…
- Stimulus package for equipment and staff EHR
- Elder home care services
- An initiative to integrate behavioral health services with primary patient care. Funding should be made available for the facility to implement the needed services and initiative
- EHR and RPMS - accelerate release of user friendly versions, software improvements and related training. This will discourage Tribal sites from looking at alternative software from other vendors. EHR and RPMS cannot be used "out of the box" and requires several "mandated" steps from IHS
- IHS currently is addressing diabetes treatment. Expand the scope and funding of prevention programs beyond the demonstration projects. Chronic care model developed in the special diabetes program should be expanded for the treatment of all chronic care illnesses
- Expand the scope of pain management and addiction in the clinic setting, including alternative treatment (physical therapy, exercise prescription, massage therapy, acupuncture)
- The Indian healthcare services provide some targeted training and assistance to tribal programs. Targeted training needs to be conducted more frequently and use of on-line (WebEx) should be encouraged. Resources need to be made available to improve and expand on-site training opportunities

- Electronic health record implementation is recommended (soon to be required) but not funded. In fact, IHS is asking tribal programs to pay for their technical assistance. Financial and technical resources need to be made available for essential improvements and upgrades (Other IHS facilities have implemented EHR, Dentrics, ScriptPro systems to enhance their programs. Tribal facilities should be given the same resources.)

Southern Caucus – Annual Tribal Leaders' Consultation Conference: Yes. Indian Health Council, Inc., firmly believes in self-governance and the sovereign ability of Tribes to design and implement health care deliver systems for their tribal communities. The role of the IHS should be to assist the Tribes in implementing their design for their community.

United Indian Health Service (UIHS): Overwhelmingly yes. The UIHS Board of Directors believes that American Indians and Alaskan Natives need to protect the rights of Tribes to select the type of healthcare delivery system that best meets the need of their local community; IHS needs to honor and support that decision.

The bureaucracy of Indian Health Service consistently interferes with our ability to provide services. IHS is inclined to work toward their interests rather than the people they are entrusted to protect. The latest example is IHS proposing to change the fiscal year for all Special Diabetes Prevention and Demonstration Programs causing a six-month gap. This would have severe and damaging effects on our ability to sustain and/or maintain our diabetes programs. This type of action shows where they believe the priority exists, to make things easier for them no matter how much it will affect the care of those relying on these services.

2. Do you think the Indian health system has sufficient resources to meet the demand for services and are these resources being applied effectively? Please explain your yes or no answer.

California Rural Indian Health Board (CRIHB), Inc.: The universal response to this question was no! The resources allocation process has been a failure. The responsibility for this failure is shared equally by the Executive Branch and Congress. Tribes have been the only consistent and reliable voice on this subject. The IHS resource allocation system has not changed the relative status of tribal health programs in California in spite of the Rincon decision in XXXXX. This lack of resources stunts the development of a rational delivery system in California, fosters fragmentation, and negatively impacts on the availability and quality of care. Until the resource allocation problems are addressed, all efforts to appropriately shift programmatic focus to health promotion and disease prevention, improved care management, and clinic redesign will be less than successful. Recently peer reviewed and published CRIHB research documents that comparative under-funding of clinical services has a statistically significant impact on patient health outcomes. In short chronic under-funding hurts the providers and their clients. More observably the constant competition for scarce resources between the IHS Areas and within the IHS Areas or at least the California Area fosters further program fragmentation. There is also a sense that the IHS direct operated service units and the tribally-controlled portion of the IHS delivery systems are in competition against each other. For the IHS providers, the whole concept of federal funding for Contract Support Costs seems unfair. Conversely, for the tribally operated health programs, there are concerns that IHS residual functions are abused by the direct care side

of the delivery system to "capture" added resources for the remaining IHS operated sites. In California, with our unique mix of IHS clients: members of local federally recognized Tribes, California Indians who are not members of federally recognized Tribes and members of federally recognized Tribes outside of California we are increasingly experiencing a systematic efforts to restrict services only to members of resident federally recognized Tribes. In general the available resources are being applied effectively, however, increasing fragmentation creates smaller and smaller delivery systems that are less resilient, less cost effective and less able to provide and adequate level of service. The agency has resisted movement towards the use of actuarially based resource allocation as evidenced by the dearth or resources assigned to the Indian Health Care Improvement Fund. This resistance stems in part from a resistance to accept that the ability to bill Medicare and Medicaid and now CHIP, first established in 1976, changed the nature of the Agency in a fundamental way. Ignoring the actuality of these non-IHS resources as a strategy for protecting the IHS appropriation has instead allowed for a deterioration in Congressional and Executive Branch support. In fact the IHS has invested almost no resources into improving their resource allocation capacity in over a decade.

Consolidated Tribal Health: No. The proposed 2010 president's budget of $4 billion is only less than one-half of one percent (.5%) of the entire budget of HHS ($750 Billion). The Native American/Alaskan Native population of 4.1 million represents 1.5% of the total 200 U.S. population of 281.4 million. If Native Americans/Alaskan Natives were funded proportionately, notwithstanding the gross disparities in health status, Indian Health Service should be receiving in excess of $11.25 billion in annual funding. On a per capita basis, we still would be receiving less funding than federal employees, federal prisoners, veterans, etc. Over the past 25 years, Consolidated Tribal Health Project, Inc. has been able to continually provide quality services (medical, dental, & behavioral health) with accreditation from the AAAHC to our tribal communities. As a tribute to the dedication of the board and the employees in their daily efforts, we have been able to "survive" despite the lack of funding and the recent severe economic challenges at the federal, state and local levels. There is a significant shortage of qualified providers in our rural areas that cannot be addressed with the lack of funding provided for comparable salaries and signing bonuses at other I.H.S. facilities or in urban areas.

Karuk Tribe: No, they don't appear to have sufficient resources because there are deferred referrals. Tribes have to deny services due to lack of funds. Not enough CHS dollars to help all tribal people in CA. Inpatient, surgical and specialty care is not available to most Indian people.

Northern Caucus – Annual Tribal Leaders' Consultation Conference:

- No
- IHS Level of Need Funding is 54%. This is not sufficient resources to provide the healthcare needs
- IHS has mandates such as GPRA and EHR. Tribes are requested to improve and submit the required data. Resources for staffing, services, and training need to be available at the program level to meet mandates
- CHS provides levels of care (I, II, III, IV and V) based on funding and priority rating. The criterion for the referral system needs to be changed to include services not currently covered (chiropractor, long-term care, specialty care, surgery (hip/knee replacement, hearing aids,

- IHS does not provide resources for emergency medical ambulance services and long term care for elderly. Expand resources to include these essential services
- Currently, IHS/Tribes receive hospital funding for facility, construction for hospitals in their Area. California Area does not have hospitals. The funding should be shared equally among the Areas and dispersed to Tribes
- California Area needs a federal facility hospital. This facility should include outpatient sub-specialty services to reduce CHS cost. Transportation increase will be needed to transport patients to the facility for care

Southern Caucus – Annual Tribal Leaders' Consultation Conference: There are insufficient funds to operate both CHS and direct care services in a clinic in California. There needs to be equity in funding between California and all other IHS Areas. There needs to be sufficient funding and services in the area of substance abuse, including prevention and aftercare. Once a client participates in the program, there are no dollars for a much needed aftercare treatment. Too often a client participates in a program but is left to his or her own devices to transition successfully back into life, clean and sober. Unfortunately, many clients do not have the next structured phase to help be successful in recovery and then they return back to life of an addict.

United Indian Health Service (UIHS): Yes, there are insufficient resources in the federal healthcare delivery system. But more importantly, the UIHS Board of Directors believes that resources are not applied effectively or equally. There needs to be some fair and equal method of allocation of federal funds in Areas with IHS hospitals and in Areas that are CHS-dependent. For example, when hospitals are built by IHS, then an equitable amount of funding should then be allocated to those Areas that are CHS-dependent.

Rethinking the Indian Health System

1. What ideas do you have for how the Indian health system should be structured?

California Rural Indian Health Board (CRIHB), Inc.: The current IHS system should be restructured along clear lines of system capacity. Twelve Areas could be replaced by three focal points for system delivery. This approach tries to build on what ate now chaotic and competing systems. In short, tries to turn a determent into an asset. The first focal point would be "IHS Vertical Systems" that would bring together what is now Aberdeen, Alaska, Albuquerque, Billings, Oklahoma, Phoenix or at least those parts of those areas that had access to three levels of IHS funded care. The second would be "IHS Primary Care Systems" built around the California, Portland, Bemidji and Nashville Areas. All of Nevada could be added to this last group. The third focal group could be grant based urban programs. Equitable actuarial based funding that measured inputs from all major funding streams would allow each focal group to focus on service delivery within a single model. Support services would be identical within each focal group and would evolve over time to uniquely fit the needs of each focal group. All

three administrative focal points should enhance access to culturally competent patient focused public health informed community medicine.

Consolidated Tribal Health: We (Indian Health Service & Tribes) need to follow a formal strategic planning process that will include objective analysis based on accurate, timely information. As a result of this process, "structure" will follow. Before we build a new "health/medical home"…we need to know what should be in it! (Thought>Action>Results)

Karuk Tribe:

- IHS/CA located hospital where inpatient, surgical and specialty care can be provided instead of more CHS dollars
- Expand MOA to include behavioral health services case managers. MOA to cover most services that medical pays in private sector

Northern Caucus – Annual Tribal Leaders' Consultation Conference:

- Super clinic development for specialty medicine visits with hospital with specialty clinics
- More emphasis on preventative community health for health promotion/disease prevention
- Expansion of tele-health and video conferencing equipment and capabilities for patient care
- IHS should implement at all tribal program sites the capabilities to view meetings, trainings, conferences instead of traveling, to cut cost
- Expand IHS MOA to include more billable services

Southern Caucus – Annual Tribal Leaders' Consultation Conference: Indian Health Council, Inc., firmly believes in Tribes designing their own healthcare delivery systems.

United Indian Health Service (UIHS): The UIHS Board of Directors fully supports the right of self-determination and believes that American Indians and Alaskan Natives need more tribal controlled health programs and do not want that to change. The Area Offices should give full support to not only the tribal health programs but the consortiums they may form. It should not be viewed as a negative when Tribes exercise their right to contract certain IHS functions through tribal health consortiums. IHS should willingly support and encourage this to happen and not be so overly protective of the existing federal bureaucracy at the expense of the building of tribally operated systems. IHS must have a strong partnership with the tribal programs and consortiums that carry out its mission and responsibilities.

#2. In looking at the Indian health system's delivery infrastructure, both the types and location of its healthcare facilities, are there changes you would recommend?

California Rural Indian Health Board (CRIHB), Inc.: In California, the type and location of services are products of funding, geography and tribal self-determination. Nationally, the IHS, operating in a resource constrained environment, consistently favors those sites with the greatest population density. At best, the IHS facilities construction program poorly serves the needs of only a small portion of the system. Most all of its resources are targeted at densely populated vertically integrated sites. In short, about thirty operating units out of 250 will always receive

the vast bulk of the available funding. Like the problem of integrating non-IHS patient resources listed above the facilities construction program has had a problem integrating non IHS facility resources. The Agency needs to find a way of assuring that all sizes of operating unit have access to the construction and staffing resources they need. Those operating units that have built new facilities with loans and grants and have built IHS sustainable space should receive staff support equal to their facility. Loan retirement costs should be factored into resource allocation formulas. CHS funds should be allocated in a manner that counter balances the availability of the direct care system capacity.

Consolidated Tribal Health: We don't really "know" the I.H.S.'s "delivery infrastructure" to recommend changes, other than to comment on ……with your staff and resources (nationally/regionally), we should be working better to be more effective and efficient. Are we on the same path? Does I.H.S. really "know" what it is like to be on the frontline each day trying to care for very ill patients with such a shortage of funds, staff, equipment, etc.?

Karuk Tribe: Delivery infrastructure, types, locations of facilities changes recommended. IHS vs tribal health – both serve Indian people but CA tribal programs are not provided services at the same level as IHS. This needs to change to the same level of care.

Northern Caucus – Annual Tribal Leaders' Consultation Conference:

- EHR to facilitate patient record availability among multiple facilities to improve patient care services
- CAO-IHS needs two establish federal hospitals facilities in the north and south regions
- All programs should advertise their services with other facilities to share cost and resources for direct services
- Standard training and certification process for all staff (Alaska model for CHR program). This will ensure level of care is consistent, JCAHO/AAA accreditation process and creditability of health care
- Resources should be made available to provide much needed services such as; dialysis, physical therapy, nutrition education, long-term care, orthodontics, and other specialty services
- IHS facility master plan needs to be adhered to include funding and implementation of the plan. Several years ago IHS hired a private consultant firm, INNOVA, to identify facility needs in a national master plan for facility short-fall

United Indian Health Service (UIHS): If Congress would allocate additional funding based on the "Level of Need" tribal health programs in California would receive more funding. Several years ago, IHS hired a private consultant firm, INNOVA, to identify facility needs in a national master plan for facility short-fall. UIHS recommends that IHS' Master Plan be funded and implemented as soon as possible.

2. What level of care should the Indian health system seek to provide within each Tribal community?

California Rural Indian Health Board (CRIHB), Inc.: The IHS should seek to provide the same level of care to all IHS eligible clients starting with those who are active patients and view their IHS provider as their medical home. This goal is only possible if the agency moves towards an actuarially based system of resource allocation.

Consolidated Tribal Health: The level of care treatment is dependent upon funding (contract health service) and types of providers and specialties available and willing to work with us in the rural environment. It is ludicrous to ask a physician to be a "doc" and uphold your sacred oath to do no "harm", but we don't have the funds to order the medical tests, procedures, referrals that the patient requires! What kind of medicine is that? (The electronic health record is a great program for the clinic and the patient…….where do the funds come from to implement?? Should they come from CHS??)

Karuk Tribe: A California IHS hospital would even out services and save CHS dollars.

Northern Caucus – Annual Tribal Leaders' Consultation Conference:

- Ambulance Services
- Skilled Nursing, 24 Hour Coverage
- Home Health Care after discharge, chronic care, rehabilitation
- Hospice Services/Training for end of life care
- Physical Therapy – Rehabilitation for injuries, Pain Management, Obesity
- Behavioral Health
- Wellness Center/Program – Obesity, Exercise, Nutrition
- Alternative Therapy (homeopath, acupuncture…)
- More advanced services, more specialty care at Tribal sites or Intermediate Care site?
- After hours emergency care due to the distance from the nearest hospital
- A constant upgrade in care within budget constraints
- Accredited facilities

United Indian Health Service (UIHS): The level of care for every tribal community in every state in the country, should be modernized to reflect the health care needs that are self-determined by that Native American community. This level of care should focus on true prevention activities and use a community-based approach. In fact there should be a drastic reformulation of health care funding for Native Americans throughout the country: in states where there are no direct IHS-managed hospitals or facilities, then IHS should become a "pass thru" agency that simply administers federal funding to Native controlled community-based organizations (CBOs) and non-profit corporations delivering direct health care benefits to American Indian populations and communities.

Specific Issues (Questions Suggested By "Options")

1. What should be the criteria for an individual to receive care from Indian health system?

California Rural Indian Health Board (CRIHB), Inc.: The current criteria are appropriate but are not uniformly enforced. The IHS should publish regulations implementing the California Indian eligibility established in the IHCIA, clarifying the open door policy, the equality of access for all three classes of beneficiaries.

Consolidated Tribal Health: This is mandated by Indian Health Service and the U.S. Government, not by the Tribal clinic. Can a Tribal clinic place demands on a patient?? Can we charge the patient a fee for a cancelled appointment as in the private sector? Can there be "eligibility" criteria that patients must follow to be eligible for contract health services? If we follow the health promotion/disease prevention initiative of I.H.S. and a patient does not have regular preventative exams/tests, should that patient be eligible for expensive CHS funds? From a "treaty" perspective, should we not be providing total care to those Natives that are in need? Refer to all the recommendations/comments in "Broken Promises" and other reports from the U.S. Civil Rights Commission that studied Indian healthcare.

Karuk Tribe: Criteria for care from IHS/eligibility. Don't even go there!

United Indian Health Service (UIHS): Federal regulations currently cover the criteria for eligibility for direct care at 42 CFR Section 36.12, which states that services will be made available "to persons of Indian descent belonging to the Indian community served by the local facilities and program". This requirement allows the local program to have some say in the issue of eligibility by establishing some community standards for eligibility which may be unique to that community. However, the "community standards" requirement of the regulations has been suspended from implementation by letter of Dr. Trujillo on January 10, 2000. Since that time, the only criteria for eligibility for direct care has been "persons of Indian descent". The UIHS position is that the regulations should be allowed to be fully implemented by allowing utilization of objective "community standards" which fit the local community.

Federal regulations covering eligibility for contract health services are set forth at 42 CFR Section 36.23 which require that a person first meet the requirements of Section 36.12 and then also meet some additional requirements. Therefore, all of the persons who are eligible for direct care are not necessarily also eligible for contract health services.

The criteria for eligibility, as set forth in 42 CFR Sections 36.12 and 36.23, do work for our local facility. However, the issue of "community standards" does need to be looked at by IHS. If the standard is not to be implemented, the requirement should be removed from the federal regulations, not restricted from use by a letter.

3. Should eligibility criteria for CHS care and direct care be the same? If these eligibility criteria were to change, should current beneficiaries be grandfathered in?

California Rural Indian Health Board (CRIHB), Inc.: Yes, CHS eligibility and direct care access should be the same but only CHS coverage should require documentation of a lack of other coverage. All references to on or near criteria and close social and economic ties criteria should be dropped. These changes however are only workable if adequate funding is provided.

Consolidated Tribal Health: Contract health service rules should be stricter than direct care but the clinic should be able to set these rules without board or I.H.S. interference, i.e. broken appointments, level of care and payments, etc. It is one thing not to be properly funded to do what we do each day, BUT, quite another to then to tell us how we are to do what we do with the unfunded programs. Our patients deserve better. Why not fund Native health at the same level that all federal employees receive health insurance and we can then do the right thing and move on! For rural areas, we need additional funding /reimbursement from the state/ I.H.S. for "transportation" for access to our care. Additional funding is required for "substance abuse" programs as Medicaid does not reimburse for substance abuse counselors only LCSW and for limited visits.

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- If eligibility criteria changed for all patients to be eligible for both direct and CHS, funding will need to drastically increase. An implementation process for the new criteria and adequate resources will need to be established
- If criteria changed that all patients are CHS eligible, all patients' will need to apply for 3rd party reimbursement programs
- IHS should conduct a study to determine the impact if direct care and CHS criteria became the same
- Consolidate certain specialty services in a central location for sharing resources to offset CHS cost. Where would the facility be located? Will IHS funding be available for facility, equipment, staff and overhead cost?

United Indian Health Service (UIHS): In a perfect world, the answer would be yes. In the IHS world, the answer could only be yes if appropriate funding were made available to meet the health care needs of the eligible clients. At the current time, if CHS funding is not available, the local health programs are required to change priorities to a higher level, or to shut down. The better question to ask would be "should funding criteria for all IHS direct service facilities and tribal health facilities be the same?" If the funding criteria were equal throughout the IHS funded system, we would be better able to discuss these issues. When the funding issues are not equal, we all tend to make decisions which are best for ourselves and to protect the status quo.

The question posed by IHS does not indicate whether, if the eligibility criteria were to change, the change would be less strict (such as "Indian descent" only) or more strict (as currently exist in the CHS requirements). If it was less strict, there would be no need to have current

beneficiaries grandfathered in. The question only seems to make sense if the eligibility requirements are made more strict.

4. What are your thoughts about a system in which "funding follows the patient" – meaning that patients, assigned to a "home facility", could be referred to any facility within the system and the facility providing the care would be able to collect reimbursement from the patient's "home" facility.

California Rural Indian Health Board (CRIHB), Inc.: This approach is very attractive, if and only if, there is an administratively easy method of approving and recording expenditures. Small tribal health programs can not easily be converted into stand alone insurance entities so the most likely method of implementing this approach requires individual beneficiary cards, a method of making base allocations to each facility and of crediting that base for each service provided to an IHS client not included in the base funding amount. Questions that arise include at least the following. On what basis would the reimbursements be made? Would there be one IHS reimbursement center? Would the FI contractor in Albuquerque serve the whole nation? What method would be used to inform patients that they had to identify a medical home? Could eligibility criteria be kept uniform enough to assure equal access? Do we have the information technology and capacity to maintain such a system. Your example suggests that the patient could be referred to any facility within the system. What about those vast areas of IHS country that only have primary care services how does this help them? Is there that much "benefit shopping" in the current highly individualized delivery system?

Consolidated Tribal Health: A system in which the "funding follows the patient" is too difficult with transient patients, Tribes being able to dis-enroll members, and patients falsifying where they live, etc. This would be labor intensive on eligibility workers. How to do you "force" the home facility to carry through?

Maybe the Native should be provided with a "healthcare" credit card that they present to any clinic, provider, hospital, etc and then the U.S. Government: Health & Human Services pays the bill directly. We accept all credit cards and gold!

Karuk Tribe: Before we would accept a bill from another facility, we would have to provide pre-authorization for the care. This could be an avenue for prejudice between facilities. Karuk is not in favor of this suggestion.

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- If funding follows the patient, some services can be consolidated in a central location with a substantial cost saving to the home programs
- What services will be available at a central facility? What will be the assurances that services are shared equally among tribal programs? What happens when the facility cannot provide the higher level of care? CHS?

- Currently, each facility has different on-site level of care, services and specialist. Should these services be outsourced to programs that do not have the level of care at a minimum cost in return? Should all these services be placed on at consolidated central location?

United Indian Health Service (UIHS): The UIHS Board of Directors believes the concept is not feasible. The tracking would be a nightmare and ultimately IHS would be left with determining which tribal health program is the primary clinic. This would create more confusion and frustration then the fiscal benefits imagined.