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

Individual Responses

April 15, 2009

Current Indian Healthcare System

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

- Not the delivery of care in California. No extra dollars in California
- Needs improvement
- No
- I believe that most days it meets a satisfactory grade but not across the board
- The current system is clearly not satisfactory for American Indians in California, although it may work well for patients near large IHS or tribal hospitals in other Areas
- No, could be better
- It has been a number of years since I was provided care by IHS but I was satisfied when I did

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

- The concept of changing a system has always been a way to make cuts in the budget of the entity and finding ways to cut services to American Indians
- Need to eliminate underutilized IHS hospitals and redirect resources to poorly funded programs
- CA needs to be made whole based upon parody, users, population, etc. CA needs access to EMS ambulance funds the same as other IHS Areas
- Yes, there are consultation or dialogues that happen with tribal leaders or designees that actually don't do the day to day
- Yes, the system needs to change to address inequities in terms of services available between IHS Areas and within an IHS Area. The emphasis on and provision of preventive care and on care for diabetics are things that IHS does right. Work on the Chronic Care Initiative is also something the IHS has done right
- With urban sprawl, there is a need for more urban Indian programs or satellite clinics to reach outlying areas where families have limited transportation
- Yes, there are needs for improvement and always will be. The IHS has found ways to provide basic services for very little but is strained for providing services beyond basic.

3. **Do you think the Indian health system has sufficient resources to meet the demand for services and are these resources being applied effectively?**

- Sufficient resources, no. California has always been short of resources, ever since the termination era. A figure has been developed as to the amount needed. No changes can really be made without more money
- No, there is not sufficient resources to meet the demand
- Only if you redistribute the IHS resources across the U.S., based upon the same formula and based upon land base, population, service area, and number of active users
- Allow individual Tribes access to IHS scholarship funds
- Funding for each IHS Area should be prorated based upon patient need
- No, there needs to be funding for long term planning, more resources for clinics, and greater emphasis on 3rd party funding
- The Indian healthcare system appears to have insufficient resources to meet the demand for services. The current resources are not applied as effectively as they could be. One example of this ineffectiveness is the tribal procurement process, which negates the entire contracting office. Why have a contracting office and then do the work with tribal procurement?
- Overall, there is insufficient funding and in California in particular, the situation is acute
- Need more funding for referrals if services cannot be provided by the urban or rural Indian health clinics. Need a hospital in CA which provides full services
- I believe that the IHS has provided the greatest "bang for the buck" it can with all things considered. No, there are not sufficient resources to meet the demand

Re-thinking the Indian Health System

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

- The concept of 638 was to move programs/functions to the lowest level which for California is the clinics that are controlled by the Tribes
- Decentralize – Let Areas make scholarship decisions and Area allocation for CHEF funds
- I need to know the structure and sit in on a more detailed session to know what they do
- Continue the emphasis on preventive and primary care. Include integrated behavioral health services in clinics and ensure an adequate number of YRTCs. Finance the system to be sure patients can get care at accepted standards at IHS, tribal, or private facilities
- If urban Indian health program funding cannot be increased, then a CHR program with transportation services would be beneficial
- One new trend that is taking place is implementation of critical access rural hospitals to bring emergency capacity to a greater population. Targeted health care to the needs of an individual population would be a step in the right direction

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?

- Smaller health stations in the local communities where services would be provided from the main clinic
- CA needs parody or the access to the same funds that other IHS Areas have
- An unknown to me at this time
- The existing health care services should be expanded to offer more services but that requires more resources which we do not have
- Need to be able to recruit/retain health professionals at all locations, especially isolated duty stations, including provision of benefits/retirement package. Need to consider civil service memorandum of agreements (MOAs) in addition to commissioned officer MOAs at 638 tribal sites
- Renew the agency to embrace and respond to epidemiologic behavioral lifestyle challenges
- Need to shift paradigm to ensure treatment includes healing and patient empowerment
- Need to increase behavioral health support, training, and staff in all locations
- In terms of infrastructure, IHS should build clinics to provide primary care wherever the population justifies and expand the network of YRTCs. This assures a minimum level of culturally appropriate care will be available to all. Beyond that, the Agency needs to work with healthcare economists to develop criteria that the agency can use to identify under what circumstances standalone outpatient surgical centers and hospitals should be constructed. Where IHS or tribal facilities are not justified, provide adequate CHS dollars to meet patient needs for care that is considered medically necessary and is evidence based. Another infrastructure issue is that of information technology. electronic health records and a system that allows patient records to be accessed from any site, as is possible within the VA and also in private networks like Kaiser, is a critical infrastructure need that should be addressed. Ideally, all sites should be on the same system in order to support this kind of access. Setting an IT standard that supports appropriate care and valid reporting of that care at all locations throughout the IHS network is not and should not be allowed to be treated as an issue of self-determination. Many dollars that could be spent on patient care are being wasted on experimentation with different EHR systems in the name of self-determination
- California needs full service hospitals or more urban Indian health clinics with more referral dollars
- Greater access to already developed health care systems will alleviate some stress

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

- The highest level of care possible within the confines of resources. The level each community would like can be set as a goal and the community can work to achieve it
- What level is acceptable nationally for members of Congress? What is an acceptable standard for the U.S.? And are all services going to be able to be provided to the tribal program as is offered at a public health or VA facility?

- I believe that there are too many differences between Tribes and/or clinics to set or establish an across-the-board level of care. At a minimum, I believe that a level of care for any clinic is Level III but each clinic/Tribe should negotiate what works for them
- The Indian health system should seek to provide the highest level of care within each tribal community. The goal should be a fully functioning hospital that can provide most if not all services that are needed by a community
- In each community, a primary care clinic with integrated behavioral health should be required
- Preventive maintenance, aftercare, and support
- Size and location of each community varies greatly. Considering also the urban or rural component makes this question hard to answer

Specific Issues (Questions Suggested By "Options")

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

- For California, "25 USC Section 1679-Eligibility of Indians" shall continue. American Indians need to be taken care of first, no matter what. Currently, an American Indian is eligible for health care at any facility that provides health care to Indians at no cost, except for CHS. The issue would be the cost of services and who pays? The other issue is those patients across state lines
- Member of a federally-recognized Tribe
- I feel the current criteria is acceptable, it just needs to be narrowed for better decision making/clarification. It's a little vague and not clear on type of paperwork is required
- Anyone should be able to receive care from the Indian health system, or any system that offers health care
- The current criteria seem reasonable, although the issue of beneficiaries who suddenly lose coverage because a Tribe changes its membership requirements should be address somehow
- Proof of Indian blood
- I believe that the CHS requirement for alternate resource utilization, should be applied to direct care. I sat on the Business Plan Workgroup and most ITUs are sustained by their third-party collections. Having an alternate source requirement for direct care and refusing to see a patient unless they apply for Medicaid (including SCHPs) and Medicare sends the message that IHS direct care programs are the "provider of last resort". Hopefully, this would give Indian patients access to a higher level benefits package than what ITUs can provide. We have patients who "don't want to apply for welfare", and would rather sit back and let IHS pay for their care instead of using existing resources, Kaiser, preferred providers, BCBS, Veteran's Administration, etc.

2. **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?**

- CHS for California, without hospitals, shall be kept separate like insurance for other than direct services. Any insurance–like system could destroy the current Indian health care system
- What effects will this have on existing CHS patients? Where is the additional money?
- Would like to see the funds be equal for both CHS and direct service but I do not believe the funding is available at this time but should be the goal
- As long as the funding is increased. Yes, current beneficiaries should be grandfathered in
- No, they should not be the same, especially if it were to change current beneficiaries
- Yes, current beneficiaries should be grandfathered in
- Yes, patients entitled to basic care should also be entitled to CHS care
- Yes
- Yes and yes

3. **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.**

- There should not be a need for alternate resources in order to obtain CHS
- What happens if the home facility does not have money to pay?
- As long as the funds are increased or made equal to other areas, especially education funds
- I believe that there should be funding available for facilities that provide care to patients outside of the home facility. But to expect a facility, especially a small one, to reimburse an expense that may not be billed or asked for in a timely manner could be cumbersome, if not impossible. There needs to be a pot of money established in IHS HQ/Washington DC, for these costs. Maybe an analysis of what this cost could be. It is necessary to have facilities to be left whole to know that the head count used in any given year can be affected by different procedures from one to another (CHS and direct services) of who can utilize these services or payments. So basically, my point is that additional funds or a pot of money needs to be created
- This system would make a lot of sense if IHS is going to provide regional or Area specialty services like outpatient surgical centers and specialty inpatient facilities
- Restriction should be put in when a patient becomes a citizen of location where he is referred. Only visiting patients should be referred and home facility charged
- Wouldn't it be easier to fund facilities on a patient visit basis rather than trying to track funds as the patient moves from facility to facility? This could create an accounting nightmare! In California, schools receive funding on a $/student day. The more student days there are, the more funds received for the school