Selected Priorities for Internal IHS Reforms Suggested by Tribal Officials

Applicable Categories	Priorities Suggested in this Response (summarized)	Tribal Official
Federal Obligation, Laws **Chg Budget Priority/Use, Other Coverage, More Funding** **IT/EHR/RPMS/Tele-med** **Uneven/Inequitable**	• Health care for Indian people should be an entitlement program • Make insurance subsidies available to the tribal government to offset the cost of acquiring coverage that should be available to Indian people without cost. • Increase contract health services dollars and re-establish the guidelines for what qualifies for those dollars • Expand Infrastructure, telehealth, and Electronic Health Records in all I.H.S. and tribal faculties. • Improve the systematic approach to funding of Indian Health Service to tribes.	

Applicable Categories	Priorities Suggested in this Response (summarized)	Tribal Official
CHS Chg $/Elig/Use, Prevention/Wellness, 24/7, more comprehensive **Chg/Realign Functions**	• Contract Health Services does not adequately fund services universally and results in "rationing" funds for selected cases. Enhance policy and funding. • Continue to support prevention or preventative programs to enhance self management of chronic and other illnesses for improved quality of life. • Rethink IHS' breath of services. Current practices exclude some services, and isolated Service Units are burdened with high volume of cases that have to be referred out. Consider hospitals vs. out-patient (ambulatory) clinics; wider inclusion of services for isolated regions; and inclusion of disallowed services. Referring patients out of the community impacts the healing process and family support. These facilities need enhanced staffing, practice of broad services including minor/major surgery, larger impatient wings and other ancillary support care and services.	

Applicable Categories	Priorities Suggested in this Response (summarized)	Tribal Official
Eligibility, Tribal Consultation **CHS Chg $/Elig/Use** **Recruit/Retain - Incentives/Pay, Chg Policies/Procedures**	• User population definitions and formula undergo tribal consultation. • Physician Recruitment and Retention receive greater development for I/T/Us to provide a professional service body within the Area Office to focus on professional support, collegiality, cutting edge research and high quality service delivery. • Contract Health regulations reviewed with recommendations by tribal consultation.	

Applicable Categories	Priorities Suggested in this Response (summarized)	Tribal Official
638/Federal Chg Budget Priority/Use, More Funding Specific Hlth Condition, Transport/Travel, Specialty Svs	• Increase funding to provide Diabetic services like enhanced prevention services to reduce and prevent the onset of type II. Rural tribal communities requires more money to transport to Speciality clinics for dialysis and supplies for foot and wound care. • Sauk-Suiattle Indian Tribe assumed its Contract Support Services without any funding for Contract Support Cost. Tribe needs more funding to cover program developmental costs. • Sauk-Suiattle Indian Tribe started Direct Care services in the Tribal Clinic, which resulted in increased costs to the tribe for clinic supplies, additional staffing and equipment. The Tribe's AFA is not funded adquately to meet the needs of Tribal members.	

Applicable Categories	Priorities Suggested in this Response (summarized)	Tribal Official
Other Fed Govt Laws CHS Chg $/Elig/Use, Chronic & LTC IT/EHR/RPMS/Tele-med Measures/Benchmarks	• Improve the structure to allow treatment of tribes like states via pass through funding, specifically for long term care needs and the ability to access Medicaid payments. Keep people in small communities for long term care instead of institutions • Contract Health Funding. CHS funding is not keeping pace with demand. Quantify this deficit along with outcomes measures to provide a stronger argument for funding. • Improved information technology. As some tribes use proprietary claims management systems or contract for claims management, valuable data is lost which could be used to justify budgetary increases as well as redefine programmatically best practices.	

Applicable Categories	Priorities Suggested in this Response (summarized)	Tribal Official
Other Fed Govt Federal Obligation More Funding Chg/Realign Functions Qualifications/Credentials, Customer Service	• Fund 100% of the Indian Health Care Improvement Act from Congress. • Restructure/evaluate all programs, review contracts, certify staff and improve customer services. • Educate Congress on who we are and who we serve.	

Applicable Categories	Priorities Suggested in this Response (summarized)	Tribal Official
Defined Benefits/Portability, Eligibility CHS Chg $/Elig/Use Facilities/Housing UFMS Ineffectual Chg Policies/Procedures	• Reform Space and Facilities Construction Processes. The current facility construction priority system is subject to political interference and funding swings. IHS should have dedicated new facility construction dollars and evaluate each site based on the clinical needs of the population. Allow each facility to keep and prioritize their own collection dollars to address space and equipment needs. • Align of Contract Health Service eligibility with direct care eligibility and increase funding of Contract Health Services to an appropriate level to cover patients who move among sites. • Financial Reform: UFMS needs fiscal flexibility to support a 24/7 health care operation. Unpaid vendors and contractors refuse to do business with IHS.	

Applicable Categories	Priorities Suggested in this Response (summarized)	Tribal Official
Authorities, Eligibility More Collections, More Funding CHS Chg $/Elig/Use Facilities/Housing UFMS Ineffectual, HR Ineffectual Chg Policies/Procedures	• Review the IHS HR system and change it to meet the needs of the IHS and direct patient care services. Streamline HR services and return to the Area and local IHS service unit. • UFMS is not efficiently meeting the needs of the IHS direct patient care facilities. Review the role of the acquisitions and simplify the procurement system policies for improved efficiency. IHS procurement is not standardized between the Areas and is untimely in performance. UFMS monthly closing is problematic and debilitates provision of services. • Direct service facilities need access to their entire amount of service unit carryover funds, which would allow funding the large contracts needed to provide adequate services. • IHS should to assist the Southwest Oklahoma Intertribal Health Board in addressing priority concerns: Space, Personnel, Equipment, Service, Contract Health Services, Collections, Obstetric Care, and Inpatient Services. • The Caddo Nation Community Health Representatives identified concerns as: Increased funding for IHS facilities/seek more funds/contract health services; Under staffing at IHS facilities and insufficient equipment and technology; Re-examine the eligibility of services for IHS facilities; Re-vamp Human Resources/realign staffing; and Communication.	

Authorities, Defined Benefits/Portability, Federal Obligation, Laws, 638/Federal

More Collections, Chg Budget Priority/Use, Other Coverage, More Funding

ExtSvs (Den/Vis/Rehab), Specific Hlth Condition, Transport/Travel, Emergency Svs, Self-Care/Support Svs, Addiction Svs, Specialty Svs

Self-Determination Issues

IT/EHR/RPMS/Tele-med

Motivation/Attitude/Values, Chg Policies/Procedures

Patient Incentives/Responsibility, Remoteness

- Change IHS policies on "payor of last resort" rule. Create an Indian Medicaid/Medicare program that bypasses the States' policies and programs. Standardize M&M benefits for Tribal members nationwide.
- Eliminate CHSDA policies to allow full access to care
- Eliminate the 72-hour CHS notification rule and review by a CHC review board. Coordinate with Medicaid travel to allow multiple patient needs to be addressed on the day.
- Need more travel/lodging policies & funds for remote communities. Consider IHS contracting with hotels (like Medicaid) for a special rate for patients. Consider a federal rate for airline medical travel.
- Use the National Guard or Coastguard for Alaska medivacs.
- Develop a commissioned corps medical e-vac staffing program for remote locations.
- Include CHAP, DHAT & BHAs under the loan repayment program & develop a distance delivery program for PAs & RNs or pay for living stipend for families when spouse goes to school.
- Need more eye, dental, ortho, elders, nursing home and prevention care dollars and staffing.
- Need oncology services and access to cancer screening for everyone.
- Need more tele-health including tele-rad and tele-pharmacy operating funds and tech support.
- Need cheaper medical equipment maintenance support and access to medical equipment.
- Need standardized training/orientation & attitude screening for IHS/Tribal staff to reinforce respectful treatment of patient as well as supportive internal policies and evaluations.
- Need to address a dignified solution for inebriates in the ER and keep staff safe.
- Enable Tribal participation in all levels of budget formulation with OMB and the President.
- Tribes should get a share of funding from non-IHS federal programs directly vs. grants or streamline application/award process for Tribes to reduce administrative burden.
- Negotiate Village Built Clinic leases in Alaska and pay based on actual costs like other federal leases.
- Increase federal CMS reimbursement, include facility costs.
- Increase IHS funding so tribes can recapture facility construction & operating costs as an on-going cost of doing business so Tribes can get loans to build facilities.
- Support R&D for OIT, establish a joint I/T/U IT cost-effective investment strategy to fully meet all I/T/U future needs.
- Fully fund IHS, focus on quality care. Beneficiaries prepaid for their Healthcare.
- Make IHS a mandatory vs. discretionary federal responsibility & fund with monies set aside in a trust build from revenues made from taking Tribal lands and resources.
- Support Title VI. Facilitate easier tribal implementation of Self Governance. Set up technical support with experienced Self Governance Tribes.
- Fully fund Contract Support Costs & liability costs not covered by FTCA.
- Incentivize self management of health care.
- Incentivize seeking alcohol/drug treatment and family wellness (model after the SCF Family Wellness Warrior program).
- Support elevating the IHS Director to a Cabinet level.

• Support true Tribal/US Government to Government policies/protocols

Applicable Categories	Priorities Suggested in this Response (summarized)	Tribal Official
Chg Budget Priority/Use CHS Chg $/Elig/Use Facilities/Housing Uneven/Inequitable	• Equitable direct services funding for all Tribes even if it requires a disproportionate distribution of new funding. Treat newly recognized Tribes as existing Tribes. • Equitable Contract Health Services funding for all Tribes. Even if it requires a disproportionate distribution of new funding. CHS funding must be adjusted for IHS areas that do or do not have IHS hospital(s) in the area. • Equitable facility funding for all Tribes. All forms of IHS facility funding must include staff allocations. (Small Ambulatory Projects).	

Applicable Categories	Priorities Suggested in this Response (summarized)	Tribal Official
Prevention/Wellness Technology/Equipment/E-Systems Recruit/Retain - Incentives/Pay Lifestyle/Behavior	• Increase recruitment/retention of and training for healthcare professionals. • Increase resources to preventive activities, early detection and intervention, and education. Promote health lifestyles to decrease costly treatment. • Modernize its technological services in both the provision of healthcare and the measurement of outcomes.	

Applicable Categories	Priorities Suggested in this Response (summarized)	Tribal Official
Specific Hlth Condition	• Diabetes • Cardiovascular Issues • Respiratory diseases including childhood and adult asthma	

Applicable Categories	Priorities Suggested in this Response (summarized)	Tribal Official
Prevention/Wellness, Transport/Travel, 24/7, more comprehensive Recruit/Retain - Incentives/Pay Remoteness	• Provide 24/7 pharmacy services and transportation services to patients for appointments. • Reduce turnover rates of doctors and staff • Increase preventative services to rural communities	

Applicable Categories	Priorities Suggested in this Response (summarized)	Tribal Official
CHS Chg $/Elig/Use, Medications/Formulary Technology/Equipment/E-Systems	• Additional funding for contract health services, give direct referral authority to local providers, and allow tribes to establish partnerships with outside specialists for referrals • Include "wonder drugs" in the I.H.S formulary • Ensure rural Tribal clinics are fully equipped and trained with the proper information management technology	

Applicable Categories	Priorities Suggested in this Response (summarized)	Tribal Official
Authorities, Laws, Tribal Consultation More Collections, Chg Budget Priority/Use Mental/Behaviorial, Specific Hlth Condition, Chronic & LTC Recruit/Retain - Incentives/Pay	• Respect Tribal sovereignty status and assure Indian people and health care programs can participate in and benefit from health care reform legislation. • Amend/enhance IHCIA to meet Indian Country health care priorties. • Authorize long-term care and support services. • Increase recruitment/retention of clinicians. • Extend FTCA to cover health care professionals who volunteer services/facilities to I.H.S beneficiaries. • Authorize tribes/tribal organizations to use appropriated funds and M/M revenue to purchase health care coverage (benefits). • Authorize access to the Federal Employees Health Benefits Program. • Expand prevention, intervention, and treatment activities for additional cancer screening and research, a comprehensive behavioral health approach to mental health services, tribal epi centers as public health authorities and establish an Indian Men's health program. • Permanently authorize the Special Diabetes Program for Indians. • Increase access to alternate resources -- codify payor of last resort language, clarify authorities for third party collections.	

Applicable Categories	Priorities Suggested in this Response (summarized)	Tribal Official
Tribal Consultation More Funding CHS Chg $/Elig/Use, Addiction Svs Communications/Feedback/PR Open/Transparent	• True consultation with all Tribes of California. • IHS-wide transparency and improve communications to all Tribes in California. • Equality in contract care dollars for all I.H.S Areas. • Build two YRTC in California. • Improve federal funding for all Tribes in California; less funding cuts.	

Applicable Categories	Priorities Suggested in this Response (summarized)	Tribal Official
Defined Benefits/Portability **IT/EHR/RPMS/Tele-med, Data/Collect/Report, Continuity/Succession** **Recruit/Retain - Incentives/Pay**	• Reform health care staffing recruitment, retention, training. Change OPM guidelines. Apply succession planning for all levels. • Enhance portability of services and infrastructures to make available national electronic patient records, master patient index, and incentivize use of RPMS. • Improve utilization of clinical data to improve care, use in budget justification, efficient use of local systems, mandated data sharing among the national data warehouse and epidemiology centers.	

Applicable Categories	Priorities Suggested in this Response (summarized)	Tribal Official
Eligibility **CHS Chg $/Elig/Use, Prevention/Wellness, Primary Care Svs** **Chg/Realign Functions** **Chg Policies/Procedures**	• Regionalize Fiscal Intermediary Services - consider Tribal Bid. Resolve issues and adverse effects on patients and non-IHS provider relationships resulting from non-payment for services. • Rescind IHS open door policy. Tribes should determine who is Indian and eligible for service. • Set aside dollars for preventative services outside of CHS priority system (colonoscopy, mammography, imaging, etc) to reduce costs and extend patient's life. Current policy/procedures result in advanced illness and expensive treatment. • Allocate funds on priority basis for Service Unit most dependent on CHS to build H&C infrastructure and capacity. Add resources to build tribal capacity to provide primary care and extend access that could be provided to secondary care through CHS. • Develop within IHS management an education component to work with local schools/tribes to prepare young students with math and science backgrounds to succeed in post secondary training programs.	

Applicable Categories	Priorities Suggested in this Response (summarized)	Tribal Official
More Funding **CHS Chg $/Elig/Use, Prevention/Wellness, Specific Hlth Condition, Addiction Svs**	• Increased funding of Contract Health Services. • Increased funding of the Diabetes Program. • Increased funding of prevention of Substance Program.	

Applicable Categories	Priorities Suggested in this Response (summarized)	Tribal Official
Tribal Consultation **Clinical Process** **Customer Service**	• Administrative Practices: Conduct consultation and request input before a decision is made. • Customer Service: Focus on how patients are treated. Train all staff on case management and implement the procedure at each level. Require all clinical staff be aware of the case manager's procedures including customer service, follow-up and case management. • Clinical Services: Improve follow-up and informing patients, before they leave the clinic. Inadequate follow-up procedures have caused patients to have contributed to medical problems.	

Laws

Public Health Svs, Specific Hlth Condition

Facilities/Housing

● Shift to a bifocal health care system with focus on: access to care; long term care; collaboration and cost sharing among federal, state and local providers; facility and infrastructure improvement and an integrated care system. Establish and improve public health care services and system with an emphasis on prevention.

● Address construction for health care, specialized service and sanitation facilities, such as for elder care, mental health, rehabilitation and detention centers.

● Public Health Infrastructure/Manpower Development: Navajo Nation requests support for planning, development of the Department of Public Health to protect and promote the public's health, including intentional and unintentional injuries, homicide, obesity, cancer, disease outbreaks, natural disasters, and other health issues and promote healthy behaviors. This initiative will require infrastructural development such as, assessments and planning, training needs assessment and manpower development. Revisit the existing IHS Scholarship program : consider a method of distributing funds to the Areas based on manpower needs and population and explore how to expand the IHS scholarship program to coordinate and collaborate with other programs (I.e. TANF) to train Native Americans in IT, telemedicine and public health.

● Amend and enhance the IHCIA and permanent reeauthorization and fully fund the Special Diabetes Program for Indians (SDPI). Maintain the specific provisions outlining resource allocation methodologies under Title III. Increase SDPI level of funding. Distribute non-competitive SDPI funding based on population, rate of prevalence, and incident of diabetes.

● Develop a comprehensive trauma system, especially in rural, isolated communities for the Navajo Nation. Needs support for planning and implementation.

● Long term care - incorporate comprehensive long-term care (long term care, nursing care, home health, assisted living, and hospice care) into the IHCIA reauthorization and provide specific funding information.

● Reform contract health service to improve access to specialty services and program funds to access specialty and emergency care. Address the issues re: eligibility criteria. Fund Arizonia as a CHSDA, like Oklahoma. Fully fund IHS system with an express expansion of funded medical priortiy cases.

● Address prevention, intervention, and treatment activities to expand health screenings. Continue to focus on prevention efforts. Further develop wellness programs to minimize incidents of chronic disease.

● Telemedicine and IT. Resources 1) to support sites, medical staff and other required staffing, equipment and facilities 2) build infrastucture and funding to sustain IT and expand IT.

● Reduction of patient wait time at IHS facilities to improve customer service.

● Restore 90-day pharmaceutical refills in IHS facilities. Eliminate the 30-day medication refill for patients with chronic conditions.

Applicable Categories	Priorities Suggested in this Response (summarized)	Tribal Official
Other Fed Govt More Funding CHS Chg $/Elig/Use Facilities/Housing Chg Policies/Procedures, Uneven/Inequitable	• Change the CHS funding formula to address the needs of the Tribes that are primarily dependent on CHS - without access to Indian hospitals. • I.HS-funded health facililties. Process for funding, constructing health facilities is not working. Increase funding avenues to help small tribes build facilities: Small Ambulatory Grant with a larger funding amount. Need true partnerships between the IHS and Tribes to alleviate the backlog of the Health Facilities list. Increase funding for the joint venture construction program. • Federal programs efficiency and collaboration. IHS should include greater collaboration across federal agencies, such as SAHMSA, CMS, HRSA, VA and others deal with health care resources. The mandate to utilize EHR by a certain timeframe in all medical facilities should lead to the ability to refer patients to other government resources without the barriers. Incentivize agencies and Tribal entities that successfully implement collaborative efforts or formal authorities to establish formal cooperative arrangements. Funding involved in these collaborations, including programs under SAHMSA/HRSA/CMS, should be direct to Tribal Clinics, rather than "passed-though" the State bureaucracies. Explore the possibility that Tribes might receive authority to collect 100% reimbursement from Medicare versus the 62% currently allowed. •	

Applicable Categories	Priorities Suggested in this Response (summarized)	Tribal Official
Tribal/Community Orgs Authorities, Laws Communications/Feedback/PR	• Streamline the communications process between Tribes and IHS to eliminate delays in responses. • Clarify or extend Federal Tort Claims Act coverage for services provided by tribal facilities and clarify if employees need to purchase "tail" insurance when leaving employment at a facility. • Provide exemptions from state licensure requirements for health care professionals working for 638 programs consistent with federal sites to allieviate retention and recruitment problems. • Appoint a Task Force to address disparities in the levels of care and funding to ensure equal access to adequate levels of care across the IHS system. Address inequities in the health facility construction funding process.	

Applicable Categories	Priorities Suggested in this Response (summarized)	Tribal Official
Other Fed Govt Laws, Tribal Consultation Other Coverage	• Expand enrollment in Medicaid and CHIP. • Advance the Indian Health Care Improvement Act amendments • Ensure tribal involvement/representation on key commissions, boards, and other groups created by health care reform legislation, and ensure HHS consults with Tribes on health care reform policies and regulations. Ensure views of federally funded programs serving Indians in urban communities.	

Applicable Categories	Priorities Suggested in this Response (summarized)	Tribal Official
638/Federal, Urban Indian Svs, Tribal Consultation Specialty Svs Realign Org Structure, Service Areas Communications/Feedback/PR Uneven/Inequitable Study/Assess/Plan	• Review PIMC services and users. Consult with outlying reservations about the mix of specialty services for them and include their needs in long range planning for PIMC. Consider complete separation of the provision, supervision and administration of Urban Indian care, Phoenix Area Service Unit care, and referral to specialty care. Enable the Urban Indian and Phoenix vicinity tribes to refer patients for specialty care like the outlying services units and programs do. Allocate specialty care resources more efficiently to Native Americans living outside the Phoenix region. Review the detemination that PIMC services are non-divisible and not contractible under PL 93-638. • Determine Government Residual Services for Phoenix Area Office and publish a list of residual services. Evaluate how well those services are provided and how they might be improved by contracting under PL 93-638. Implement an ongoing Area Office Quality Assurance Program to improve communication, services and relationships between PAO and the contracting tribes, and more equitable utilization of services by contracting tribes. • Clarify who in PAO is resonsible for advocating for Fort Mojave regarding funding and services.	

Applicable Categories	Priorities Suggested in this Response (summarized)	Tribal Official
Chronic & LTC Self-Determination Issues Communications/Feedback/PR, IT/EHR/RPMS/Tele-med Open/Transparent	• Commitment to Technological Advancements. Take an inventory or assessment of the technological needs within the Indian health care system and develop a plan, including necessary funding. Expedite implementation of electronic health records, telemedicine, health information exchange, etc. in an efficient, secure, and user-friendly manner. • Commitment to Long-Term Care Services and Support. Cherokee Nation supports a stronger, more visible effort to address the long-term care needs of the AI/AN population. • Supporting Tribal Efforts under the Indian Self-Determination and Education Assistance Act (ISDEA). Lack of transparency and accountability within the agency, especially in the areas of agency budget and finance. Open communication with Tribes is in the best interest of the patient, carrying out the intent of the ISDEAA, and understanding the resource needs of the agency. Cherokee Nation supports efforts to provide the greatest degree of flexibility to the IHS and Tribal Nations to best utilize federal resources to meet the AI/AN health needs in an innovative manner. • The Cherokee Nation does not support revisiting funding formulas/allocations until all IHS Operating Units are funded at an 80% level of need under the Federal Disparity Index. Implement the Indian Health Care Improvement Fund to achieve parity.	

Applicable Categories	Priorities Suggested in this Response (summarized)	Tribal Official
Self-Determination Issues Communications/Feedback/PR, IT/EHR/RPMS/Tele-med IP Application	• We want honesty, trust and transparency from IHS. Tribe cites lack of tribal consultation on Recovery Act funding for IT and IHS's proposal to use Health Vault. Also, concerned about IHS's application of Indian Preference policy. Suggests OEH&E provide a new equal share system to redistribute funding according to per capita (individual) use. • Improved, coordinated Technology. RPMS implementation is costly (tech support, down time which costs man-hours, licensing, and the clinical application coordination). RPMS takes clinical staff away from patient care to perform administrative duties. Need an updated Pharmacy package. • Honor the Self Determination Act and P.L. 93-638. Our Tribe has suffered through 4 years of lawsuits and a difficult declination of our 93-638 contract. Our attorneys and yours delayed the process .	

Applicable Categories	Priorities Suggested in this Response (summarized)	Tribal Official
More Funding CHS Chg $/Elig/Use Facilities/Housing Chg Policies/Procedures, Uneven/Inequitable	• Fully fund IHS. • Ensure sufficient construction funding is available • Increase Contract Health Care funding. We recommend that the CHS Allocation Workgroup develop another methodology for distribution to include expenditures of prior years and consider this along with the User Population.	

Applicable Categories	Priorities Suggested in this Response (summarized)	Tribal Official
Other Fed Govt CHS Chg $/Elig/Use Facilities/Housing Chg Policies/Procedures	• Better Support in Medicare Part D Interpretation and Identifying Pharmacy Services Alternatives - Ensure that the Part D program operates more effectively for Native Americans by identifying new and diverse ways to support the pharmaceutical needs of Native Americans. • Better Support in Health Care Facility Design and Construction – IHS needs to better assist in designing and constructing facilities to house the clinical programs needed by the tribal citizens it serves, better expenditure of limited funding, and better planning. • Better Support in Contract Health Services Utilization and Implementation – Provide more assistance and support for program design (e.g., staffing, systems training), program development (e.g., working with tribes to develop/suggest specific Level I & II Priorities), and consultation services to assist local CHS staff with particularly difficult financial cases.	

Applicable Categories	Priorities Suggested in this Response (summarized)	Tribal Official
Chg Budget Priority/Use, More Funding CHS Chg $/Elig/Use, Mental/Behaviorial, Prevention/Wellness, Primary Care Svs	• Increase funding and improve HHS and IHS advocacy to bring Indian healthcare in line with the total U.S. Population and fund population growth and inflation like other mandatory federal programs • Additional resources to fund contract health care to cover medical inflation, preventative services, and other non-life threatening conditions. • Expand options in the delivery of behavioral health services, including additional care once the insurance benefit has been exhausted.	

Applicable Categories	Priorities Suggested in this Response (summarized)	Tribal Official
Chg Budget Priority/Use, More Funding CHS Chg $/Elig/Use Self-Determination Issues Uneven/Inequitable	• Fund all IHS Areas equitably at the same level of need funded. • Reform Contract Health Services (CHS) and provide more funding for expanded coverage that includes medical standards of care testing based on "best practice" treatment protocols and for medications not on tribal or IHS formularies, like mental/ behavioral health. Extend the Medicare-Like-Rates to Physician fees. Provide sufficient funds for the Catastrophic Health Emergency Fund (CHEF) to prevent lack of funding before the fiscal year is over. • Fully fund self-governance tribes and tribes who compact for all of the Contract Support Costs to administer all of the programs. • Train all IHS employees on trust responsibility to improve their understanding of tribal sovereignty and true tribal consultation.	

Applicable Categories	Priorities Suggested in this Response (summarized)	Tribal Official
Realign Org Structure	• Eliminate the IHS Area Offices and middle management layers and make the funding availability for local services. For instance, why not send $ .50 from DC, eliminate all of the "middlemen" and the $ .50 would get to the Agency/Reservation level! This is my recommendation for IHS reform.	

Applicable Categories	Priorities Suggested in this Response (summarized)	Tribal Official
Direct Services Issues Billing/Collections, HR Ineffectual	• IHS needs to increase funding to the Direct Service Tribes, to adequately address the health issues of the Mescalero Apache Tribe. • Change or overhaul the Human Resources - process to employ people, develop, utilize and compensate them. It takes too long to fill key positions like medical providers. • Improve or change practices for obtaining reimbursements.	

Applicable Categories	Priorities Suggested in this Response (summarized)	Tribal Official
Tribal Consultation **Prevention/Wellness, Specific Hlth Condition, Transport/Travel**	• Reform the priorities and place emphasis on prevention and intervention. • Fund transportation for dialysis patients and incoporarte treatment. • IHS needs tribal advisory boards at the area level.	

Applicable Categories	Priorities Suggested in this Response (summarized)	Tribal Official
Laws, Tribal Consultation **CS - CC, Deployment**	• Reauthorization of the Indian Health Care Improvement Act. • True and significant efforts for government to government consultation. • MOA between Indian Health, U.S. Public Health, and Commission Corps - regarding the Detailing of Officers, on a rotating basis for emergency • Access to Behavioral Health. • Indian Health Service as financial primary care provider. • Legislative -- Change of payer of last resort.	

Applicable Categories	Priorities Suggested in this Response (summarized)	Tribal Official
More Funding **CHS Chg $/Elig/Use, Prevention/Wellness, Primary Care Svs** **Admin/Business, IT/EHR/RPMS/Tele-med** **Uneven/Inequitable**	• Funding: Ensure contract support costs are fully funded. Achieve funding equity among the IHS Areas. Extend Medicare-Like-Rates to cover physician fees. • Preventative Care: Revisit the Contract Health Priority lists and consider standardized test protocols under medical standards of care for Contract Health care coverage. Provide appropriate preventative care by using the" best practices" approach and models like SPDI. • Improved information systems. System needs capability to capture information on contract health referred patient care and follow-up, be more user friendly. Provide RPMS/EHR training and technical assistance at each service unit. Provide annual training to the entire Indian health system to operate as a business, revenue-generating system.	

Applicable Categories	Priorities Suggested in this Response (summarized)	Tribal Official
Tribal/Community Orgs **Federal Obligation, 638/Federal, Urban Indian Svs, Tribal Consultation** **More Funding** **Quality of Care**	• Preserve a unique Indian health care system • Preserve tribal control over health care program that serve Indians • National health care reform must ensure an independent, Indian-controlled health care is maintained, fully funded, and provides a level of quality that meets or exceeds national standards. • The NCAI/NIHB/NCUIH paper (5/31/09) and the NIHB paper (5/22/09) provide general recommendations that can serve as a guide of how to fit Indian Country into national health care reform.	

Applicable Categories	Priorities Suggested in this Response (summarized)	Tribal Official
Tribal/Community Orgs **Tribal Consultation** **Chg Budget Priority/Use, More Funding** **Community/Home-Based, Prevention/Wellness, Primary Care Svs, Public Health Svs, Emergency Svs** **Copays** **Realign Org Structure** **Community Links, IT/EHR/RPMS/Tele-med, HR Ineffectual** **Health Status, Study/Assess/Plan**	• Reorganize IHS Area based on Tribes with greatest land base. • Remove all references to "I/T/U" from all legislation, regulations because it undermines meaningful Tribal consultation. • Fund IHS and tribal partners based on need with priority at reservation level. • Fund strategic planning with full tribal leaders/communities consultation and shift IHS from crisis management to total quality of care on reservations. • IHS be the Agency of Primary Health Care Services with need-based funding; other coverages be secondary, supplemental sources. • Exempt Indians from premiums, co-pays, deductibles where Federal programs are accessed by eligible individuals. • Provide tribal employees' health coverage same mechanism/funding as tribal members, incentives and invest in workforce development. • Address health care workers shortages/retention issues. • Address promising, best practices specific to Indian communities/patient populations. • Address early diagnosis/treatment, long term care, and catatrosphic health care as a Funded Health Services Priority(s). • Provide 1) continuum of care for Indians addicted to alchohol, meth, and prescription drugs and 2) assessment/review of health facilities for IHS and Tribal health departments. • Tribal governments, and designated agents, determine all research on Tribe. Provide funding for Institutional Review Boards at Tribal and Area levels. Tribal ownership of research. • Tribal providers on reservations have internet infrastructure/program/ and health information technology same as States and private sector health providers. • Develop, and fund based on need, a universal plan for sustainability for Indian health care . • Ensure safety net of health services for all Indians and historical practices of Federal Government. • Provide supplemental funding for Indian health care priorities (see 22 sub bullets of last bullet in Respondent Comment section).	

Applicable Categories	Priorities Suggested in this Response (summarized)	Tribal Official
State Local Govt, Tribal/Community Orgs Federal Obligation, Laws, 638/Federal, Tribal Consultation Chg Budget Priority/Use, More Funding Study/Assess/Plan	• Retain federal/tribal trust relationship, authority to determine tribal membership. • Funding based on tribe's level of need, tribal-specific needs and priorities, and tribal health departments' need. • Remove payer of last resort clause from all legislation, rules, regulations and guidelines. • Provide for 1) tribal consultation with all federal health agencies and with OMB, 2) waiver and reimbursement to Indian health care rescessions to the budget for Indian Country, 3) training/technical assistance on tribal tax exempt bonds for joint venturing, facilities, 4) same access to/eligibility as States for federal grants listed on Grants.gov, 5) training for tribal health departments on project management, skills acquistion, and certification/ credentialing; third party eligibility/certification/billing; health department standards/certification; 6) equitable distributions for State health block grants directly to Tribes or provide Tribal health block grants. Ensure 1) IHCIF passage, 2) compliance to Tribal, Area IRBs, 3) tribal ownership is retained of all research/data, 4) protection/advocacy for tribal participants in research projects, 4) HHS Civil Rights Office protects tribes, tribal governments, and tribal citizens, 5) tribal governments gain equal access as States and county governments (see 20 sub bullets in Respondent Comment section), 6) sovereignty by consulting with Tribally elected leaders; not "representative" Indians. • Exempt Tribes from penalties - mandatory insurance requirements and tribal members from employer or individual mandate penalities. • Develop patient bill of rights and beneficiary package of services for Indian patients. • Increase Indian enrollment in M/M, SCHIP but only as secondary to treaty obligations for health care. • Emphasize need for services to large, land-based federal recognized tribes.	

Applicable Categories	Priorities Suggested in this Response (summarized)	Tribal Official
Tribal/Community Orgs Tribal Consultation Chg Budget Priority/Use, More Funding CHS Chg $/Elig/Use	• Fully fund Contract Support Costs • Contract Health Services funds for California tribes need to be increased as there are no IHS hospitals in California • Follow-up with recommendations by tribal leaders (.e.g, no accessible YRTC for the community yet)	

Applicable Categories	Priorities Suggested in this Response (summarized)	Tribal Official
CHS Chg $/Elig/Use Financial Limits Uneven/Inequitable	• Lack of appropriated funds to meet all CHS needs and all tribal contract/compact support costs.	

Applicable Categories	Priorities Suggested in this Response (summarized)	Tribal Official
Tribal/Community Orgs 638/Federal Chg Budget Priority/Use CHS Chg $/Elig/Use, Inpatient Svs, Specialty Svs Chg/Realign Functions, Facilities/Housing, Add/Realign Staffing Accountability, Uneven/Inequitable	• Improve resource allocation -- move away from a data deficient base budget plus percent of increase process to one that is more data driven and actuarially sound, accounts for all sources of sustainable funding, and reasonable variation in local operating costs. Provide the same ease of access to the same continuum of services across the entire delivery system. • CHS line item allocations must fully reflect the true dependence of some care delivery sites on non IHS funded providers. IHS reform should quickly improve access to inpatient and specialty care services for American Indian and Alaska Natives in California. • Establish a multi tracked allocation process that recognizes the equality of all tribes and the disparity in tribal population sizes and population density. The tougher transition is how to delink facilities from new staffing support as the agency moves more clearly to a percapitated from of program support. Establish Area-wide facility constuction pools. • To reform the I.H.S IT system, invest in the building of inter face software that will facilitate a limited number of off the shelf health information systems. Support the implementation and utilization of the NextGen system and other OTC systems. • Other issues are: 1) IHS has not developed a HIPAA and Privacy Act compliant process for sharing patient registration data. 2) Placement of Commission Corp staff in California and the charge levied by the Area Office for the provision of required reporting to the Corp. • Make Area Directors more accountable to the Tribes and Tribal Organizations they serve. Tribes do not have access to or consultation on the annual review system, Area Director annual work plans, or annual bonus payments. • Embrace Tribal Contracting as a method of increasing community participation in health improvements to achieve lasting change in community norms requires community participation and this is best achieved thorough self determination not social engineering from afar.	

Applicable Categories	Priorities Suggested in this Response (summarized)	Tribal Official
Urban Indian Svs **Chg Budget Priority/Use** **Chg/Realign Functions** **Data/Collect/Report** **Measures/Benchmarks**	• Infrastructure support for Title V Organizations - new funding distribution; eligibility to apply for I.H.S competitive grants; reinforce infrastructure/quality improvement initiatives by prioritizing IHS investment in facilities, equipment, and health IT; address health care workforce shortages, utilizing alternative provider types; extend FTC and student loan repayment; targeted data collection and best practice benchmarking appropriate to and with the sufficient representation of, the Urban Indian population; consultation on new drafts of the HIS Urban On-Site Review Manual and appropriate mark-up period to allow for input from Title V direct service providers. • Update scope of Title V contracts- eligibility for MOA reimbursements between CMS, State Medicaid programs and IHS; adoption of a medical home service model and inclusion of a fee-for-service component to Title V contracts. • IHS Response to Health Care Budget Cuts in California. IHS approach to protect and maintain medical, dental, mental health, substance abuse, and wellness programs for the growing numbers of uninsured and unemployed American Indian individuals and families in California.	

Applicable Categories	Priorities Suggested in this Response (summarized)	Tribal Official
State Local Govt **Urban Indian Svs**	• seeks to begin collective dialogue on IHS reform that supports Urban Indian health organizations, • addresses the scope of Title V contracts, • and minimizes the impact of State budget cuts in California.	

Applicable Categories	Priorities Suggested in this Response (summarized)	Tribal Official
Other Fed Govt **Laws, 638/Federal** **Chg Budget Priority/Use, More Funding**	1. Support for the Office of Tribal Self-Governance (OTSG) : restore and increase OTSG funding to provide for adequate staffing and resourcess. 2. Expand Self-Governance within the Department of Health and Human Services : Support Title VI legislation to expand Self-Governance to non-IHS programs 3: Support for fully funding Contract Support Costs (CSC) & further increases to Mandatories: advancing and advocating for these increases as our top budget priorities.	

Applicable Categories	Priorities Suggested in this Response (summarized)	Tribal Official
State Local Govt More Funding Emergency Svs Clinical Process Other	• The Churchrock Chapter hereby strongly support the Administration and Medical Staff of Gallup Indian Medical Center within the Navajo Area IHS. • The Chapter further requests that Federal and State funds be made available to enable the GIMC to become a Level III trauma center. • The Chapter further requests support for the Gallup Service Unit Health Board and Navajo Eastern Agency Council, other elected Navajo tribal officials and Yvette Roubideaux, Director IHS and New Mexico Governor Bill Richardson to designate GIMC as a Level III Trauma Center.	

Applicable Categories	Priorities Suggested in this Response (summarized)	Tribal Official
Other Fed Govt More Funding ExtSvs (Den/Vis/Rehab), Prevention/Wellness, Self-Care/Support Svs Lifestyle/Behavior, Patient Incentives/Responsibility	• Support personal responsibility for health. • Provide adequate health care funding for Indians living on reservations. • Suggests FDA be more open to health benefits of cherries and nutritional supplements, recognize the health hazards of high fructose corn syrup, and stop the sale of tobacco (except use for Native American religious purposes). • Be more aggressive in shifting to a wellness model. • Remove limits on Americans' ability to import lower-priced prescription drugs. Place less focus on prescibing drugs and emphasize diet, exercise and nutritional supplementation. • Redirect IHS direct care and reprioritize CHS from funding treatments for preventable diseases to a strong wellness program. • Adopt the Health Equity approach. • The current system is resistant to change because of the initial costs involved.	