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Tribal governments as rural health providers: final report.

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RURAL INDIAN HEALTH ROUNDTABLE CONFERENCE

TRIBAL GOVERNMENTS AS RURAL HEALTH PROVIDERS

FINAL REPORT

INDIAN HEALTH SERVICE
OFFICE OF PLANNING, EVALUATION AND LEGISLATION
AND
AMERICANS FOR INDIAN OPPORTUNITY, INC.

WASHINGTON, D. C.
September 27-28, 1990
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PREFACE

The Rural Indian Health Roundtable Conference was held September 27 and 28, 1990, in Washington, D.C., as one of five roundtable meetings sponsored by the Indian Health Service (IHS) Office of Planning, Evaluation and Legislation (OPEL) in 1990. The purpose of the IHS roundtable meeting was to bring together experts in the fields of health care, community development, tribal governance, academia and policy to chart pathways for enabling tribal governments to become providers of rural health services. With this focus, the Roundtable participants were reminded that health is just one of a whole range of social, political and economic development areas for which tribal governments need to find innovative ways of assuming traditional responsibility.

More tribal governments are now beginning to assume control over health services in their communities. Tribal leaders now articulate the consensus within Indian communities on issues around health services. It must be local tribal people themselves who take on responsibilities for their own health and the health of their community. Yet, the Indian Health Service holds the purse strings and sets policies which affect tribal health planning and community attitude. Now is the time to reexamine the overall role of tribal governments in the provision of health services and to question the practices and priorities of IHS. Does the Federal government foster community empowerment or community dependence through its health delivery system?

The question of responsibility and community ownership is at the core of community dissatisfaction with the existing system of health services and must be recognized by decision-makers, both Indian and non-Indian alike, in their attempts to redress the faltering systems of basic services to Indian communities. Community empowerment is critical to the success of health improvement efforts in Indian communities.

The Indian Self-determination Act of 1975 and its 1988 amendments attempted to reinstate this kind of local control and responsibility for government funded services. That effort has experienced other kinds of difficulties as tribes encounter numerous bureaucratic obstacles to self-determination. It is all the more
important, then, that the participants of this Rural Indian Health Roundtable have taken a broad perspective in assisting IHS to rethink the issue of innovative rural Indian health services and to develop recommendations to improve its quality and quantity.

Rural communities all across the United States are faced with a health services crisis as more and more rural hospitals close their doors. Services available to rural families vanish as it becomes more difficult to recruit physicians and other health care providers to remote areas. While most eligible Indians receive services from the Indian Health Service, they are directly affected by the depletion of resources in their local non-Indian communities. Adequate funding for IHS activities has never kept pace with demand for care or with the escalating cost of providing services. Rationing care by type of service and by size of community has become a reality which has left many unsatisfied with the current system. Many in-patient services, for example, are purchased from local hospitals through the Contract Health Services (CHS) program. These CHS funds have been limited to only dire emergency care for the past eight (8) years. Even if there is an IHS hospital nearby rural communities may still be at risk.

Announcements by the Indian Health Service of plans to close down nine small, rural hospitals ignited protests by many tribal governments and sparked interest in finding a more innovative solution to the rural health crisis. The Roundtable is particularly relevant at this time considering the U.S. Senate Select Committee on Indian Affairs' recent hearings on IHS facility management and the introduction of Senator John McCain's bill, the Innovative Indian Health Facilities and Delivery System Demonstration Project, S.2850. This bill would authorize the IHS to fund 25 to 35 innovative projects including the nine IHS sites targeted for hospital closure.

The IHS Office of Planning, Evaluation and Legislation asked the Americans for Indian Opportunity to assist in pulling together some of the Nation's leading experts in the field of health care and Indian community development. The roundtable meeting provided two days for participants to review pertinent information, hear presentations and most important to shape specific recommendations to the Indian Health Service related to rural Indian Health.
Time was set aside for the group to formulate specific recommendations or statements to the Indian Health Service. Rather than predetermine the categories in which these recommendations should be, it was the responsibility of the group to develop the framework for these recommendations.

The meeting was moderated by Michael Mahsetky from the IHS/OPEL office and Jo Ann Kauffman consultant to AIO. LaDonna Harris, President of Americans for Indian Opportunity coordinated the meeting and was a participant in the roundtable discussions.

The Indian Health Service and Americans for Indian Opportunity, wishes to thank the Roundtable participants for their time and interest in this effort. The recommendations and consensus statements developed by the group are intended to spark the interest and actions of the Indian Health Service, other Federal agencies, private foundations and most important, Indian communities.
FINDINGS AND RECOMMENDATIONS

Most of the Roundtable participants are directly involved in community development as activists, policy-makers, advisers or funders. The Roundtable’s first step was to establish a foundation of the parameters of the "ideal model" for rural Indian health systems. An array of characteristics inherent to the ideal model were discussed. After lengthy examination, the group prioritized the following characteristics as most desirable in an "ideal model" for Indian communities:

FEATURES OF THE IDEAL MODEL

* COMMUNITY BASED/COMMUNITY CONTROLLED
* INTEGRATED COMMUNITY DEVELOPMENT
* TRUE STRUCTURAL POWER SHARING
* EMPHASIS ON PRIMARY CARE
* MARKET ANALYSIS FOR SERVICES AND SCOPE
* OPEN DOORS TO FINANCING IN DIFFERENT WAYS
* VERTICAL AND HORIZONTAL COORDINATED CARE

The level of ownership at the local community was determined to be the most critical factor for the success or failure of any community health services development effort. There was no other single factor which rated one-fifth as high as the need for community based control of any innovative health service development. This factor is defined to include community participation in identifying health needs and the manner in which these needs will be addressed. It also includes community input and control in the governance of the program. Community based services implies the employment of indigenous health care workers and a health delivery system which incorporates the cultural aspects of the community. Major decisions of the project are based on community participation.

Successful development of tribal based health service models must take into account community development priorities covering the economic, social, religious, cultural, environmental, historical and political spectrum. The health needs of Indian communities today are inseparably tied to lifestyle, behavior and community dynamics. Health services developed in isolation of the tribal environment will have difficulty impacting the major health problems of the community. The health improvement efforts of the community must
be a part of their overall community and economic planning and development.

The Roundtable felt that the ideal innovative model must be based on the concept of power sharing and that the Indian Health Service and other funding sources need to concur and comply with this approach. Too often, innovative models are constricted by the heavy hand of over-regulation and over-supervision from the funding agencies. In return, the governing body of the health program needs to agree to some level of accountability to the Indian Health Service or other agencies providing the financial support to the effort. The concept of power sharing must extend beyond the health program and overlap with the community, allowing consumer feedback to the program and participation in the development and direction of the services.

The Roundtable participants felt that the ideal model will emphasize "primary care" over "hospital based care", as a means to have a long range impact on the health status of the community. While much attention has been given to stopping the impending closures of hospitals in rural communities, the ideal model should combine its community needs assessment with the market analysis in order to arrive at the kind of services to be developed. Hospital based services are costly and are the least likely to have an impact on the health status of the community. The ideal model, according to this Roundtable, will address the needs of the community as a means to elevate the health status of that community.

The ideal model will be open to multiple avenues of financing the construction of its facilities and the operation of its services. The array of services required by Indian and non-Indian communities will likely exceed the funding capacity of any one funding agency.

Care must be taken, however, to guard against enthusiastic community policy makers who try to develop services or facilities without first conducting the necessary analysis to determine community needs, particularly in cases of facility development. The opportunity available for innovative approaches to health services development also presents a certain amount of risk for the community. Adequate planning is recommended to assure that the demand for services is reflected in the design of the model. Projects which anticipate a certain amount of third party revenues, from
Indian or non-Indian patients are advised to conduct a thorough analysis of the market in advance.

The local community must keep its doors open to the discussion of multiple financing options. Such options could include, private foundations, other federal programs, billing third parties such as Medicare, Medicaid or Insurers for health services, and even billing individual patients on an ability to pay basis. Multiple financing options should be discussed by the planners of these innovative health programs and shared with the community for feedback.

Vertically integrated care means that the ideal community health service model must link up to services which it cannot provide directly, but which will be needed by its patient population in the spectrum medical technology. Prevention services, primary care, secondary care, tertiary care and emergency services must be considered in the planning of the health program. The program must define how and where it fits into this spectrum of care and clearly educate its patient population about how other services can be accessed. The ideal model will establish linkages with providers of other levels of health services which define how their patients will be served.

Horizontal integration of services implies that multiple disciplines of health and social services will be coordinated for the benefit of the patients. For example, a medical based health program will have the responsibility to establish working coordination with providers of mental health, substance abuse, child protection, social welfare, social work and other lateral providers in the human service field. It is incumbent upon the ideal health model to insure that the beneficiary of these services will be given the opportunity for referrals and coordinated services with other disciplines of health services. The ideal model will elevate this coordination of disciplines to a level of quality care through case management and continuity of care for the patient or family.
KEY ISSUES TO BE ADDRESSED

In order to identify practical steps that would enable tribal governments and Indian communities to become the providers of tribal-based, rural health services, the Roundtable discussed a number of key issues considered critical to the process of achieving the ideal model. These issues fell into three general categories: (1) Governance/Community Development; (2) Service Delivery; and (3) Information.

GOVERNANCE AND COMMUNITY DEVELOPMENT

The Roundtable participants felt strongly about the need to blend governance with community development. The two categories were combined to show the interdependence and mutual benefit between quality governance and positive community development in Indian communities. The major barrier to achieving the kind of governance and community development necessary for an ideal health delivery model was felt to be the current "top to bottom" management approach applied to Indian communities by the Indian Health Service, the Bureau of Indian Affairs and other federal agencies which have major influence over tribal development. There is no encouragement for innovation in this type of relationship and it diminishes any sense of teamwork at the local level between IHS and Tribal health staff. Federal employees have the option to be above or outside the reality of the Indian community and its development efforts.

A variety of partnerships between related agencies would enable tribes to assume responsibility to manage their own health services. Diminishing resources with a single agency such as the Indian health Service only leads to counter-productive turf battles. Additional funding to spark innovative tribal health programs is needed. And, along with that, awareness about the needs of Indian communities must be raised to stimulate involvement within other agencies of the Federal government. These additional resources are needed for innovative programming.

Tribal governments must themselves be strengthened as part of the process of becoming effective providers of rural-based community health delivery systems. Improved leadership stability will be reflected in more consistent policy directions, allowing better partnerships with other participants in the ideal health system.
Funding agencies, cooperating hospitals, other local governments and most important, the Indian patient will depend upon the reliability of a competent, stable government to provide quality, consistent services.

Perhaps the first step for tribal governments is to take a lead role in changing overall community attitudes toward development. The system of Federal services in Indian communities has created a pattern of dependence which must be dismantled through community education and locally governed community development. A community-wide sense of empowerment will strengthen the development of the innovative, community based health program.

Skill development and access to information is necessary to transform community enthusiasm into an action plan for community development. The Indian Health Service can be extremely helpful to Indian communities by providing community specific data related to the development project.

SERVICE DELIVERY

The aspects covered under this category include facilities, manpower, supplies, equipment and programs. The Roundtable participants supported the definition of health care to be holistic, and that services developed under ideal circumstances would take into account the traditional Indian belief of health as not merely the absence of disease, but the balance of physical, mental, spiritual and social aspects of life. While the Indian Health Service view of health care exceeds the contemporary health industry's medical model, to include environmental and prevention services, IHS still has not developed the bridges necessary to address the Indian patient in her or his social community. For IHS and for tribes, this challenge is more important today as the leading health problems of Indian people tend to be lifestyle, behavioral influenced.

Given support and technical assistance through innovative partnerships with IHS and other agencies, tribal communities themselves can best identify the services needed in their population. Using paraprofessional and professional staff who are indigenous to the community would lessen the impact of the current high turnover of IHS staff and help overcome the obstacles created by feuding among professionals like those involved in the alcoholism and mental health delivery systems.
Rewards and reimbursements for services can then be redistributed to more paraprofessional health staff who are the primary providers in many isolated communities.

Arbitrary barriers which prevent rural Indian communities from developing needed health care facilities should be eliminated. Such barriers serve to discourage innovation at the local level. While IHS may require a means to regulate its own obligations for facility funding, it should not restrict tribal innovation. Many other federal and private funding resources hold the notion the Indian communities are taken care of by the IHS. This makes it more difficult for Indian communities to break through and become innovative in resource development.

Efforts are needed to ensure that tribal communities and the IHS more equitably measure resources available to tribes for development efforts. Innovative tribal contracting of services is one way of salvaging eroding tribal resources such as those Contract Health Services which are subject to annual Pay Act increases nationally.

INFORMATION AND DATA

Tribal health programs and IHS Service Units are constantly feeding comprehensive data into the IHS data system, but rarely receiving back timely or useful information. It was felt by the Roundtable that the most important technical assistance IHS can provide to tribes is timely, accurate and comprehensive data about their own population.

Indian tribes need to become partners with IHS in determining specific epidemiological studies to be conducted in their regions. Tribes need to receive adequate training regarding the world of possibilities available to them through the IHS data system. The Roundtable feels that a well informed community will make the best decisions and set a course for community health which is most likely to succeed.

Cultural and historical data is not a standard aspect of IHS data collection or analysis. The Roundtable viewed this as a major shortcoming in the existing system and a barrier to quality health planning. The lifestyle, behavior based health problems which
plague Indian populations today could benefit from a more focused examination of multigenerations experiences of Indian communities and its impact on community wellness. Cultural oppression and its affect on mental health and substance abuse is not well know nor adequately acknowledged by IHS. Family systems studies have been conducted in some tribal communities which reveal a strong connection between current health problems and the historical, cultural experiences of the tribe.

Many Indian people and services provided to Indians are not included in the IHS data system. For example, services provided to Indians through Medicare, Medicaid, health departments or private insurance is not included in "national" IHS data about Indians. This should receive attention and be corrected. The reverse is true for many national health studies, which ignore the IHS, tribes and reservations in data collection. IHS needs to extend itself into the broader national data system and count all the Indians if possible. The Roundtable also felt that IHS must begin to collect economic data along with workload data, if it plans to assist tribes to build their information base needed to conduct market analyses and financial assessments of tribally operated health programs.

The Roundtable believed that additional attention was needed to the issues around health data for tribes. Adequate time was not available to fully discuss the realm of problems and possibilities in this regard and the group requested IHS to provide a Roundtable specifically dedicated to the issue of data and information systems.
RECOMMENDATIONS

The following recommendations address the three basic categories of (1) Governance/Community Development; (2) Service Delivery; and (3) Information Systems. The following statements were developed by the group and received the consensus of the group as an accurate reflection of the Roundtable position. The Roundtable also developed Overriding Recommendations which follows this section.

GOVERNANCE AND COMMUNITY DEVELOPMENT

STATEMENT: Tribes are at a unique moment in their histories; some are and all should be involved in an ongoing process of redefining and restructuring their governments. The goal in this redefining is to maintain their autonomous tribal identities in a changing world. This means in part governing themselves using traditional values and cultural beliefs. Within this process of retribalizing is the essence of the participatory community development model that will allow tribes to develop the health programs and services that they determine they want and need.

A. The PROCESS of community development must be people oriented. This includes:

1. Identification of leaders as catalysts
2. Establishing a support network to train and reinforce grass roots leadership.
3. Establishing community training and skills development
4. Promote tribal/community government changes and activism.

B. The PROCESS for IHS, tribal and other related health delivery systems to promote program change, must take into consideration:

1. Partnership in the decision making process as the changes in the health system are planned.
2. Priorities for program changes must coincide with community needs and community priorities.
3. Evaluation and change process must be responsive to the need to maintain continuity of care.
RECOMMENDATION: To enable tribal governments to establish these health services and programs, the IHS needs to re-examine their programs and services to make them more responsive to the needs and priorities of Indian communities. Congress, the Indian Health Service, and tribes should support the process of consensus building in tribal communities and make other traditional forms of Indian decision-making a contemporary part of IHS-tribal government relations. This will allow tribes to flourish culturally, socially, economically and will release traditional intellectual creativity inherent in Indian communities.

SERVICE DELIVERY RECOMMENDATIONS

STATEMENT: Health care needs should be specifically defined and be framed within a broad definition of "health" as not merely the absence of disease, but also physical, mental and spiritual well-being. The health care system should be locally controlled and responsive to locally defined needs. The health care system must have adequate financial, human, and technical resources as well as appropriate facilities. The system should be well coordinated with other health and social service programs in the geographic area. Developing services should be rooted in the reality of a sound market-based business foundation. Health education and promotion should be an integral part of health services and should be communicated in culturally appropriate manners. Quality of services and evaluation should be built into services and programs regardless of whether the services are provided directly or under contract.

RECOMMENDATIONS:

A. The IHS should support tribes in efforts to develop alternative systems in the following ways:

- Support loan guarantees through FHA and other sources
- Provide technical assistance to develop agreements with alternative funding sources, FHA, Municipal Bonding, etc.
- Provide an information center on alternate financing
- Improve timing and process to confirm IHS support
- Establish an initiative giving emphasis to such efforts.

B. The IHS and tribes work together to improve the success of third party billing systems and financial rewards for billing efforts, such as:
-Investigate reimbursement possibilities and improvement through Medicaid, Health Care Financing Administration and Federally Qualified Health Centers.

-Improve access to technical assistance for tribes regarding computerized billing systems, collections, capitated program participation.

-Emphasize local control of billing systems, collections and maintained revenues for local priorities.

-Explore new billing mechanisms/policies for billing services provided by paraprofessionals.

C. Emphasis should be placed on training, recruiting and retaining local indigenous members of the community for health professions and employment in the health center. This effort could be enhanced in the following ways:

- Increase coordination between the IHS and tribal colleges and other local institutions to develop health careers training and education opportunities.

- Develop health careers internship placements in tribal health centers programs.

- Expose Indian children to health careers opportunities.

- Include Indians in minority health career initiatives.

- Develop career ladders and other retention programs at all levels of the health system for Indian people.

- Utilize available technology via telecommunications to improve training opportunities for rural providers.

- Include health professionals in the community development planning, decision-making process.

D. The Indian Health Service can improve efforts to encourage innovative health services delivery by undertaking the following efforts:

- Existing and new demonstration authorities should be funded and enhanced.

- Successes and failures need to be disseminated and more open discussion of possibilities provided for tribes.

- Develop inter-agency agreements for demonstrations.

- Encourage foundations to fund innovative Indian health care projects.
-IHS should take a supportive role wherever possible.
-Funding incentives and disincentives based on performance should be applied appropriately.

DATA AND INFORMATION SYSTEMS RECOMMENDATIONS

STATEMENT: Appropriate, timely and affordable information is critical to the local management and control of health care. Individual patient data should be confidential and the responsibility of the provider tribe should decide how health care is delivered if tribes manage health care. They should collect data using mechanism agreed upon jointly between the Indian Health Service and the tribe. Reports should be provided to IHS. If the tribe chooses not to manage care, IHS should collect data and report that data to the tribe.

RECOMMENDATIONS:

A. Health care delivery data needs to be collected with tribal membership as a key identifier.
B. A system needs to be developed to transfer patient data between IHS and non-IHS facilities.
C. Ideal health information systems should include: Market analysis; resource analysis; epidemiological information.
D. Information should be actively disseminated to the community it serves.
E. Federal agencies, no limited to the IHS, should collect and report health information on Native Americans as is done for other races.
F. The Indian Health Service should include data collection as a reimbursable expense under IHS contracts.
G. Data should identify needs as well as services delivered.
H. Tribal government has a role in interpreting and analyzing the data.
I. Tribal communities have a role in interpreting data.
J. Expertise and TA for epidemiological analysis should be provided to tribes on their data.
K. Focus should be provided on Risk Analysis of target groups.
L. Data analysis should be converted as soon as possible to consumer health promotion, disease prevention information.
M. Data must be disseminated to tribes, the IHS and other Federal agencies as needed for appropriate planning efforts.
OVERRIDING RECOMMENDATIONS

The Roundtable participants formulated additional recommendations as a result of their experience with the IHS roundtable process. These recommendations are made to improve the roundtable process and as an effort to ensure further discussion and action related to fostering Indian community development in the context of health services delivery.

1. An IHS Roundtable on Indian health data should be held so that tribes, IHS and others interested in health data can improve the existing systems.

2. Innovative partnerships should be developed to bring health planning expertise to the local communities and to facilitate tribal community development efforts. The IHS, other Federal agencies, and private foundations should examine how each can contribute to the health planning expertise in Indian communities in preparation for increased activities related to innovative health programming at the tribal level.

3. All IHS Roundtable Final Reports should be disseminated to tribal leaders to elicit feedback and to spark further discussion and action.

4. Private foundations should be encouraged to support tribal community development efforts which are innovative and culturally relevant in nature.

5. The Indian Health Service needs to research and discuss with tribal leaders the effects of community stress, cultural conflict, poverty, spiritual losses, and chemical addictions on the physical and mental health of Indian communities.

6. The IHS and tribes need to develop a means to document and disseminate "success stories" about innovative Indian health models.

7. Other Federal agencies need to be brought into the holistic definition of health to become partners with tribes and the Indian Health Service.

8. A "national" Indian voice and advocate other than IHS is desperately needed to keep tribes and IHS at the forefront of health services development.
BACKGROUND

The Indian Health Service (IHS) provides preventive and curative health care to over one million eligible American Indians and Alaska Natives in the United States. An agency within the U.S. Public Health Service, the IHS is organized into twelve (12) IHS Area Offices. The IHS operates directly or by way of contract with tribes or Indian organizations over 50 hospitals, 139 health centers, over 500 smaller health stations and satellite clinics, and approximately 2,000 units of staff housing. Services are provided in accordance with various laws which the U.S. Congress has passed pursuant to its authority to regulate commerce with the Indian Nations as described in the U.S. Constitution.

The Indian Health Service was created in 1955 following the enactment of Public Law 83-568, the Transfer Act on August 5, 1954. This act removed the Federal responsibility to provide health services to Indian people out from under the Bureau of Indian Affairs (BIA) placing it under the Surgeon General of the U.S. Public Health Service. A legislative history related to innovative rural Indian health services and facilities models, according to the IHS Division on Legislation and Regulation, is as follows:

-The Snyder Act of 1921, provides such moneys as Congress may from time to time appropriate.

-The Transfer Act of 1954 (PL 83-568), provides the Indian Health Service transferred to U.S. Public Health Service.

-The Indian Health Facilities Act of 1957 (PL 85-151).

-The Indian Self-Determination Act of 1974 (PL 93-638) provides the means for tribes to contract for the management of IHS and other Federal Indian programs.

-The Indian Self-Determination Act Amendments of 1988, provides consideration for innovative models under:
Section 102(c)(1)(a) - Federal Tort Claims Act Coverage
Section 103(d) and (e) - Technical Assistance to Tribes
Section 104(b) - Commission Corps and IPA assignments
Section 105(c) - 3 year grants and (f) Property Transfer
Section 106(a) - Savings from contract may go to services
The Indian Health Care Improvement Act Amendments of 1988 (PL 100-713) provides incentives for innovation:

Section 110-Grants for Tribal Retention/Recruitment
Section 206-Third-party Reimbursement authority
Section 207-Crediting Reimbursements to Program Source
Section 301-Facilities Methodology
Section 305-IHS Assistance to Facility Renovated with non-IHS funds is authorized.
Section 401-IHS/Tribal Facilities for Medicare Reimb.
Section 402-IHS/Tribal Facilities for Medicaid Reimb.
Section 404-Grants to Tribes to Enrol Eligible Indians
Section 405-Demo Program for Tribes to Bill Medicaid and Medicare Directly
Section 704-Leases with Tribes for Tribal Facility Use by IHS authorized
Section 711-Repair to Leased Facilities on Same Basis as an IHS Facility is authorized.
Section 713-Service to Ineligibles and FTCA Coverage for such Services from IHS/Tribal Facility
Section 716-IHS-VA Facilities and Services Sharing Feasibility Study Report on Ft. Duchesne
Section 718-Tribal Management Demonstrations

The Omnibus Drug Acts of 1986 and 1988 (PL 99-570 and PL 100-690) provides related support, via:

Section 4209-Federal Facilities Property Use, Leases
Section 4227-Use of Excess Federal Structures
Section 4228-Demonstrations for Health Promotion and Disease Prevention Projects

The difficulty of the Indian Health Service to keep pace with the escalating cost of providing health services combined with a steady increase in the eligible IHS service population has led to a situation where health services are often rationed. The IHS eligible service population has grown from just over 800,000 in 1980 to over 1,105,000 in 1990, according to IRS data. Once adjusted for inflation, the IHS budget has grown only 2% during that same period, according to a recent study by the Office for Congressional Research. This dilemma has created an environment where tribes and the Indian Health Service are frustrated by the limited resources available to meet basic needs and reexamining the existing delivery model.
More and more tribes have begun to exercise their authority to contract for the management of direct services under the Indian Self-Determination Act. While this authority provides tribes with the opportunity to contract for existing services, many tribes have had difficulty in their efforts to expand services beyond existing levels. Facility expansion has been an area which has received extreme monitoring and tight controls by the IHS, even for facilities owned and operated by tribes for the delivery of health services.

Eight years ago Congress required the Indian Health Service to implement a priority system for the construction of new facilities. That system is known as the Health Facility Construction Priority System (HFCPS). While many worthwhile hospitals and outpatient clinics have been constructed under that system, the priority rating process has come under criticism by other Indian communities in need of facility replacement or new construction which have not benefited from the system. The formula applied to facilities under consideration for the priority list weighs heavily on workload volume. Others have complained that even when a project makes it onto the IHS facility priority list, it could take as long as twelve years before the building has completed all the stages of construction.

Many tribal communities have looked to alternate forms of financing to construct health services facilities. The Cour d'Alene Tribe in Idaho, joined with the local non-Indian community to find the resources necessary to build and operate their own clinic. The tribe contracted away its portion of IHS dollars otherwise spent through the local service unit to go toward this effort. The Warm Springs tribe from Oregon and the Nez Perce tribe from Idaho have proposed building their own replacement facilities with tribal financing and leasing the space to the IHS. Although the Indian Health Care Amendments of 1988, provided language authorizing IHS to lease clinic space from tribes, IHS is prevented from utilizing any appropriated funds to enter new facility leases without the explicit approval of the U.S. Congress.

The focus on facility management intensified when the Indian Health Service announced plans to shut down nine rural IHS hospitals which it had determined were underutilized. Those nine rural hospitals were located in the following areas:
An outcry from those communities, combined with ongoing complaints about the priority system for new construction projects prompted a hearing by the Senate Select Committee on Indian Affairs in March of 1990. The hearing on IHS facilities elicited concern from the nine communities who wanted the opportunity to examine alternatives to closing the hospitals in their communities. Some of the suggestions made at the hearing included: utilizing the in-patient facility to serve both Indian and non-Indian patients in remote areas where little else was available for the non-Indian patient; altering the kind of services offered at those sites to meet other needs, such as in-patient substance abuse treatment, nursing home care, limited in-patient procedures.

For other tribes attempting to finance their own replacement or new construction facility with alternate resources, the dilemma of IHS participation was still in question. Tribes with their own financing capabilities must still go through the HFCPS process if IHS participation is needed for an expanded program, even if a bulk of the financing is assured from other resources. The caution that IHS exercises around new, expanded or replacement facilities centers on its need to insure some control over increased costs. The fear of opening the flood gates to new and expanded programs for which IHS would then be obligated to staff, equip and lease is the basis for IHS reluctance to join in innovative tribal ventures. IHS has been so concerned that it requests prohibitive language each year in Interior Appropriations Acts. The IHS Fiscal Year 1991 Justification of Appropriation Estimates for Committee on Appropriations asks that Congress include in the FY 91 Appropriations law, the following language:

*Provided, That none of the funds appropriated under this Act to the Indian Health Service, but no funds, shall be available for the*
initial lease of permanent structures without advance provision therefor in appropriations Acts.

This language in essence eliminates any opportunity to utilize the authority of the Indian Health Care Amendments Act of 1988 which authorized IHS lease of tribal clinics.

The Secretary of Health and Human Services annual report to Congress on the IHS' facility priority system identifies a total price tag of $520 million to complete all the construction projects which are now on the IHS priority list. The communities listed on the priority list represent but a small fraction of the Indian health facility needs nationally. IHS seems to be caught in a dilemma of discouraging innovative project development on the one hand and encouraging new innovative approaches on the other.

In 1987, Assistant Surgeon General David Sundwall convened a meeting of tribal leaders and health industry experts to examine several innovative demonstration projects which seem to be working in Indian Country. Among those were the Creek Nation Community Hospital which is tribally operated and service both Indian and non-Indian patients; the Suquamish Tribal Project, which contracts with Blue Cross to manage health resources; and the Pawnee Benefit Package, which transferred limited Contract Health Service dollars into a benefit guarantee purchase of certain hospital based services for enroled members.

Much of the Indian Health Service delivery system is located in rural and remote areas, and at least partially dependent upon local non-IHS health facilities. The shift in rural America away from in-patient facilities and reduced populations has implications for tribal health care. Strategies to build reasonable, quality health care services for remote Indian populations must consider the broader community and health resource environment.
RURAL HEALTH CARE

The Senate Committee on Labor and Human Resources reported that health care in rural American is in a state of crisis. Over 77% of the land base of the United States is designated rural and is home to only 23% of the Nation's population. Of those people who live in rural areas, there is a higher likelihood that they will be poor, elderly and uninsured as compared to people in urban areas. Among the poor who live in rural areas they are much less likely to qualify for such health care benefits as Medicaid than urban poor. In fact, national data states that only one-third of the nation's rural poor qualify for Medicaid, while up to 48% of those urban poor in the United States are Medicaid qualified. For rural hospital administrators and planners these numbers spell fiscal trouble.

Over 206 rural hospitals have closed their doors in the past ten years, unable to make these numbers mesh with the high cost of health care. Among those rural hospitals which have not closed, national data indicates that 42% have experienced declines in patient admissions; 11% have decreased their average length of stay; and 32% have dropped in occupancy rates. Hospital closures is one of the major problems in rural health care today. The high percentage of the uninsured patient load does not provide the ideal mix of patients most urban hospitals depend upon to survive. Sparsely populated rural areas do not provide rural hospitals with the volume of patient care necessary to take advantage of the economies of scale. The economies of scale is what allows urban hospitals to hire specialists, purchase new equipment and provide comprehensive care. Without a large volume of patients, these specialists and expensive equipment sit idle and create a money drain on the facility.

Attracting health care providers, particularly physicians, to remote rural areas is also a major issue in maintaining adequate rural health care resources. Although recent national data suggests the number of physicians choosing to practice in rural areas has recently increased, the ratio of physician to population is still below acceptable standards. Several factors weigh into this dilemma. The obvious concerns for quality school systems, housing, social activities and higher education opportunities for the physician and his or her family must be addressed. Other factors, which are more difficult to address create barriers to rural physician placements.
The escalating cost of medical malpractice is driving many rural family practice physicians out of the practice or into very limited forms of practice, according to a 1989 Institute of Medicine study. The American Medical Association estimated that premiums for all physicians increased 81% between 1982 and 1985. The premiums for physicians practicing obstetrics increased over 113% during that same period. Due to a lack in the economies of scale needed to support a full time obstetrician, most rural areas depend on family practitioners for their prenatal and obstetrical services. In fact, the IOM study found that two-thirds of all private obstetrical care in rural areas is provided by family practitioners. Lack of intensive care facilities, nearby hospitals and other resources make the practice of obstetrics more difficult for these rural practitioners. Their medical malpractice premium is also adversely affected due to their less than desirable working conditions, and what many insurance carriers view as high risk patients. The IOM study found that the number of obstetrical providers in non-metropolitan areas has fallen by approximately 20% in just the last five years.

The National Health Service Corps (NHSC) used to be the primary vehicle by which physicians and other health professionals were placed in rural areas. The Indian Health Service has depended upon NHSC placements for a large percentage of its direct service workforce. NHSC has gone through a major scaling down over the past ten years however. The program was designed to provide scholarship incentives for medical students who would then be obligated to serve two years in a health manpower shortage area. The program reached its peak in service delivery field strength in 1986, with 3,217 assignees. Since then, the numbers have dropped proportionate to the decrease in scholarships awarded. The projected number of assignees in the field in 1991 is 655 practitioners, and only 435 practitioners by 1992.

Rural communities looking to maintain quality and comprehensive health care must be innovative in their approach. The Community Health Centers program of the U.S. Public Health Service is one resource which assists rural areas. Of the Nation's 357 community health centers, 65% are located in rural areas and often provide a network of satellite clinics to remote regions, according to the Kennedy Report.
INNOVATIONS IN INDIAN HEALTH CARE

The Porcupine, South Dakota community is a good example of innovation in Indian health care. Community activism and persistence have driven the development of the Brotherhood Community Health Clinic. The facility, built with non-IHS funding now has the cooperation of the Indian Health Service and houses IHS and non-IHS health programs. The Cour d'Alene Tribe in Idaho is another example of Indian innovation. The tribe is located in a remote area in the panhandle of northern Idaho. The tribal health services represent the only health care in the entire community. The non-Indian community had much to gain by coordinating with the tribe. Today, the tribe and the local community have pooled resources to provide their members with basic primary health care in an otherwise remote and underserved area.

When the Assistant Surgeon General, David Sundwall convened the group of national Indian leaders and community health providers in 1987, the result was an impressive display of Indian innovation. The sites which were selected as demonstrations of alternative delivery systems and which participated in the 1987 meeting were described as follows:

Mid-Dakota Hospital. This community hospital has a contract with the Indian Health Services (which was mandated by Congress) to provide basic outpatient and in-patient services to eligible Indians, in lieu of maintaining an IHS facility at this site. The tribe is guaranteed two out of thirteen seats on the hospital board of directors. The funds going to the hospital under this contract represents approximately half of the hospital total funding.

Mt. Edgecumb Hospital. This IHS hospital is managed by the tribe under an Indian Self-Determination contract for the total Service Unit. The facility focuses on Behavioral diseases, which represent the largest health problem for Indians in Southeast Alaska. The report indicates an increase in patient satisfaction under tribal management.

Kanakanak Hospital. The tribe has assumed total control of the IHS Service Unit through a contract under the Indian Self-Determination Act. The Bristol Bay Area Health Corporation serves the entire population in the area, utilizing IHS funds for the 32 Native Alaska villages in the catchment area. They have been
successful at recruiting and retaining Native American physicians for this effort. Three of the five hospital physicians are Native American.

Pascua Yaqui Health Maintenance Organization (HMO). The IHS has contracted with a local HMO to provide in-patient and outpatient services to the enrolled members under this program. The tribe has retained responsibility to provide public health nursing, home health, and environmental health services. This alternative delivery system has potential for tribal communities located near urban areas where there is a high likelihood of HMO bidders for a contract.

Suquamish Project with Blue Cross of Washington and Alaska. The Suquamish Tribe has negotiated with IHS a tribal fee-for-service contract with Blue Cross for administrative services only. This includes marketing, billing, collection of reimbursement from Medicaid, Medicare and other third party payors. There is no financial risk to Blue Cross. The tribe provides the coordination of activities including patient registration and eligibility determination. Enrollees have ready access to the system with a Blue Cross card which can be presented at participating clinics and physicians. There is a broad range of medical services covered under the plan and the report indicates a very high rate for consumer satisfaction.

Creek Nation Community Hospital and Clinics. The Creek Nation owns and operates a hospital which serves the entire community including Indians and non-Indians. Services to the eligible Indian patient load is financed by their Indian Self-Determination contract. This contract covers approximately 75% of the hospitals operating expenses. The remainder of the financial resources for the hospital comes from Medicaid, Medicare, other private insurers and self-payments from non-Indian patients. The tribe also owns and operates a system of four outpatient clinics including dental services.

Pawnee Benefit Package Program. In this case, an IHS hospital which was closed created the incentive for a benefit package program for the Pawnee beneficiaries. The IHS coordinates the Contract Health Services (CHS) funds to provide specific services for the enrollees including in-patient care, emergency room treatment and surgery center services. The enrollees can select their own provider in the community among a list of participating providers. An identification card similar to the Blue Cross approach is used by
the enrollees and recognized by the provider. All outpatient services must be received from the IHS operated health centers.

These projects provide a glimpse at the range of possibilities for tribal innovation. A key ingredient to all projects described above is the community control of the effort. Research performed in Native American communities in Canada (H.Bain) has shown that simply providing an Indian community with quality primary care has little or no impact on that community's health status unless that community is intimately involved and takes ownership in the effort. The enthusiasm of the communities described above has much to do with the success of their efforts. Eliminating the barriers to allow that creativity and innovation to occur was a focus of the Sundwall meeting in 1987. Some of the recommendations which the 1987 group developed included:

- **Improving Mechanisms and Conditions for Tribal Management.** Changes to the federal procurement system were requested to make contracting easier. These changes included, three year contracts; IHS Area staff to assist in the effort; gradual phase-in time for tribes; elevate the function of self-determination with the IHS headquarters operation.

- **Funding Policies.** Funds sufficient to cover all the costs to tribes incurred in the Indian Self-Determination contracting process should be provided, such as medical malpractice insurance and legal fee. Funding should keep pace with the health cost index. Tribal facilities should be allowed to keep their Medicaid and Medicare reimbursements within their own program to create an incentive for collection. Additional funding is needed to bring facilities up to standard, if they are below standard at the time of tribal contracting. Tribal health managers should be given latitude in the use of resources.

- **Community Relations.** IHS should work with the local communities to better negotiate health care resources. IHS should be ready to deny future contracts to community hospitals that decline to include a reasonable level of tribal representation on their boards of directors and to employ tribal people.

- **Financial Management.** Cost accounting and other financial management services for current and future tribal managers of health services is needed.
The 1987 Sundwall meeting asked IHS to provide new moneys and new staff to implement a demonstration project which would allow tribal development of alternative delivery systems. In many ways, the bill introduced by Senator McCain, S.2850, could accomplish much of the recommendations from the Sundwall meeting. A major problem with S.2850 is that it is limited to serving at the most only 35 communities. The IHS works with over 500 different tribal groups and communities. However, viewed as a demonstration model, with the anticipation that system changes may be forthcoming which would allow a broader application of new approaches to health delivery in Indian communities, the bill offers an excellent testing ground.

There are likely many other opportunities to allow for tribal innovation which will not require legislation. The needs of rural non-Indian communities and tribal communities may provide the key to a partnership to expand the horizons for Indian health care in the United States.
"Tribal Governments as Rural Health Providers"

AGENDA

RURAL INDIAN HEALTH ROUNDTABLE CONFERENCE

AT
AMERICANS FOR INDIAN OPPORTUNITY
CONFERENCE ROOM

3508 Garfield Street, N.W.
Washington, D.C. 20007
(202) 338-8809

WEDNESDAY, SEPTEMBER 26, 1990

6:30 p.m. - 8:00 p.m. Get Acquainted Reception

THURSDAY, SEPTEMBER 27, 1990

9:00 a.m. Welcome and Introductions - LaDonna Harris
President, A.I.O

9:30 a.m. Review Format of the Meeting - Michael Mahsetky
IHS-Moderator

10:00 a.m. PRESENTATION: Social/Economic/Political Perspective
Andrea Smith, First Nations

11:00 a.m. PRESENTATION: Collaborative Rural Alternatives
Cathy Wasem, Office of Rural Health

12 Noon Lunch Provided

1:30 p.m. Develop Ideal Model for Rural Indian Health Care -
Group Discussion

3:00 p.m. Identify Constraints With Ideal and Current Systems

5:00 p.m. Adjourn for the Day

FRIDAY, SEPTEMBER 28, 1990

9:00 A.M. Sort and Prioritize Issues

12 Noon Lunch Provided

1:00 p.m. Develop Roles, Responsibilities and Recommendations

5:00 p.m. Adjourn
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SELECTED AND ANNOTATED BIBLIOGRAPHY

Backup, R. W.
*Puyallup Medical Clinic Self-Determines Health Care for Indian Clients*, Washington Nurse, (June, 1986), 16 (6), 8-9.

An active member of the Washington State Nurses Association, Ruth Backup is featured in this article as she describes the history of the Puyallup Tribe's effort to build a comprehensive community health center which serves not just Puyallup tribal members, but other Indian patients in the Tacoma area. The Puyallup Clinic is the first tribal health clinic contracted under the Indian Self-Determination Act.

Bain, H.W.

This editorial focused on research by Drs. Evers and Rand on the morbidity among Canadian Indian and non-Indian children during their first year of life. It also examines the experience by the University of Toronto's health care delivery project in the Sioux Lookout Zone of northwestern Ontario. The editor summarizes that simply providing a greatly improved quality of health care delivery may have little or no impact on the overall health status of the Indian population. He cites additional research by T.K. Young, which shows no correlation between the health status of the Indian population and the quality of primary medical care available to that community. Dr. Bain contends that the critical ingredient is the involvement and sense of ownership by the Indian community itself in the effort to improve health care. He summarizes that health problems among natives can be corrected only by a total community approach by the natives themselves.

Baldwin, D.C., Jr., Baldwin, M.A., Edinburg, M.A., and Rowley, B.D.
*A Model for Recruitment and Service-The University of Nevada's Summer Preceptorship in Indian Communities*, Public Health Reports, (January-February, 1980), 95 (1), 19-22.

This article describes the Health Careers for American Indians Program which operated under the University of Nevada at Reno. Its mission was to improve the quality and quantity of health services to Indians in rural Nevada by increasing the number of Indians entering health care professions. It offered a summer preceptorship to teams of Indian and non-Indian students to do health screening in clinics serving remote reservations sites throughout Nevada. The goal was to enhance the motivation and interest of Indian health science students and non-Indian students to seek health occupations serving Indian communities.

Black, Sherry Salway,

An analysis of the status of Indian Health Service delivery mechanisms and its impact or lack of impact on the local Indian economy is the focus of this article. The author establishes the relationship between the health status of Indian people with the economic well-being of the tribal community. She calls upon the Indian Health Service and tribes to be more cognizant of their potential contributions to local economy and to maximize the number of times each dollar changes hands within the Indian community. Key to accomplishing this relationship is tribal control of health care resources. A partnership for change is proposed which would create a synergistic relationship between economic and health care interests in Indian communities.
Dunn, E.V., and Higgins, C.A.  

This research measured the frequency and type of diagnoses made by physicians, nurse practitioners, and minimally trained health aides serving a remote Indian community in northwestern Ontario, Canada. The Sioux Lookout Zone residents included approximately 10,000 Native Cree and Ojibway Indians scattered among 27 smaller communities. None of the communities was large enough to support a full-time physician. The results of the research showed that the minimally trained health aide made more signs and symptoms diagnoses and asked for help more frequently. Physicians diagnosed medically sophisticated conditions more frequently and nurses provided preventive measures and made diagnoses in the supplementary diagnostic class. The summary of this data suggests that when planning health care services in remote areas which must utilize minimally trained personnel, a concerted effort should be made to provide assisting practitioners to deal with undifferentiated illnesses and acute problems.

Fox, J.E.  

Health Resources and Services Administration (HRSA)  

Assistant Surgeon General, David Sundwall, M.D., called a meeting of Indian leaders from national Indian organizations, Indian communities involved in innovative approaches to health care delivery and health industry experts for the purpose of developing recommendations to encourage and assist tribes to examine potential alternative delivery systems. The workshop focused on: (1) the potential level of interest among tribes in demonstration projects for alternative delivery systems; (2) the conditions that might make sponsorship of such projects attractive; (3) ways in which tribal governments might seek outside resources for enhancing health care for Indian people; and (4) possible elements of new demonstrations.

Seven current IHS/tribal demonstrations of alternative delivery approaches were presented and represented at the workshop. The included: (1) Mid-Dakota Hospital, a community hospital on contract with IHS to serve Indian patients with tribal representation on the hospital board; (2) Mt. Edgecumbe Hospital, tribal management of the entire Service Unit; (3) Kanakanak Hospital, tribal management of the entire Service Unit; (4) Pascua Yaqui HMO, IHS contract with a local HMO for inpatient and outpatient care to Indians; Suquamish Project with Blue Cross of Washington and Alaska, tribal fee-for-service contract with Blue Cross for certain administrative services; (6) Creek Nation Community Hospital and Clinics, tribal ownership of a hospital and clinics which serve the entire community, including non-Indians; and (7) Pawnee Benefit Package Program, IHS management of Contract Health Services to cover certain services for all enrollees.

The workshop participants called for the development of demonstration programs available to all interested tribal communities to begin alternative delivery systems. Specific recommendations were also presented dealing with potential problems surrounding contracting mechanisms, funding policies, community relations and financial management.
Indian Health Service (IHS)
Justification of Appropriation Estimates for Committee on Appropriation: Fiscal 1991,
Detailed description of the Indian Health Service budget request for Fiscal Year
1991, this document also provides the IHS requested special language to be included in the
Appropriations Act. The prohibition of new IHS leases for facilities in included in the
Interior Appropriation Act on an annual basis. This language in essence, prohibits the
ability of IHS to carry out the authority provided in the Indian Health Care Amendments
Act of 1988, to lease tribally constructed clinics.

Indian Health Service (IHS).
Indian Health Service Trends in Indian Health: 1989, U.S. Department of Health and
Human Services, Public Health Service, IHS Office of Planning, Evaluation and
Legislation, Division of Program Statistics.
This IHS publication provides a comprehensive statistical overview of the structure
and operations of the Indian Health Service. In addition to workload data, morbidity and
mortality data is provided on the Indian population.

Institute of Medicine (IOM)
The IOM released its study in 1989 which revealed that the escalating cost of
medical malpractice and the fear of getting sued are driving physicians out of the practice of
obstetrics. The hardest hit communities by this trend are rural and minority communities.
The IOM recommendations called for Congressional intervention by creating protection
under the Federal Tort Claims Act for providers in the public sector, such as in community
health centers.

Jackobs, Joe, M.D., M.B.A.
Indian Health Policy in the 20th Century--Can it Adapt? First Nations Financial Project:
A member of the St. Regis Mohawk Tribe, Dr. Jacobs is currently Medical Director
for New Program Development for the Aetna Life Insurance Company. Dr Jacobs
describes the potential for Indian tribes to form health care coalitions with non-Indian
communities as a means to address rural health care needs, including provider recruitment.
The author encourages the Federal government to coordinate multiple resources through
joint ventures with Indian and non-Indian rural communities. He suggests that Indian
patients will begin to view health care delivered to them as quality health care as opposed to
IHS charity care. Tribal management of health care as a corporate operation is needed.

Kennedy, Edward M.,
Sparta, Georgia: The Health Care Crisis in Rural America, The Health Care Crisis in
America: A Report to the American People, U.S. Senate Committee on Labor and Human
Resources, U.S. Government Printing Office, Washington (June 1990) S. Print 101-100,
57-72.
United States Senator Edward Kennedy is Chairman of the Committee on Labor
and Human Resources. In this special report from his committee, the chapter on the health
care crisis in rural America gives an excellent background on issues common throughout
rural areas while focusing on a community in Sparta, Georgia. It cites that 77% of the
Nation is designated as rural and contains 23% of the Nation's population. A higher
percentage of rural Americans are uninsured for health coverage. Only one-third of rural
poor qualify for Medicaid, while 48% of the poor in inner cities qualify. More of the Nations elderly population reside in rural areas. They account for 25% of the total rural population, while making up only 12% of the National population.

Hospital closures is a major problem in rural areas. From 1980 to 1990 over 206 rural hospitals have closed, primarily because they have fewer people to serve and their patients are poor or elderly. Over that same ten year period, all rural hospitals nationally have experienced declines of 42% in admissions, 11% in the average length of stay, and 32% in occupancy rates. Smaller, rural hospitals do not have the patient volume needed to take advantage of the economies of scale which allows larger hospitals to hire specialists and purchase the latest medical technology and equipment.

Recruiting and retaining professional staff is a problem in remote areas. Solo practitioners in rural communities often find their job is a 24-hour a day requirement, lacking adequate back-up systems. One of the nation's most important resources for placing physicians in underserved rural communities, the National Health Service Corps (NHSC), has been drastically reduced. Providing 3,127 NHSC health professionals in the field in 1986, the projected number for 1991 is 655 and in 1992 only 435 health care providers. Another important health care resource for rural areas has been the Community Health Centers program of the Public Health Service, which funds local non-profits operating health centers. Of the Nation's 357 community health center, 65% are located in rural areas.

Korczyk, Sophie M., PhD. 

This report reveals to the difficulties faced in rural communities with regard to health services. Although the number of physicians practicing in rural areas has increased slightly, the ratio of doctor to population is still below desired levels. Hospital closures, poorer communities, impossible reimbursement systems and a medical liability insurance crisis are all cited as contributing factors to the decline in rural health care. The author calls for a national rural health policy overhaul which would address the insurance crisis, alter medical practice to consider the needs of the rural poor, and provide subsidies and improved risk pooling arrangements for rural businesses and households.

Kunitz, S. J., Temkin-Greener, H., Broudy, D., and Haffner, M. 

This research examined the hospital utilization rates on the Navajo Indian Reservation in comparison to changes in the delivery system, including the community distance from the hospital. It found that distance from the community to the nearest hospital was the best predictor of hospitalization rates in that community. Other factors to be considered included wage income, age of the patient, dependence on welfare and household size. Variations were also noted in the cause for hospitalization. The rate of cholecystectomies in a community is best explained by distance to the hospital, whereas the rates for appendectomies and hysterectomies seem to be more significantly related to measures of acculturation to the dominant society.
McCain, John. 

United States Senator John McCain addresses the problem of an Indian health delivery system which is in a mode of scaling down as it plans to close facilities. As a member of the Senate Select Committee on Indian Affairs, Senator McCain describes his efforts to seek input from Native American communities related to Indian mental health and health care facilities. Senator McCain announces his intention to seek legislation to facilitate more flexibility for tribal communities planning innovative or expanded programs. The effort will involve the creation of an alternative priority system for the construction of facilities utilizing combined IHS and non-IHS funding. The existing IHS facility priority system would not be replaced or threatened by this demonstration approach. Senator McCain states that this is an effort toward Native community empowerment and placing the keys of change in the hands of the Indian community.

Oklahoma Business Alert. 

No author is cited in this provocative article about Oklahoma's Indian population and the significant contribution their economy makes to the overall state economic health. Several examples are described where tribes have developed major economic development ventures in the state and employed many Indian and non-Indian residents. The turning point for Indian economic development is cited as 1974, after the passage of the Indian Self-Determination Act and the Indian Financing Act. The article also cites Public Law 100-442 enacted in 1988 which allows prime government contractor to earn a 5% rebate on any subcontract awarded to an Indian organization. This creates an incentive for tribal enterprises which interface with government contractors. While this article does not examine the economy generated from Indian Health Service and Bureau of Indian Affairs presence in the state, it does set the tone for joint ventures between Indian and non-Indian enterprise.

Sky, B. 

The efforts of the Association of American Indian Physicians (AAIP) to recruit and prepare Indians for medical school and eventual service to Indian communities is described. Cultural differences can be a barrier for many Indian medical students entering the rigorous training. The efforts of the members of AAIP prepare potential and current Indian medical students with emphasis on building a commitment to serve Indian people.

Smith, Andrea L., 
*Brotherhood Community Health Clinic Provides Services.* First Nations: Business Alert, (Fall 1989) 12 and 15.

This article describes the struggle of a community in Porcupine, South Dakota to develop a health services delivery program. Unable to receive the priority rating in the IHS master plan, the community undertook to develop their own facility through other funding resources. Once completed the community successfully negotiated a memorandum of agreement with the Indian Health Service to house IHS field staff in the Clinic and to become a partner in the delivery of health services to that community. Known as the Brotherhood Community Health Clinic, it now provides quality services to the Porcupine community.
Smith, E.M.  

Ellen Smith is a policy analyst with the U.S. Congress Office of Technology Assessment (OTA) and she participated on the OTA report, Indian Health Care published in April of 1986. A thorough description of the Indian Health Service is given in her commentary. Underfunding of the IHS to meet its mission is detailed. Yet, IHS is the largest direct provider of health care remaining in the U.S. Public Health Service, consisting of 51 hospitals, 124 outpatient clinics, nearly 300 smaller health stations and over 10,000 employees, 60% of whom are American Indian or Alaska Native.

Of the existing hospitals most are small and rural. Five of the 51 hospitals have less than 15 beds; only five have more than 100 beds. The largest IHS hospital has 170 beds. These hospitals are limited in the type of care that can be provided. Many specialized services, such as cardiac intensive care, radiation therapy, organ transplants, burn care, neonatal intensive care, and renal dialysis services can only be made available to IHS beneficiaries through the Contract health Services purchase from outside providers.

As a result, IHS and Indian communities depend heavily on alternate resources. Medicaid payments for Indian people in 1985 were $197.5 million, of which $15.6 million was for service provided directly in IHS facilities to Medicaid eligible Indians. IHS collected $17.3 million that same year from Medicare. The national Health Service Corps (NHSC) has provided many of the IHS physicians, however that resources is expected to be depleted by 1988. Until IHS is given the funding and resources it needs to fully address Indian health care it will continue to rely heavily upon other Federal programs such as Medicaid and Medicare.

Sullivan, Louis W., M.D.,  

As required in Section 301 (d) of Public Law 100-713, the Indian Health Care Amendments Act, the Indian Health Service by way of the Secretary of HHS must file a report with the U.S. Congress on the Health Facilities Construction Priority System. This report identifies $520 million needed for construction projects which have already been approved for the priority list. It also gives a brief description of the formula used to measure all requests to be on the priority list and the process which takes place through to completion of the construction project. The complete list of all sites currently on the priority list and the estimated cost for each is attached to the report.

Sundwall, D.  
*Advances in Indian Health Care,* Public Health Reports, (July-August, 1987), 102 (4), 349-351.

This article hails the accomplishments of the Indian Health Service over the past thirty years and makes recommendations for the future. IHS plans to focus on community based prevention and treatment; eliminating risk factors which lead to disease; facilitating dietary changes, more exercise and reduced substance abuse; and targeting interventions to eliminate deaths from injuries, violence and alcoholism. IHS will also encourage tribes to look at alternate financing of health services via Health Maintenance Organizations and other innovative models.
S. 2850 DEMONSTRATION BILL

AMENDMENT NO. ____________ CALENDAR NO. ____________

Purpose: To provide a substitute.


S. 2850

To authorize demonstration projects in conjunction with providing health services to Indians.

Referred to the Committee on ___________________________ and ordered to be printed.

Ordered to lie on the table and to be printed

Amendment in the nature of a substitute intended to be proposed by Mr. McCain.

1 Strike out all after the enacting clause and insert in lieu thereof the following:

2 SECTION 1. SHORT TITLE

3 This Act may be cited as the "Innovative Indian Health Delivery System Demonstration Project Act."
SEC. 2. FINDINGS.

The Congress finds that —

(1) there is a unique relationship between the Federal Government and Indian tribes, and this Act is not intended to alter that relationship;

(2) every Indian tribe, regardless of its size, should have the ability to provide the highest possible level of health services to its people;

(3) the existing Indian Health Service facilities construction priority system and resource allocation methodologies shall not be affected by this Act;

(4) the existing facilities construction priority system does not adequately serve all Indian tribes, there are some small Indian tribes or tribes with a low patient workload at existing facilities which may require reconstituted IHS support; and

(5) there is a construction of Indian health facilities which will require at least $596,000,000 to remedy, and an essential repair backlog which will require at least $94,000,000 to remedy.

SEC. 3. PURPOSE

The purpose of this Act to is authorize demonstration projects which are intended to identify the most effective and efficient means of providing access to health care and essential health services for Indians.

This Act will:

(1) enable Indian tribes to devise alternative health care delivery systems utilizing existing or new IHS resources combined with other resources;
(2) enable Indian tribes to develop and implement financing mechanisms for health care services provided through an alternative delivery system; and

(3) enable Indian tribes to fully utilize all available resources for the benefit of all community members, whether eligible or ineligible for services provided by the Indian Health Service, through an existing or alternative health care delivery system.

SEC. 4. DEFINITIONS.

For purposes of this Act —

(a) "Secretary," unless otherwise designated, means the Secretary of Health and Human Services acting through the Director of the Indian Health Service.

(b) "Service," means the Indian Health Service.

(c) "Indian," means a person who is a member of an Indian tribe;

(d) "Indian tribe," means any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or group or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act (85 Stat. 688) [43 U.S.C.A. 1601 et seq.), which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

(e) "tribal government," means the federally recognized governing body of any Indian tribe;

(f) "tribal organization," means any legally established organization of Indians which is controlled by one or more tribal governments or by a board of directors elected or
selected by one or more tribal governments (or elected by the Indian population to be served by such organization) and which includes the maximum participation of Indians in all phases of its activities.

(g) "area," unless otherwise designated, means one of the Area Offices of the Service as defined in 25 U.S.C. 1603(i).

(h) "service unit," has the same meaning as that contained in 25 U.S.C. 1603(j).

SEC. 5. DEMONSTRATION PROJECTS.

(a) PROJECTS TO BE ESTABLISHED. — The Secretary shall, within the 60 month period following the date of enactment of this Act, establish not more than 35 or less than 25 demonstration projects to determine the most effective and efficient means of providing health facilities and services to Indian tribes. The Secretary shall establish, upon the application and at the request of a tribal government or tribal organization, a demonstration project located in each of the following service units:

(1) Cass Lake, Minnesota
(2) Clinton, Iowa
(3) Harlem, Montana
(4) Mescalero, New Mexico
(5) Owyhee, Nevada
(6) Parker, Arizona
(7) Schurz, Nevada
(8) Winnebago, Wisconsin
(b) CONTRACTS; GRANTS. — The Secretary is authorized to enter into contracts with, or make grants to, any Indian tribe or tribal organization for the purpose of carrying out a demonstration project under this Act.

(c) CONSTRUCTION; RENOVATION. — Demonstration projects under this Act may include the construction and renovation of hospitals, health centers, health stations, and other facilities to deliver health care services which meet the health needs of Indians.

(d) WAIVER AUTHORITY. — Notwithstanding any other provision of law, for the purposes of this Act, and grants pursuant hereto, the Secretary is authorized to —

1. waive any leasing prohibitions;
2. permit carryover of funds appropriated for the provision of health care services;
3. permit combining of inter-agency federal and non-federal funding;
4. permit funds and property to be donated from or by any other source for project purposes, including other federal agencies; and
5. provide for the reversion to the donor of any real or personal property which may be contributed to a project.

(e) GEOGRAPHICAL DISTRIBUTION. — In establishing demonstration projects under this Act, the Secretary shall, to the maximum extent feasible, provide for a broad geographical distribution of such projects among the Indian population. Notwithstanding the provisions of paragraph (a), the Secretary shall award at least one demonstration project in each area.
Such application shall require such information and be in such form as the Secretary shall prescribe.

(b) ASSESSMENT.— (1) Each application for a demonstration project shall be accompanied by an assessment of the status of the Indian health services and facilities currently available to the applicant.

(2) Each assessment required by paragraph (1) shall—

(A) be in such form as the Secretary shall prescribe;

(B) define the community and area to be served by the project;

(C) specify the need or needs for such a demonstration project;

(D) include a complete analysis of existing facilities, such as space, structural deficiencies, and engineering requirements;

(E) include a description of the health services currently available to the population to be served, and the impact of the demonstration project on existing health services;

(F) include an assessment of the staffing needs for the provision of services in connection with such project; and
(G) include a description of funding sources which are available for current services.

(H) include a description of funding sources which propose to tap for a demonstration project.

(c) PROPOSAL— Each application shall be accompanied by a proposal for the establishment of a demonstration project for the delivery of health care services to the Indian tribe.

(2) The proposal shall—

(A) be in such form as the Secretary shall prescribe;

(B) be submitted to the Secretary and the Area office for the area in which the project will be located;

(C) include a description of the nature of the facility to be constructed or renovated, and the health care program to be carried out in connection with the demonstration project covered by the proposal;

(D) include the data and information on which the proposal is based;
(E) describe the services to be provided by the demonstration project;

(F) include an explanation of the factors which make the demonstration project unique;

(G) include an assessment of the costs of the project, including operation and maintenance;

(H) identify and verify the funding sources for such project;

(I) include a schedule for completion of any construction or renovation involved in any demonstration project;

(J) include an assessment of the staffing requirements necessary to carry out such project; and

(K) include a statement or statements from the tribal governments, tribal organizations and any existing health service delivery systems in the area which would be affected by the demonstration project.

(d) AREA OFFICE.—Each Area office receiving a proposal pursuant to subsection (c) of this section shall consider such proposal and submit its comments and recommendations on the proposal to the Secretary.
SEC. 7. APPLICATION SELECTION AND APPROVAL.

(a) CONSULTATION.— The Secretary, after consultation with interested Indian tribes and tribal organizations, shall establish criteria for the consideration and approval of applications submitted under this Act not later than 180 days after enactment. A copy of such criteria shall be published in the Federal Register not later than 180 days after the date of enactment of this Act.

(b) CONGRESSIONAL REVIEW.— Prior to the publication of the criteria referred to in subsection (a) of this section in the Federal Register, the Secretary shall submit a copy thereof to the Senate Select Committee on Indian Affairs and the House Interior Committee. Receipt of such criteria by the Committees shall precede publishing in the Federal Register by 45 days.

(c) REVIEW PANEL.—

(1) The Secretary shall establish a panel or panels to review, evaluate and rank applications. It shall be the function of such panel or panels to advise and make recommendations to the Secretary.

(2) Any panel established pursuant to this subsection shall include at least one member who is a tribal representative, an Indian Health Service employee, an expert in rural health, and an Indian expert in health facility construction and program implementation.

(d) CONSIDERATIONS OF REVIEW.— In reviewing applications the Secretary and the review panels shall consider, among other things, the following:
(1) whether the demonstration project will provide innovative health services to Indian people;

(2) the benefit or benefits to the Indian community in the operation of the demonstration project;

(3) the extent to which health services for Indians will be enhanced as a result of the demonstration project;

(4) whether the project will provide new or expanded services within the existing health care delivery system, including but not limited to, service such as home-based care or swing-bed services;

(5) the combined Indian/non-Indian patient workload in the project service area specifically with reference to average daily patient workloads and the impact of the project on improved quality of care;

(6) the economic viability of the proposed health care delivery or financing system and tribal administrative capability to provide the proposed services;

(7) a determination of the cost benefit ratio of the project, taking into account the patient population workload and improvement in the quality of care;
(8) improved Indian patient access to health care resources and the value of such access in relation to federal funding and the overall health benefits to the Indian tribe;

(9) identification of barriers to the use of state resources;

(10) how the project will integrates with area facility master plans, other national and area strategies for eliminating health deficiencies in accordance with the Indian Health Care Improvement Act and how the project brings about an improvement in the level of need funded under the Indian Health Care Improvement Act;

(11) whatever health care services for the Indian community to be served will be impaired or diminished by the proposed project;

(12) the ability of the Department of Health and Human Services to support functions related to the demonstration project.

SEC. 8. TECHNICAL ASSISTANCE; BRANCH OF HEALTH FACILITIES DEMONSTRATION.

(a) ASSISTANCE.—The Secretary shall provide such technical and other assistance as may be necessary to enable applicants to comply with the provisions of this Act.
(b) BRANCH OF HEALTH FACILITIES DEMONSTRATION.— The Secretary shall establish, within the Indian Health Service, a Branch of Health Facilities Demonstration within the Office of Health Programs, to oversee the demonstration projects established under this Act, and to coordinate the provision of technical assistance to applicants and grantees.

SEC. 9. HEALTH CARE SERVICES FOR INELIGIBLE PERSONS, AND FEDERAL TORT CLAIMS.

For the purposes of this Act —

(a)(1) Any individual who —

(A) has not attained 19 years of age,

(B) is the natural or adopted child, step-child, foster child, legal ward, or orphan of an eligible Indian, and

(C) is not otherwise eligible for the health services provided by the Service, shall be eligible for all health services provided by an approved demonstration project on the same basis and subject to the same rules that apply to eligible Indians until such individual attains 19 years of age. The existing and potential health needs of all such individuals shall be taken into consideration by the Service in determining the need for, or the allocation of, the health resources of the Service. If such an individual has been determined to be legally incompetent prior to attaining 19 years of age, such
individual shall remain eligible for such services until one year after the date
that such disability has been removed.

(2) Any spouse of an eligible Indian who is not an Indian, or who is of
Indian descent but not otherwise eligible for the health services provided by the Service,
shall be eligible, as a class, if the governing body of the Indian tribe of the eligible Indian
has passed by resolution approval for services to the class. The health needs of persons
made eligible under this paragraph shall not be taken into consideration by the Service
in determining the need for, or allocation of, its health resources.

(b)(1) A demonstration project approved pursuant to this Act is authorized
to provide health services under this subsection through health facilities operated directly
by the approved project to individuals who reside within the service area of the project
and who are not eligible for such health services under any other subsection of this section
or under any other provision of law —

(i) the Indian tribe (or, in the case of multi-
tribal service area, all the Indian tribes) served
by such demonstration project by resolution
approves the delivery of health care services to
such individuals, and

(ii) the Secretary and the Indian tribe or tribes
have jointly determined that —

(I) the provision of such health
services will not result in a denial
or diminution of health services to eligible Indians, and

(II) there are no reasonable alternative health facilities or services, within or without the service area of such approved demonstration project, available to meet the health needs of such individuals.

(2)(A) Persons receiving health services provided by the approved demonstration project by reason of this subsection shall be liable for payment for such health services under a schedule of charges approved by the Secretary which, in the judgment of the Secretary, results in reimbursement in an amount not less than the actual cost of providing the health services. Notwithstanding section 1880(c) of the Social Security Act, section 402(c) of this Act, or any other provision of law, amounts collected under titles XVIII and XIX of the Social Security Act, shall be credited to the account of the facility providing the service and shall be used solely for the provision of health services within that facility. Amounts collected under this subsection shall remain available until expended within such facility.

(B) Under paragraph (1), health services may only be provided by an approved demonstration project to an indigent person who would not otherwise be eligible for such health services if an agreement has been entered into with a State or local government
under which the State or local government agrees to reimburse the approved
demonstration project for the expenses incurred by the approved demonstration project
in providing such health services to such indigent person.

(C) An approved demonstration project may provide health services under this
subsection to individuals who are not eligible for health services provided by the project
under any other subsection of this section or under any other provision of law in order to—

(1) achieve stability in a medical emergency,

(2) prevent the spread of a communicable disease or otherwise deal with a
public health hazard,

(3) provide care to non-Indian women pregnant with an eligible Indian’s
child for the duration of the pregnancy through post partum, or

(4) provide care to immediate family members of an eligible person if such
care is directly related to the treatment of the eligible person.

(D) Hospital privileges in health facilities operated and maintained by the
approved demonstration project may be extended to non-service health care practitioners
who provide services to persons described in subsection (a) and (b). Such health care
practitioners may be regarded as employees of the Federal government for purposes of
section 1346(b) and chapter 171 of title 28, United States Code (relating to Federal tort
claims) only with respect to acts or omissions which occur in the course of providing
services to eligible persons as a part of the conditions under which such hospital
privileges are extended.