1985

Evaluation Report on Pawnee Benefit Package Program Pawnee Service Unit for Pawnee Service Unit Health Board

Indian Health Service, Oklahoma Area

JH. Rogers

SW. Edwards

S. Huston

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EVALUATION REPORT
ON
PAWNEE BENEFIT PACKAGE PROGRAM
PAWNEE SERVICE UNIT
FOR
PAWNEE SERVICE UNIT
HEALTH BOARD
BY
DR. JAMES H. ROGERS
DR. STEVEN W. EDWARDS
MS. SHELLEY HUSTON
APRIL 3, 1985
(Final Report July 1985)
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>OBJECTIVE I</td>
<td>3</td>
</tr>
<tr>
<td>Findings</td>
<td>5</td>
</tr>
<tr>
<td>OBJECTIVE II</td>
<td>6</td>
</tr>
<tr>
<td>Findings</td>
<td>15</td>
</tr>
<tr>
<td>OBJECTIVE III</td>
<td>16</td>
</tr>
<tr>
<td>User Survey Findings</td>
<td>23</td>
</tr>
<tr>
<td>Non-User Survey Findings</td>
<td>27</td>
</tr>
<tr>
<td>Provider Survey Findings</td>
<td>30</td>
</tr>
<tr>
<td>OBJECTIVE IV</td>
<td>31</td>
</tr>
<tr>
<td>Findings</td>
<td>38</td>
</tr>
<tr>
<td>RECOMMENDATIONS</td>
<td>40</td>
</tr>
<tr>
<td>APPENDIX</td>
<td></td>
</tr>
<tr>
<td>Scope of Work</td>
<td>43</td>
</tr>
<tr>
<td>PBPP Revision of Benefits</td>
<td></td>
</tr>
<tr>
<td>Letter Dated 1/18/82</td>
<td>48</td>
</tr>
<tr>
<td>Letter Dated 4/9/82</td>
<td>49</td>
</tr>
<tr>
<td>Survey Instrumentation</td>
<td></td>
</tr>
<tr>
<td>Cover Letter for Users and Non-Users</td>
<td>54</td>
</tr>
<tr>
<td>User Survey</td>
<td>55</td>
</tr>
<tr>
<td>Non-User Survey</td>
<td>60</td>
</tr>
<tr>
<td>Cover Letter for Providers</td>
<td>61</td>
</tr>
<tr>
<td>Provider Survey</td>
<td>62</td>
</tr>
<tr>
<td>Alcohol Rehabilitation Treatment Information</td>
<td></td>
</tr>
<tr>
<td>St. Joseph's Alcoholism Rehabilitation Center</td>
<td>64</td>
</tr>
<tr>
<td>St. John's Alcoholism and Chemical Dependency</td>
<td>69</td>
</tr>
<tr>
<td>Services</td>
<td></td>
</tr>
<tr>
<td>Brookwood Recovery Center</td>
<td>78</td>
</tr>
</tbody>
</table>
INTRODUCTION

On June 1, 1981 the Indian Health Service (IHS) closed the Pawnee Indian Hospital in-patient services. The Pawnee Benefit Package Program (PBPP) was instituted to provide contract in-patient and emergency room services to eligible American Indians and their dependents residing in the seven (7) county area of the Pawnee Service Unit.

In December, 1981, at the direction of Congress, the Indian Health Service conducted an evaluation of the PBPP to determine patient utilization and actual costs for the purpose of projecting budget needs. Included in this evaluation was a survey of enrolled users, enrolled non-users and community health care providers to determine feelings and attitudes of these target groups regarding PBPP satisfaction.

An annual report on the PBPP was completed in December, 1982 and submitted to the Oklahoma City Area Indian Health Service. This report did not measure the attitudes of users or non-users of the PBPP but rather concerned itself with data that illustrated the cost effectiveness, population trends, tribal member distribution, and member population characteristics by Tribe.

Since the six (6) months evaluation of the PBPP in December, 1981 and the annual evaluation of the PBPP in December, 1982, there has not been a published report of the PBPP health care delivery system, utilization and costs. There have been significant changes in eligibility of PBPP members, in basic in-patient hospital benefits and a more stringent analysis of member claims. These changes caused concern for the Pawnee Service Unit Health Board and served as the impetus for requesting an evaluation of the PBPP by an independent source.

It is important to acknowledge that the evaluation team of Dr. Jim Rogers, Dr. Steve Edwards and Ms. Shelley Huston received enthusiastic cooperation
from the Kaw, Osage, Pawnee, Ponca, Otoe-Missouria, and Tonkawa Indian Tribal administrators, the PSUHB, the staff members at the Pawnee Indian Health Service Hospital, and the Indian Health Service Area office in Oklahoma City, Oklahoma. Without the support of these individuals and the cooperation of individual tribal members this evaluation would not have been possible.

The scope of study (see appendix) for this evaluation outlined four (4) objectives that the evaluators were to complete. Objective one (1) provided for a meeting between the evaluators and the PSUHB so that a perception of their satisfactions and dissatisfactions could be enumerated.

Objective two (2) asked for the provision of current statistics on population, funding, limitations, and services of the current PBPP as compared to the original scope of the PBPP in 1981, at its inception.

Objective three (3) was concerned with PBPP user, PBPP non-user and PBPP medical provider satisfactions and dissatisfactions regarding the overall efficiency of its administration, funding, ease of use, and program eligibility.

Objective four (4) requested an evaluation of alcoholism treatment and stroke rehabilitation services in the PSU and the feasibility of including these services in the PBPP. This was based on the high incidence of alcohol and drug abuse in the PSU and the restricted PBPP services for rehabilitation.
Objective I

The investigators met with the PSUHB on October 18, 1984 and November 19, 1984 for the purpose of detailing the concerns of tribal leaders in the Pawnee Service Unit area regarding the PBPP. The meetings gave opportunities for the appointed representatives of each tribe to share personal feelings and especially to relay their perception of tribal member areas of concern.

Without question, the issues ranged beyond current PBPP services and included questions and concerns regarding contract Health Services and clinic services. Even though, some of the complaints were not about PBPP benefits or services, it was felt that any changes that might occur to remedy a problem may, in fact, directly relate to future revisions in the PBPP and should be included in this report.

The questions, concerns and problems were classified into the following:

1. PBPP services
   a. A maximum benefit limitation of $25,000.00 per participant per fiscal year.
   b. Past policy delaying scheduled non-emergency in-patient care until the end of the year to take advantage of left over budget.
   c. Questions of how decisions are made for use of excess funds for scheduled non-emergency in-patient care.
   d. Limitation on alcohol program to cover maximum of five day medically approved detoxification.
   e. A wide range of concerns regarding denial of emergency room claims.
   f. A need for the establishment of a communication and education system that will help PBPP members better understand benefits and procedures for claim denial.
g. A definitive statement as to the permanency of the PBPP. Is this program subject to review and change? Is it possible to revert to "old" Pawnee Indian Health Service Hospital concept? If so, what are steps to begin the procedure.

h. Why can't emergency service by m.d. outside of hospital be covered?

2. Pawnee Health Service Clinic
   a. Want the consideration of a full service facility similar to the hospital in operation prior to the PBPP.
   b. Consider expanding clinic hours to include emergency services on weekends and one or two evenings per week day.
   c. Request more tribal input into staffing, budgeting, and capital outlay of the clinic.
   d. Expressed displeasure over lack of tribal input into original decision to implement PBPP.

3. Non PBPP Concerns
   a. Limited clinic hours.
   b. Non-coverage for prescriptive medicine.
   c. Lack of Indian facility for some tribal members is a deterrent to them receiving emergency care.
   d. Long waiting lines in the clinic.
   e. Complaints from some tribal members that non-Indians are using clinic and receiving preference.
   f. A concern over the large number (5687 estimated) of Indians in the Pawnee Service Unit area that are eligible but not enrolled in the PBPP.
   g. Alarm at adding estimated 5687 non-enrolled eligible Indians to the PBPP and its impact on the present budget.
Findings

1. There are significant numbers of Tribal members complaining about reduced emergency care at the Indian Health Service clinics.

2. There are approximately 5,687 eligible Indians in the PSU that are not enrolled in the PBPP.

3. There is dissatisfaction among a segment of the PSU about the elimination of the Pawnee Indian Hospital and many think that this curtails individual Tribal members from receiving emergency care after normal clinic hours.

4. There was general consensus that Tribes do not have adequate input into decisions regarding PBPP, Contract Health Service and clinic operations.
dependent children. The new revision restricts the use of the PBPP to non-Indian females pregnant with an eligible Indian's child. Eligibility is during the period of pregnancy through post-partum, and non-Indian members of an eligible Indian's household whom the IHS Chief Medical Officer determines medical services are necessary to control a communicable disease or a public health hazard.

Funding levels for the PBPP have been based on anticipated need for a growing enrollment of 7,774 in December, 1981; 9,502 in 1982 and an estimated high enrollment of 10,500 during late 1983. Staying within funding allocations (see Table 5) has been achieved by reducing benefits for eligible members and

**TABLE 5**

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Allocation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1982</td>
<td>$3,198,000.00</td>
</tr>
<tr>
<td>1983</td>
<td>3,207,000.00</td>
</tr>
<tr>
<td>1984</td>
<td>3,490,000.00</td>
</tr>
<tr>
<td>1985</td>
<td>4,130,000.00</td>
</tr>
</tbody>
</table>

by revising eligibility requirements to exclude non-Indian spouses and non-Indian children, except under special circumstances.

A cause for alarm among PSUHB members and IHS planners must be the impact of having all the eligible Indians in the PSU area enroll in the program. Even if the current user percentage of 24.1 percent for 1984 is used, the impact of adding an additional 5,000 or more members to the PBPP would place a thinly stretched budget beyond its limits.

A close look at PBPP claimant denials in FY 1983 and 1984 are broken down into five (5) categories (see Table 6) and reflect a substantial amount of savings for the PBPP. If the amount of requests for non-enrolled members was included in 1984, it would represent a ten percent demand on the PBPP budget.
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Eligible but not within medical priorities</td>
<td>564</td>
<td>432</td>
<td>$238,840</td>
<td>$47,350</td>
</tr>
<tr>
<td>2. Eligible but alternate resources available</td>
<td>230</td>
<td>300</td>
<td>$386,104</td>
<td>$434,100</td>
</tr>
<tr>
<td>3. Eligible but inadequate notification</td>
<td>186</td>
<td>128</td>
<td>$80,120</td>
<td>$90,250</td>
</tr>
<tr>
<td>4. Not enrolled</td>
<td>--</td>
<td>543</td>
<td>--</td>
<td>$344,450</td>
</tr>
<tr>
<td>5. Eligible but denied for other reasons</td>
<td>1,105</td>
<td>43</td>
<td>$607,655</td>
<td>$55,905</td>
</tr>
<tr>
<td>TOTALS</td>
<td>2,085</td>
<td>1,446</td>
<td>$1,312,719</td>
<td>$972,055</td>
</tr>
</tbody>
</table>
As can be seen in the above discussion, there is a genuine cause for concern over the financial security of the PBPP and its membership.

Findings

1. The major finding regarding the PBPP membership and user figures is that enrollment peaked between 1981 and 1984 and the PBPP is now serving fewer people than in recent years.

2. Major revisions were made in the original PBPP to reduce services and restrict eligibility.

3. The most significant finding regarding denied claims is the large number of non-enrolled claimants in 1984.
Objective III

Selection of the Samples

The original intent of the survey was to sample a fixed percentage of the seven county tribal membership. The grant application identified total tribal membership at 16,724 members so in order to obtain user and nonuser samples of approximately 500 each, it was determined that approximately 5% of the user and nonuser groups would be sampled via the survey. Subsequently it was determined that there was a substantial difference between tribal membership and actual enrollment in the PBPP. Only 6,845 tribal members were enrolled, about 40% of the tribal membership. Therefore, this original plan was abandoned in favor of selecting approximately 500 users and 500 nonusers directly from the PBPP enrollment lists. Mr. Terry Rice and a computer programmer, Mr. Dave Selby, both at I.H.S. in Oklahoma City provided a list of 412 and 515 users and nonusers respectively of the PBPP. These subjects were selected at random from the enrollment lists and comprised approximately 25% of the enrolled users and 10% of the enrolled nonusers.

Subsequently, the Pawnee Service Unit staff provided a list of provider vendors who had participated in the recent year's PBPP. Since the list only contained 153 providers, it was decided to survey them all.

Table 1 displays the PBPP cardholders and the user and nonuser samples selected for the survey portion of the evaluation.

<table>
<thead>
<tr>
<th>Tribe</th>
<th>Cardholders</th>
<th>User Sample</th>
<th>Nonuser Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kaw</td>
<td>195</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Osage</td>
<td>1,390</td>
<td>79</td>
<td>101</td>
</tr>
<tr>
<td>Otoe-Missouria</td>
<td>523</td>
<td>34</td>
<td>41</td>
</tr>
<tr>
<td>Pawnee</td>
<td>859</td>
<td>72</td>
<td>61</td>
</tr>
<tr>
<td>Ponca</td>
<td>918</td>
<td>71</td>
<td>66</td>
</tr>
<tr>
<td>Tonkawa</td>
<td>65</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Non-Indians/Others</td>
<td>2,895</td>
<td>146</td>
<td>233</td>
</tr>
<tr>
<td>Totals</td>
<td>6,845</td>
<td>412</td>
<td>515</td>
</tr>
</tbody>
</table>
The User Survey

During February, 1985 each of the user subjects was mailed a Health Care Questionnaire (see appendix for copy), a cover letter explaining the purpose of the survey, and a stamped, return envelope. Three weeks after the initial mailing, a follow-up mailing was conducted wherein each nonresponder received materials identical to the first mailing. The final return rate was 189 out of 412 users or approximately 46% of the sample.

Tabulation of the responses to the survey can be found below. The percentages listed represent the actual percent of usable responses for each question. Missing data may have occurred for one of the following reasons; the questionnaire was returned without being completed, selected questions on the questionnaire may have been omitted by the respondent, or the response to a question was ambiguous or unintelligible.

<table>
<thead>
<tr>
<th>Question</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Not Sure</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have thoroughly read the PBPP booklet.</td>
<td>10%</td>
<td>70%</td>
<td>15%</td>
<td>3%</td>
<td>3%</td>
</tr>
<tr>
<td>When I use the I.D. card, I go to the hospital closest to my home even though I can go to any hospital.</td>
<td>23%</td>
<td>61%</td>
<td>8%</td>
<td>6%</td>
<td>2%</td>
</tr>
<tr>
<td>I like the new PBPP using community hospitals better than the former Pawnee Indian Hospital contract.</td>
<td>32%</td>
<td>49%</td>
<td>9%</td>
<td>5%</td>
<td>6%</td>
</tr>
<tr>
<td>I am satisfied with the clinic hours at the local IHS clinic.</td>
<td>11%</td>
<td>57%</td>
<td>10%</td>
<td>14%</td>
<td>9%</td>
</tr>
<tr>
<td>I know who to contact if I have questions concerning the PBPP.</td>
<td>13%</td>
<td>60%</td>
<td>18%</td>
<td>6%</td>
<td>3%</td>
</tr>
<tr>
<td>I use my third party insurance more than the PBPP.</td>
<td>4%</td>
<td>25%</td>
<td>14%</td>
<td>38%</td>
<td>18%</td>
</tr>
<tr>
<td>When I go to the clinic, non-Indians seem to have priority.</td>
<td>9%</td>
<td>21%</td>
<td>20%</td>
<td>29%</td>
<td>21%</td>
</tr>
</tbody>
</table>
8. The new PBPP card makes it easier for me to receive hospital care closer to home.  
   | Strongly Agree | Agree | Not Sure | Disagree | Strongly Disagree |
   | 25% | 59% | 9% | 3% | 4% |

9. I feel that I receive better care in private hospitals than the former Pawnee Indian Hospital.  
   | 26% | 34% | 25% | 9% | 6% |

10. The services covered by the PBPP cover most all hospital medical needs.  
    | 12% | 53% | 17% | 14% | 5% |

11. The services covered by the PBPP cover most all emergency room medical needs.  
    | 13% | 55% | 14% | 13% | 5% |

12. I would like to have the clinic open until 8:30 p.m. one evening a week.  
    | 26% | 44% | 15% | 11% | 3% |

13. I would like to have the clinic open Saturday morning from 9:00 a.m. until noon.  
    | 30% | 42% | 16% | 10% | 1% |

14. I am satisfied with the overall PBPP.  
    | 14% | 57% | 17% | 9% | 4% |

15. City of Residence | % Responding | County of Residence | % Responding |
---------------------|--------------|---------------------|--------------|
Hominy               | 11.7         | Osage               | 37.4         |
Cushing             | 5.5          | Payne               | 17.2         |
Osage               | .6           | Pawnee              | 12.3         |
Pawnee              | 8.6          | Kay                 | 22.7         |
Tonkawa             | .6           | Noble               | 5.5          |
Fairfax             | 9.2          | Garfield            | 4.3          |
Ponca City          | 17.2         | Oklahoma            | .6           |
Blackburn           | 1.2          |                     |              |
Stillwater          | 5.5          |                     |              |
Pawhuska            | 10.4         |                     |              |
Red Rock            | 3.1          |                     |              |
Wynona              | 3.1          |                     |              |
Ft. Oakland         | .6           |                     |              |
Carrier             | .6           |                     |              |
Perkins             | 3.1          |                     |              |
Yale                | 2.5          |                     |              |
Skiatook            | .6           |                     |              |
Newkirk             | 1.2          |                     |              |
Perry               | .6           |                     |              |
Kremlin             | .6           |                     |              |
Enid                | 3.1          |                     |              |
Marland             | 1.2          |                     |              |
Kaw City            | .6           |                     |              |
Blackwell           | 2.5          |                     |              |
Terlton             | .6           |                     |              |
Cleveland           | 1.2          |                     |              |
Prue                | .6           |                     |              |
Ralston             | 1.2          |                     |              |
Ripley              | .6           |                     |              |
White Eagle         | .6           |                     |              |
Edmond              | .6           |                     |              |
Shidler             | .6           |                     |              |
16. Age in Years

<table>
<thead>
<tr>
<th>Age Range</th>
<th>% Present</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-10</td>
<td>19%</td>
</tr>
<tr>
<td>11-20</td>
<td>8%</td>
</tr>
<tr>
<td>21-30</td>
<td>20%</td>
</tr>
<tr>
<td>31-40</td>
<td>13%</td>
</tr>
<tr>
<td>41-50</td>
<td>8%</td>
</tr>
<tr>
<td>51-60</td>
<td>15%</td>
</tr>
<tr>
<td>61-70</td>
<td>13%</td>
</tr>
<tr>
<td>71-80</td>
<td>7%</td>
</tr>
<tr>
<td>81-90</td>
<td>2%</td>
</tr>
</tbody>
</table>

Average age: 35.9 years

17. Are you currently employed? 26% Yes 60% No 14% Retired

18. Have you ever used the Pawnee Benefit Package Program? 96% Yes 4% No

19. Would you use the program on a more regular basis if you understood it better? 78% Yes 22% No

20. What would be most helpful to you in learning about the benefit program?
   a. Workshop by tribe. 9%
   b. Individual explanations (conference with each user). 11%
   c. Written material with details. 33%
   d. Someone to explain the program when I have problems. 47%

Note: 158 respondents, 40 with multiple answers yielding 207 total responses.

21. What would you recommend that the Indian Health Service do with the program?
   a. Leave it as it is now. 23%
   b. Drop the program. 0%
   c. Make changes in how the program is administered (how payments are made and what is an approved expenditure). 21%
   d. Improve the existing medical services. 32%
   e. Reopen the hospital. 12%
   f. Other (please specify): 

Note: 158 respondents, 37 with multiple answers yielding 217 total responses.

Other Category

<table>
<thead>
<tr>
<th>Comment</th>
<th># of Comments</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Form an alcohol detoxification and treatment program.</td>
<td>1</td>
<td>4%</td>
</tr>
<tr>
<td>Be open on weekends or in the evening.</td>
<td>1</td>
<td>4%</td>
</tr>
<tr>
<td>Have more friendly personnel in the clinics and doctor's office.</td>
<td>1</td>
<td>4%</td>
</tr>
<tr>
<td>Have better health care.</td>
<td>3</td>
<td>12%</td>
</tr>
<tr>
<td>Have better service in the clinics and doctor's offices.</td>
<td>4</td>
<td>17%</td>
</tr>
<tr>
<td>Make payments sooner.</td>
<td>5</td>
<td>21%</td>
</tr>
<tr>
<td>Have expanded PBPP coverage.</td>
<td>6</td>
<td>25%</td>
</tr>
<tr>
<td>Explain the package better.</td>
<td>3</td>
<td>12%</td>
</tr>
</tbody>
</table>
22. Do you have health insurance other than the Pawnee Benefit Package Program?  
   33% Yes   67% No

23. If you answered "yes", what type of insurance do you have?  
   48% a. Group insurance through place of employment.  
   11% b. Private policy insurance.  
   6% c. Medicaid insurance benefits.  
   28% d. Medicare insurance benefits.  
   8% e. Other (please write the specific type of insurance):   
   Other Category: 2 responses: Champus and VA.

24. Were you covered by an insurance policy before accepting the Pawnee Benefit Package Program? 25% Yes 75% No

25. How did you hear about the Pawnee Benefit Package Program?  
   23% a. Community Health Representative (CHR)  
   19% b. Tribal official  
   31% c. Another tribal member  
   3% d. Newspaper article  
   24% e. Other (please specify):   
   Other Category: 161 respondents, 6 with multiple answers yielding 171 total responses.

<table>
<thead>
<tr>
<th>Comment</th>
<th># of Comments</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Received notice by mail.</td>
<td>11</td>
<td>32%</td>
</tr>
<tr>
<td>Heard from relatives.</td>
<td>9</td>
<td>26%</td>
</tr>
<tr>
<td>The hospital or clinic.</td>
<td>13</td>
<td>38%</td>
</tr>
<tr>
<td>Heard from a friend.</td>
<td>1</td>
<td>3%</td>
</tr>
</tbody>
</table>

26. How many months have you had your identification card?  
   Average: 30.2 months
   Range: 3-60 months

27. When you signed up for a card, what kind of information did you receive?  
   68% a. Written material  
   19% b. Written material and a verbal explanation  
   7% c. A verbal explanation only  
   5% d. None

28. Is the program meeting all your health needs? 66% Yes 34% No
29. How well do you feel that you understand the program and how it works (how to get services, what will be paid for and how payment is made)?
   20% a. I have no problems understanding the program.
   11% b. I do not understand about emergencies.
   31% c. I do not understand what is payable and what is not payable with this program.
   26% d. I thought this program would pay for all my health needs.
   11% e. I thought that I did not need other insurance if I signed up for this program.
   1% f. I do not understand anything about this program.
   0% g. I have never used the program because I do not understand the way it works.

Note: 155 respondents, 49 with multiple answers yielding 239 total responses.

30. Has the Pawnee, White Eagle or Pawhuska Indian Clinic being closed on weekends been an inconvenience to you? 56% Yes 44% No

31. Have the number of doctors available to you at the Pawnee, White Eagle or Pawhuska Indian Clinic been an inconvenience or problem to you? 50% Yes 50% No

32. Have you received all your necessary medication or prescriptions that you are entitled to under the PBPP program? 55% Yes 29% No 16% Haven't required medication

33. Would you say that your health in general in comparison to others of your age is: (check one)
   12% Excellent
   25% Very Good
   30% Good
   24% Fair
   9% Poor

34. Have you paid out-of-pocket for any health service, medications, or supplies in the past 30 days? 52% Yes 48% No

If you answered "yes", please describe what type of services or supplies you paid for and approximately what it cost you.

There were 81 respondents who indicated some out-of-pocket payment in the last 30 days. A summary of their comments follows.

1. Fifty respondents indicated that they had paid for medication and 32 cited a dollar amount which averaged $37.44 (range = $4.00 to $150.00).

2. Eleven respondents indicated that they had paid for doctor services and six cited a dollar amount which averaged $92.50 (range = $20.00 to $350.00). Also two people cited doctor visits and bills which totalled $2,500.00 and $4,600.00 respectively.
3. Nineteen respondents indicated that they had paid for both medication and doctor services. Twelve respondents cited a dollar amount for medication which averaged $25.83 (range = $9.00 to $46.00) and the doctor services averaged $48.00 (range = $20.00 to $170.00). One respondent paid a medication bill of $5.00 and doctor bills totalling $2,500.00.

4. Three respondents indicated that they had paid for medication and doctor services which together totalled $120.00, $200.00 and $500.00 respectively.

Comment Section

Users responded to the open-ended comment section of the instrument. Listed below is a summary of their comments with an example of each taken from a questionnaire.

<table>
<thead>
<tr>
<th>Comment Category</th>
<th># of Comments*</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Positive and negative comments about the PBPP.</td>
<td>45</td>
<td>27%</td>
</tr>
<tr>
<td>2. Negative comments about the hospital or doctors.</td>
<td>46</td>
<td>28%</td>
</tr>
<tr>
<td>3. Confusion about the program.</td>
<td>28</td>
<td>17%</td>
</tr>
<tr>
<td>4. Requests for clinic hours on evenings or weekends.</td>
<td>12</td>
<td>7%</td>
</tr>
<tr>
<td>5. Negative comments on dental care.</td>
<td>6</td>
<td>4%</td>
</tr>
<tr>
<td>6. Questions about non-Indian spouse coverage in the PBPP.</td>
<td>5</td>
<td>3%</td>
</tr>
<tr>
<td>7. Statements suggesting a new facility with good doctors in a new location.</td>
<td>11</td>
<td>6%</td>
</tr>
<tr>
<td>8. Requests to re-open the old hospital.</td>
<td>3</td>
<td>2%</td>
</tr>
<tr>
<td>9. General comments.</td>
<td>12</td>
<td>7%</td>
</tr>
</tbody>
</table>

*Some respondents gave multiple answers.

In addition to the 113 respondents who made comments, 50 respondents returned questionnaires without making any comment. Thus, 31% of the respondents made no comment.

The following section cites an example of each of the comment categories from above. The comments were taken directly from questionnaires but do not represent direct quotes.
Category #1 - The PBPP is a good program. I am satisfied with it. I have no trouble with the PBPP. I am satisfied with the emergency room treatment.

- PBPP does not pay for medications bought at personal pharmacy.

Category #2 - Have to wait too long at the clinic from time of check-in to seeing a doctor.

- Not always medication that's needed is on hand at the clinic pharmacy.

- The staff at the clinic is unfriendly and impatient. I want a staff that works well with the public.

Category #3 - I do not understand the program areas of what is paid for and what is not paid for. I do not understand where I can and cannot go for treatment and what is and is not considered an emergency.

Category #4 - There should be clinic hours on weekends and evenings for people who work and doctors should be available on weekends.

Category #5 - There is an inadequate dental program. There is a two year waiting list.

Category #6 - I want to know if non-Indian spouses are covered.

Category #7 - I want a new facility with good doctors in a new location.

Category #8 - Re-open the hospital.

Category #9 - Small tribes are not adequately qualified to manage the health facilities.

- The people were helpful and friendly.

Findings

1. Users tend to go to the hospital closer to home and like the community hospitals better than the old hospital.

2. Most of the users were not covered by insurance before using the program and they still rely on the program rather than third party insurance.

3. Most of the users do not feel that non-Indians have priority at the clinics.

4. 65% of the users feel that most of their hospital medical needs are covered by the program.
5. 68% of the users feel that most of their emergency room needs are covered by the program.

6. Most of the users would like the clinic open until 8:30 p.m. one evening per week as well as on Saturday from 9:00 a.m. until noon.

7. 71% of the users are satisfied with the overall program.

8. 78% of the users said they would use the program on a more regular basis if they understood it better. The two most cited suggestions for learning about the program are: (1) having someone to explain the program when problems arise and (2) having written material with details.

9. Most of the users felt that the program should improve existing medical services and make some changes in how the program should be administered. 23% of the users indicated to leave the program as it is.

10. Approximately one-third of the users felt that their health needs were not being met by the program. This might be due to: clinic hours unsuitable, having to pay for medical care including medications and supplies, or having too few doctors available.
The Nonuser Survey

The nonuser survey was mailed using exactly the same procedures as described for the User Survey previously (see appendix for copy). Similarly, the percentages listed below represent the actual percent of usable responses for each question.

For the nonuser survey, the final return rate was 303 out of 515 nonusers. This is a return rate of approximately 59%.

Below each response is the response which was obtained on the same question during the original evaluation of the PBPP published in December, 1981.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do you have a PBPP I.D. card for each of your eligible family members?</td>
<td>82%</td>
<td>18%</td>
</tr>
<tr>
<td></td>
<td>(72%)</td>
<td>(28%)</td>
</tr>
<tr>
<td>2. Have you read your copy of the PBPP booklet?</td>
<td>91%</td>
<td>9%</td>
</tr>
<tr>
<td></td>
<td>(94%)</td>
<td>(6%)</td>
</tr>
<tr>
<td>3. Do you understand what the program can and cannot pay?</td>
<td>82%</td>
<td>18%</td>
</tr>
<tr>
<td></td>
<td>(88%)</td>
<td>(12%)</td>
</tr>
<tr>
<td>4. Do you have a Third Party medical insurance?</td>
<td>25%</td>
<td>75%</td>
</tr>
<tr>
<td></td>
<td>(24%)</td>
<td>(16%)</td>
</tr>
<tr>
<td>5. When you use your card in the future, will you go to the hospital closer to your home although you have the option of going to any hospital you choose?</td>
<td>84%</td>
<td>16%</td>
</tr>
<tr>
<td></td>
<td>(93%)</td>
<td>(7%)</td>
</tr>
<tr>
<td>6. Although you have not used your I.D. card, would you prefer the Pawnee Indian Hospital to be reopened?</td>
<td>53%</td>
<td>47%</td>
</tr>
<tr>
<td></td>
<td>(45%)</td>
<td>(55%)</td>
</tr>
<tr>
<td>7. Was the application for the PBPP I.D. card a problem for you to fill out?</td>
<td>16%</td>
<td>84%</td>
</tr>
<tr>
<td></td>
<td>(5%)</td>
<td>(95%)</td>
</tr>
<tr>
<td>8. When you made application, did you have your Certificate of Degree of Indian Blood?</td>
<td>95%</td>
<td>5%</td>
</tr>
<tr>
<td></td>
<td>(94%)</td>
<td>(6%)</td>
</tr>
<tr>
<td>9. Do you think the services covered by the PBPP cover most all emergency medical needs?</td>
<td>78%</td>
<td>22%</td>
</tr>
<tr>
<td></td>
<td>(91%)</td>
<td>(9%)</td>
</tr>
<tr>
<td>10. Were you aware that only residents in the seven (7) county service area are eligible to receive the PBPP I.D. card?</td>
<td>70%</td>
<td>30%</td>
</tr>
<tr>
<td></td>
<td>(84%)</td>
<td>(16%)</td>
</tr>
<tr>
<td>11. Do you know who to contact if you have any questions concerning the PBPP?</td>
<td>72%</td>
<td>28%</td>
</tr>
<tr>
<td></td>
<td>(61%)</td>
<td>(39%)</td>
</tr>
</tbody>
</table>
Comment Section

Nonusers responded to the open-ended comment section of the instrument.

Listed below is a summary of their comments with an example of each taken from a questionnaire.

<table>
<thead>
<tr>
<th>Comment Category</th>
<th># of Comments</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Questions about the PBPP or requests for information about the PBPP.</td>
<td>14</td>
<td>12%</td>
</tr>
<tr>
<td>2. Comments which pertain to the hospital or doctor services.</td>
<td>23</td>
<td>20%</td>
</tr>
<tr>
<td>3. Comments regarding a question on the survey instrument itself.</td>
<td>9</td>
<td>8%</td>
</tr>
<tr>
<td>4. General comments.</td>
<td>34</td>
<td>29%</td>
</tr>
<tr>
<td>5. Non-Indian spouse eligibility questions or comments.</td>
<td>4</td>
<td>3%</td>
</tr>
<tr>
<td>6. Nonuse of PBPP benefits because of good health.</td>
<td>33</td>
<td>28%</td>
</tr>
</tbody>
</table>

In addition to the 117 respondents who made comments, 164 respondents returned questionnaires without making any comment. Thus, 58% of the respondents made no comments.

The following section cites an example of each of the comment categories from above. The comments were taken directly from questionnaires but do not represent direct quotes.

Category #1 - Our PBPP card is about to expire, will we be sent new ones?
  - Our recent fire destroyed my family's I.D. cards and PBPP booklets. Please forward your most recent information regarding this program.

Category #2 - Calling for an appointment, they said to report the next day at 8:00 a.m. I reported before 8:00 a.m. The doctor arrived at 9:15 a.m. Two women, one on each side of me, told me that it was their third trip to sit and wait all day.

Category #3 - The question #6 is a little confusing to me...I say yes, the Pawnee Hospital should be opened if the facility meets the needs of the people. I think the PBPP is really nice, I believe it meets my needs.
Category #4 - We are very thankful for the use of this program and the people and efforts put into it.

Category #5 - I would like to see our White spouses put back into the program.

Category #6 - Fortunately, I haven't needed hospitalization. However, when need be, I will most certainly use the PBPP card.

Findings

1. Nonusers tend to have cards for their eligible family members, read the information booklet and understand what the program can and cannot pay.

2. Only 25% of the nonusers have third party insurance.

3. 53% of the nonusers preferred the old hospital to be re-opened.

4. 78% of the nonusers felt that the program covered most all of their emergency room needs.

5. Most of the users had no difficulty filling out the enrollment forms and they know who to contact with questions about the program.

6. 12% of the nonusers indicated that they had failed to use the program due to good health.

7. These findings compare favorably with the original evaluation published in 1981. There were no wholesale changes in opinion evident when comparing evaluations.
The Medical Provider Survey

The medical provider survey was mailed using exactly the same procedures as described for the User Survey previously (see appendix for copy). Similarly, the percentages listed below represent the actual percent of usable responses for each question.

For the medical provider survey, the final return rate was 85 out of 153. This is a return rate of approximately 56%.

Below each response is the response which was obtained on the same question during the original evaluation of the PBPP published in December, 1981.

1. Do you like the PBPP using community hospitals better than the old contract health care system?  
   - Yes: 98%  
   - No: (96%)  

2. Are you receiving reimbursement for service quicker under the new system versus the old contract health system?  
   - Yes: 88%  
   - No: (97%)  

3. Do the cards and the Benefit Package system make it easier for you to understand what will or will not be paid?  
   - Yes: 83%  
   - No: (92%)  

4. Does the PBPP improve your relationship with the Pawnee Service Unit?  
   - Yes: 94%  
   - No: (6%)  

5. Does the PBPP improve your relationship with the Indian patient?  
   - Yes: 88%  
   - No: (12%)  

6. If you had a choice, would you like to see the entire Indian Health Service Contract Health Program under the automated, I.D. card system?  
   - Yes: 89%  
   - No: (96%)  

7. In your opinion, do you think that the PBPP would be better served if administered by a health group plan such as Blue Cross?  
   - Yes: 14%  
   - No: 86%
Comment Section

Medical providers responded to the open-ended comment section of the instrument. Listed below is a summary of their comments with an example of each taken from a questionnaire.

**Comment Category**

<table>
<thead>
<tr>
<th>Comment Category</th>
<th># of Comments</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Positive and negative evaluations of the PBPP.</td>
<td>22</td>
<td>71%</td>
</tr>
<tr>
<td>2. Suggestions offered for the PBPP.</td>
<td>3</td>
<td>10%</td>
</tr>
<tr>
<td>3. Questions about the PBPP.</td>
<td>1</td>
<td>3%</td>
</tr>
<tr>
<td>4. Negative comments about Blue Cross or third party insurance.</td>
<td>5</td>
<td>16%</td>
</tr>
</tbody>
</table>

In addition to the 31 respondents who made comments, 51 respondents returned the questionnaires without making any comment. Thus, 62% of the respondents made no comments.

The following section cites examples of each of the comment categories from above. The comments were taken directly from questionnaires.
Comment Section

Medical providers responded to the open-ended comment section of the instrument. Listed below is a summary of their comments with an example of each taken from a questionnaire.

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<td>10%</td>
</tr>
<tr>
<td>3. Questions about the PBPP.</td>
<td>1</td>
<td>3%</td>
</tr>
<tr>
<td>4. Negative comments about Blue Cross or third party insurance.</td>
<td>5</td>
<td>16%</td>
</tr>
</tbody>
</table>

In addition to the 31 respondents who made comments, 51 respondents returned the questionnaires without making any comment. Thus, 62% of the respondents made no comments.

The following section cites examples of each of the comment categories from above. The comments were taken directly from questionnaires but do not represent direct quotes.

Category #1 - We have been very happy with the PBPP and the information and assistance given to us.

- We don't have that many patients from the PBPP, the ones we have had don't pay that much. One patient was very unhappy with his coverage.

Category #2 - It is easier for hospital procedures to be billed by this card system but much better to have personal individual communication for required office procedures due to the variety of possible needs of individual patients.

Category #3 - I am a participating member of this group. Can you advise me the procedure to follow when we find it necessary to care for the Indian patient using this facility?

Category #4 - I would never consider Blue Cross for a plan. It would cause more problems leading ultimately to less care for the Indians.
Findings

1. The medical providers like the new PBPP system better than the old contract health care system. They receive reimbursement quicker and understand better what will and will not be paid.

2. The medical providers feel that the program improves their relationship with the Pawnee Service Unit and Indian patients.

3. 89% of the medical providers would prefer that the entire IHS contract health program be under the automated, I.D. card system.

4. The medical providers are not in favor of having the PBPP be administered by a group health plan such as Blue Cross.

5. These findings compare favorably with the original evaluation published in 1981. There were no wholesale changes in opinion evident when comparing evaluations.
After the ten (10) week program is completed, a three (3) month after care program consisting of individual counseling for one (1) hour every two (2) weeks is recommended.

The TTAP had contacts with 128 individual clients for a total contact number of 591 times. TTAP referred 57 individuals to medical detoxification and accepted 84 new clients into the program.

The situation has changed dramatically since January 1985. The Tribes in the PSU have expressed concern over the efficiency of the TTAP and two Tribes, the Osage and Pawnee, have received funding to initiate out-patient services in their tribal area. The TTAP has not received an annual budget and currently is operating on a month to month basis. Staff members are unsure of future funding and this has caused the TTAP client to counselor ratio to be reduced significantly. TTAP feels that they have not had enough IRS assistance and that the TTAP is close to being terminated.

2. **Native American Women's Alcohol Rehabilitation Center (NAWARC)**

The NAWARC is a ten (10) bed residential facility that is staffed by eight (8) persons, including a director and two counselors. Normal services include a sixty (60) day resident program with the possibility of a half-way house situation for two (2) individuals upon request.

The Center is certified by the State of Oklahoma as an Alcohol Treatment Facility and served 85 clients in an in-patient/out-patient capacity in 1981; 86 clients in an in-patient/out-patient capacity in 1982; 54 in-patient clients in 1983 with a recidivism rate of 15 percent; and 66 in-patient clients in 1984 with a recidivism rate of 11 percent.

Budget increases have been modest. The 1983 budget was $165,300; the 1984 budget was $178,313; and the 1985 budget is $187,585.

There is a need for additional space to allow for individual, confidential counseling. Multiple use of current space does not provide an adequate environment for effective counseling.
Out-patient services for women have been lacking from the TTAP and this has forced the NAWARC to conduct limited out-patient programs to try and meet this need. An additional counselor is needed to meet this expanded service.

3. Social Development Center (SDC)

The SDC is a ten (10) bed primary care facility for men. The program consists of a thirty (30) day non-medical detoxification program followed by a thirty (30) day rehabilitation program. An additional thirty (30) days in a half-way house status is possible upon request and space availability.

The SDC has expanded its services to include out-patient counseling and has had case loads of 108 in-patient and 20 out-patient clients in 1981; 100 in-patient and 45 out-patient clients in 1982; 112 in-patient and 24 out-patient clients in 1983; and 110 in-patient and 8 out-patient clients in 1984. The recidivism rate has been very low with only sixteen (16) returning clients during the past four (4) years. This can partially be explained by the standard procedure of sending patients to rehabilitation programs in different parts of the state.

The SDC has received IHS funding in the amount of $130,879.00 in 1981 and $131,746.00 in 1982. This amount was increased to $136,468.00 in 1983 and $155,191.00 in 1984. The current budget for 1985 is $163,261.00.
TABLE I

Comparison of Budgets and Case Loads Between Native American Women's Alcohol Rehabilitation Center and Social Development Center, 1981-1985

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>SDC</td>
<td>$165,300</td>
<td>$178,313</td>
<td>$187,585</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>NAWARC</td>
<td>$130,879</td>
<td>$131,746</td>
<td>$136,400</td>
<td>$155,191</td>
<td>$163,261</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>In-Patient Case Load</th>
<th>1981</th>
<th>1982</th>
<th>1983</th>
<th>1984</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>SDC</td>
<td>108</td>
<td>100</td>
<td>112</td>
<td>110</td>
</tr>
<tr>
<td></td>
<td>NAWARC</td>
<td>85*</td>
<td>86*</td>
<td>54</td>
<td>66</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>SDC</td>
<td>20</td>
<td>45</td>
<td>24</td>
<td>8</td>
</tr>
</tbody>
</table>

*Includes in-patient and out-patient numbers.

Each of the alcohol treatment programs expressed concern over the lack of supervision and assistance from the Oklahoma City area office. The communication system is less than adequate and there is lack of information and data (computer) from IHS. Each felt that greater efforts should be made to promote the residential treatment centers and that increased funding was needed.

The investigator reviewed the Valley Hope Alcoholism Treatment Center, the Brookwood Recovery Center, The St. John's Alcoholism and Chemical Dependency Center, and the St. Joseph's Alcohol Rehabilitation Center to ascertain the feasibility of implementing an alcohol rehabilitation agreement with one of the programs.
1. Brookwood Recovery Center (BRC)

The BRC is located in Tulsa, Oklahoma and is Joint Commission for Accreditation of Hospitals (JCAH) certified. This medically supervised facility provides medical detoxification and a 28 day rehabilitation program with a two (2) year after care component included for a total cost of $7,800.00 per person. This plan also includes twice a week family counseling.

The BRC specializes in opiate and cocaine detoxification and charges $11,000.00 for a 42 day drug rehabilitation program. It is a 40 bed facility in an attractive and professional setting. The BRC is agreeable to negotiating special rates for contractual services (see appendix).

2. Valley Hope Alcoholism Treatment Center (VHATC)

The VHATC in Cushing, Oklahoma is a 60 bed treatment facility that provides a 30 day non-medical detoxification and alcohol rehabilitation program.

The VHATC has fees of $97.00 per day and clients average 30 days per treatment period. The total cost of $3,000.00 includes a medical examination and all services. Spouses and families are encouraged to stay with the patient and may do so for an extra fee of $95.00 per day.

The VHATC has excellent facilities and maintains active communications with local and state referral agencies. They have one or two Indians on the program throughout the year and have had success in working with this cultural difference.

There is an after care program that maintains contact with each client through newsletters and personal contacts throughout the life of the recovering alcoholic.

3. St. John's Alcoholism and Chemical Dependency Center (SJACDC)

The SJACDC is located in St. John's Hospital in Tulsa, Oklahoma. The JCAH approved medical detoxification and alcoholism center provides a variable after care program that normally lasts for one (1) year. The center accepts
all ages and problems with the exclusion of psychiatric disorders.

The program costs an average of $6,987.00 to $7,563.00 depending on the number of days of medical detoxification required.

The SJACDC is an excellent facility and would provide ancillary medical services for those individuals with special health needs (see appendix).

4. St. Joseph's Alcoholism Rehabilitation Center (SJARC)

The SJARC is located in Ponca City, Oklahoma and is an integral part of St. Joseph's Hospital. The JCAH approved program excludes individuals under the age of 18 and without psychiatric disorders.

There is an all inclusive cost of $1,150.00 for medical detoxification regardless of number of days required. The standard 28 day rehabilitation program costs $6,600.00 and includes a two (2) year after care program.

This program is in close proximity to the Tonkawa, Kaw, Ponca, Pawnee, and Otoe-Missouria Tribes and is willing to negotiate a reduced rate for a contractual agreement (see appendix).
Table II
Comparison of Alcoholism Rehabilitation Programs

<table>
<thead>
<tr>
<th>Program</th>
<th>BRC</th>
<th>VHATC</th>
<th>SJACDC</th>
<th>SJARC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Length of Stay (days)</td>
<td>28</td>
<td>30</td>
<td>30</td>
<td>28</td>
</tr>
<tr>
<td>Cost</td>
<td>$7,800</td>
<td>$3,000</td>
<td>$6,987*</td>
<td>$6,600*</td>
</tr>
<tr>
<td>Medical Detoxification</td>
<td>yes</td>
<td>no</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>Non-Medical Detoxification</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>After Care</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>Joint Commission for Accreditation of Hospitals Certification</td>
<td>yes</td>
<td>no</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>Willingness to reduce fees through contractual agreement with PBPP</td>
<td>yes</td>
<td>no</td>
<td>no</td>
<td>yes</td>
</tr>
</tbody>
</table>

*Does not include medical detoxification costs, if needed.

A second area that was included in the scope of study was to determine the feasibility of a rehabilitation program for stroke victims. Presently the PBPP does not offer any financial assistance for stroke rehabilitation. Individuals in the PSU area are responsible for their own expenses and are using the O'Donahue Diagnostic and Rehabilitation Center in Oklahoma City and the Jane Phillips Memorial Hospital in Bartlesville for rehabilitation services.

The costs of these programs average $300.00 plus per day and often exceed $10,000.00 per month. The prohibitive costs makes it difficult to enter into any agreement with a medical facility for these services. A more appropriate function of the PBPP may be the consideration of providing rehabilitation benefits for individuals suffering closed head injuries and spinal cord injuries as a result of accidents.
The advancing concept in hospitals of Diagnostic Related Groupings (DRG) which set a fee structure for specific services which may include several hospital functions may expand to include rehabilitation, out-patient counseling and physical therapy.

The IHS should include, in its planning, the impact of DRG procedures in participating hospitals in the PBPP service area.

Findings

1. IHS area office is not furnishing monthly, quarterly or annual computer feedback on programs.

2. Impossible to determine exact figures in the incidence of alcoholism in the PBPP area but each rehabilitation center expressed a concern for the high (IHS uses 28% figure) incidence among all ages of alcoholism and inhalant abuse.

3. The Tonkawa Tribal Alcoholism Program is ineffectual due to uncertainty of funds and commitment.

4. The Native American Women's Alcohol Rehabilitation Center is in need of space to provide counseling services.

5. The Native American Women's Alcohol Rehabilitation Center and the Social Development Center have been forced to undertake greater responsibilities for out-patient. The impact of this demand should be analyzed to determine staff needs for the future. This is especially true if the Tonkawa Tribal Alcoholism Program is dissolved.

6. There are alcoholism rehabilitation centers in the PSU area that are interested in negotiating reduced rates for specified contractual services with the PBPP.

7. The Valley Hope Alcoholism Treatment Center has a significantly lower cost program and has had success working with Indians.
8. The present costs of providing rehabilitation programs for stroke victims appears to be prohibitive for the PBPP. However, consideration of rehabilitation for closed head injuries and spinal cord injuries due to accidents should be explored.
RECOMMENDATIONS

1. That the PSUHB should be notified of any pending changes in PBPP benefits, services and eligibility requirements and have ample opportunity to provide feedback from each tribe prior to implementation.

2. That the PBPP consider implementing a 24 hour "hot line" for providing information to members and providers about non-scheduled emergency requests.

3. That an aggressive enrollment and education campaign should be initiated and maintained to bring PBPP memberships into line with total eligible tribal membership.

4. That the IHS should make a concerted effort to increase the PBPP funding level in anticipation of the expanded enrollment.

5. That the PBPP should develop an evaluation form that would be used throughout the year by each user to provide feedback as to the quality of care.

6. That the PBPP develop a newsletter to be distributed periodically to each members' family in order to improve communications and public relations.

7. That, even though the satisfaction level of participants is moderately high, the substantial number of participants that are dissatisfied with various aspects of the PBPP indicate that an on-going evaluation should be implemented and maintained.

8. That the PBPP administrative staff should be increased to reflect the anticipated workload with these recommendations.

9. That, even though the Valley Hope Alcoholism Treatment Center does not have Joint Commission for Accreditation of Hospitals certification, that negotiations should be initiated to provide alcoholism rehabilitation services for PBPP members.
10. This investigation found, unrelated to the PBPP evaluation, that the alcoholism rehabilitation programs in the PSU area were in a state of uncertainty. It is our recommendation that the PSUHB begin an in-depth investigation of the referral system, rehabilitation services and out-patient programs to be coordinated throughout the PSU area.


2. Contact the Pawnee Service Unit for information regarding the following:

a. Number of eligible card holders.
b. Current services available.
c. Original services provided.
d. Funding available by year for the PBPP.
e. Number of persons receiving services by year per tribe.
f. Services provided per year by type of service.

3. Determine the categories and amount of denied claims.

4. Display the result from the above in a comprehensive report.

**Objective III.**

A consultant will be hired to study physicians' and patients' acceptance of the PBPP and the outpatient services of the Pawnee Service Unit. This objective will be met by:

1. Working with the Pawnee Service Unit staff to identify a random sample of 500 PBPP users and 500 PBPP non-users who will be studied.

2. Compiling a list of physicians to provide information as to the acceptance or non-acceptance of the PBPP.

3. Study the users and non-users about the following:

   a. Program eligibility.
   b. Explanation of services.
   c. Availability of third party insurance.
   d. Location of services obtained.
   e. Comparison with old Pawnee Indian Hospital System.
   f. Ease of access to hospital care.
   g. Evaluation of services (both inpatient and emergency room).
   h. Comparison with other service units in Oklahoma.
   i. Satisfaction with clinic hours.

4. Interview the physicians about the following:

   a. Perceptions of the automated PBPP system vs. the old system.
   b. Reimbursement for services.
   c. Explanation of services.
   d. Improvement in the PBPP system.

5. Display the results from the above in a comprehensive report.
Objective IV.

A consultant will be hired to conduct a feasibility study for providing alcoholism treatment and rehabilitation services for stroke patients in the Pawnee Service Unit. This objective will be met by:

1. Working with the Pawnee Service Unit staff and local alcoholism programs to get a population figure of persons who would benefit from a long term alcoholism program.

2. Developing statistics regarding the number of persons receiving detoxification treatment and their recidivism rate.

3. Developing statistics regarding the number of alcohol-related medical treatments and the approximate cost of these services.

4. Working with the Valley Hope Alcoholism Treatment Center in Cushing, Oklahoma for the following information:
   b. Dollar amount of treatment.
   d. Possibility of cooperation with PBPP.

5. Working with three (3) other centers for the information in #4 above.

6. Based on the results of #4 and #5 above, compute any possible savings if PBPP patients were treated elsewhere.

7. Working with the IHS staff to develop statistics for the number of stroke victims who could benefit from rehabilitation.

8. Determine the costs involved in #7 above.

9. Display the results from the above in a comprehensive report.
APPENDIX

PBPP REVISION OF BENEFITS
Dear P.B.P.P. Participant and/or Provider:

The following revisions are being made in the Pawnee Benefit Package Program Booklet. Please note these revisions as they affect specific benefits allowable under the Pawnee Benefit Package Program.

Revisions # 1 - Page 5, Paragraph 2 is changed to read as follows:

Medical Alcohol Detoxification and/or Drug Rehabilitation

100% of covered expenses in a hospital based medical Alcohol Detoxification and/or Drug Detoxification Unit. Admission will be limited and all admissions will be done only as a direct referral basis from a Pawnee Service Unit IHS Physician with concurrence and consultation from the Mental Health Branch of the patient's home IHS Facility. A participant is limited to a maximum of thirty (30) days in his/her lifetime.

Revision # 2 - Page 5, Paragraph 3 is changed to read as follows:

Maximum Benefits

There is a Fiscal Year (October 1 through September 30, of the following year) benefit limit of $25,000 per participant.

Revision # 3 - Page 8, Paragraph 3 is changed to read as follows:

Days of Care

Up to 30 days per Fiscal Year are provided for hospitalization of nervous or mental disorders and pulmonary tuberculosis, only as a direct referral by a Pawnee Service Unit IHS Facility.

Revision # 4 - Page 8, Paragraph 4 is changed to read as follows:

Days of Care

Up to 30 days in a participant's lifetime are provided for medically indicated drug or alcohol detoxification upon a direct referral by a Pawnee Service Unit IHS physician with concurrence and consultation from the Mental Health/Social Service Branch of the patient's home IHS Facility.

These revisions will become effective February 1, 1982.

Bill McKee
Acting Director
Pawnee Benefit Package Program
Dear Participant:

Your participation in the Pawnee Benefit Package Program has been very much appreciated because it has contributed towards better health care services to all concerned.

By this letter your continued participation, cooperation, and understanding is requested. Since the Pawnee Benefit Package Program does not receive unlimited funding certain changes must be made in the immediate future. Due to increased utilization and funds limitation, it is necessary to reduce the benefits as published in the Pawnee Benefit Package Program booklet dated June 1, 1981. This letter also supercedes letter dated January 18, 1982 signed by Mr. Bill McKee showing four previous revisions. It is hoped this reduction will be sufficient to stay within the Fiscal Year 1982 appropriated resources. If further reductions are required, you will be notified prior to implementation of further reductions.

The attached revisions beginning on the back of this letter are to be effective April 15, 1982:

Revision #1 - Part 4 - Summary of Benefits
Revision #2 - Part 5 - Basic Inpatient Hospital Benefits
Revision #3 - Part 7 - Basic Surgical and Medical Benefits (New Addition - Examples of Elective Surgery to be funded by IHS when funds are available.

As of April 15, 1982, prior written authorization for payment must be obtained for all inpatient care other than emergencies. For emergency inpatient care, the IHS must be notified within 72 hours of admission before payment can be considered.

If you have any questions concerning these revisions, please feel free to contact Mr. Bill McKee at (918)762-2517.

A. N. James
Service Unit Director

Attachments
REVISION #1 - Replaces Pages 4 & 5 of Pawnee Benefit Package Booklet and Letter of January 18, 1982

PART 4 - SUMMARY OF BENEFITS

Do not rely on this chart alone to find out just exactly what is covered by your Pawnee Benefit Package Program. Read the entire Booklet because the following is only a summary.

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Inpatient</td>
<td>100% of the usual and customary charges for up to 90 days per admission for those inpatient services authorized after the hospital has billed any and all available alternate resources (i.e., private health insurance, Medicaid, Medicare, etc.) available to the participant.</td>
</tr>
<tr>
<td>Hospital Emergency Room</td>
<td>100% of covered expenses for true medical emergencies (as defined on page 15) in Emergency Room and outpatient department of a hospital for (1) the accomplishment of an operative or cutting procedure (2) for accidental injury where treatment is provided within 24 hours of the accident or (3) radiation therapy and chemotherapy (4) for onset of a medical emergency as defined on page 15. The hospital must bill any and all alternative resources available to the patient.</td>
</tr>
<tr>
<td>Skilled Nursing Home</td>
<td>100% of covered expenses in a Medicare approved skilled Nursing facility for up to thirty (30) days per admission after a direct transfer from a hospital in which the participant was confined as an inpatient. The facility must first bill any and all alternate resources available to the participant.</td>
</tr>
<tr>
<td>Rehabilitative Care</td>
<td>100% of covered expenses in a rehabilitative unit for up to thirty (30) days per admission after a direct transfer from a hospital in which the participant was confined as an inpatient. The facility must first bill any and all alternate resources available to the participant.</td>
</tr>
<tr>
<td>Alcohol, Detoxification and/or Drug Rehabilitation</td>
<td>Where treatment, care and counseling services are needed for Alcohol and Drug over use, your Benefit Package provides 100% payment coverage for up to thirty (30) days only for each patient in their life time. Admission to a medical alcohol Detoxification and/or Drug Rehabilitation Unit is only by referral by IHS staff.</td>
</tr>
<tr>
<td>Elective Surgery</td>
<td>Approved only if funds are available with prior written authorization from IHS staff. Call Pawnee #1-800-722-3588 to obtain prior written authorization. Surgery should not be expected to be funded unless signed authorization is in hand. See Revision #3 for conditions considered as elective surgery.</td>
</tr>
<tr>
<td>Maximum Benefits</td>
<td>For each Fiscal year (October 1 through September 30 of the following calendar year) your Benefit Package provides payment for all services (hospital, physician, emergency rooms, skilled nursing homes, Alcohol/Drug Rehabilitative Care, and ambulance) up to $25,000 for you and all others covered by the Benefit Package.</td>
</tr>
</tbody>
</table>
PART 6 - BASIC INPATIENT HOSPITAL BENEFITS

A. Non-scheduled inpatient care.

Inpatient care for a life threatening emergency which is an acute medical condition, sudden in onset, with severe symptoms, posing an immediate threat to life, limb, or organ must be authorized within 72 hours.

B. Scheduled Non-emergency Inpatient Care

These benefits will be provided if funding is available in excess of that required to provide non-scheduled inpatient benefits and Emergency Room Care. All scheduled non-emergency inpatient care must have prior written authorization before IHS payment can be expected.

EXAMPLES OF SCHEDULED NON-EMERGENCY INPATIENT CARE

- Inpatient care for any admission which can be delayed or rescheduled
- Inpatient rehabilitative services
- Elective Surgery (see Revision 3)
- Nervous or mental disorders and pulmonary tuberculosis

DAYS OF CARE

- Up to 90 days of care per admission are available. If discharge from and readmission to a hospital occur within thirty (30) days, it is counted as the same confinement. If the covered person remains out of any hospital for 30 consecutive days, another 90 days of inpatient care are available.

- Up to thirty (30) days per Fiscal Year are provided for hospitalization for nervous mental disorders and pulmonary tuberculosis.

- Benefits are provided for thirty (30) days of medical treatment per admission in a Medicare-approved skilled nursing facility. Admission to the SNF must be a direct transfer from a hospital in which the patient was confined as an inpatient.

- Coverage for rehabilitative care is available for thirty (30) days per admission to a rehabilitation unit, when the admission is a direct transfer from a hospital in which the patient was a regular inpatient.

- Up to thirty (30) days in a participant's lifetime are provided for medically indicated drug or alcohol detoxification upon a direct referral by a Pawnee Service Unit IHS physician with concurrence and consultation from the Mental Health/Social Service Branch of the patient's home IHS facility. All detoxification admissions whether at an acute care hospital or rehabilitative center are included in this thirty (30) day lifetime limitation.
EXAMPLES OF ELECTIVE SURGERY TO BE FUNDED BY IHS WHEN FUNDS ARE AVAILABLE

- Eye, ear, nose and throat surgery
- Gall bladder and bile duct
- Hernia of the abdominal cavity
- Utero-vaginal Prolapse
- Orthopedic surgery
- Cardiovascular surgery
- Human organ transplant, excluding heart
- Male and female genital organs, etc.
- etc.
APPENDIX

SURVEY INSTRUMENTATION
Dear PBPP Member:

Since 1981, the Kaw, Ponca, Otoe-Missouria, Osage, Pawnee, and Tonkawa tribal members have had medical services provided through the Pawnee Benefit Package Program. In an attempt to assist the Health Advisory Committee in determining the suitability of this program on meeting member health needs, we are surveying users and non-users of this program to find out as many facts as possible to help us make decisions regarding possible changes in PBPP services.

We are asking you to complete the enclosed questionnaire as accurately as possible and return to us as soon as you can. If you are under 18 years of age, please have your parent or guardian complete the questionnaire. There will be a general meeting in your area that will give you a chance to discuss the results after all returns are in and tabulated. You will be notified of the time and date of the meeting in February, 1985.

Our success in meeting the changing medical needs of you and your family is dependent on your completion of the enclosed questionnaire. If you need assistance in completing the questionnaire, please call your health board member listed below. Thank you for your help and cooperation.

Sincerely,

Veleya Adams
Ponca Tribe
(405) 762-8104

John G. Allen
Tonkawa Tribe
(405) 628-2561

Dewey Bailey, Jr.
Otoe-Missouria Tribe
(405) 723-4334

Ed Red Eagle, Chairman
Pawnee Service Unit Health Board
Osage Tribe
(918) 287-4822

V. J. Roberts, Pawnee Tribe
(918) 762-3624

Newman Little Walker, Kaw Tribe
(405) 269-2552
HEALTH CARE QUESTIONNAIRE

PAWNEE BENEFIT PACKAGE PROGRAM (PBPP)

YOUR SATISFACTION WITH THE PBPP

Directions: For this part of the evaluation, you will read a series of statements that could be made about the Pawnee Benefit Package Program. Indicate whether you agree or disagree with each one of the statements.

Sample Question: If you were to read the statement below and Agree with it, it would be marked as shown.

<table>
<thead>
<tr>
<th>The PBPP has been very helpful to me.</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Not Sure</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0   0 0 0 0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. I have thoroughly read the PBPP booklet. 0 0 0 0 0
2. When I use the I.D. card, I go to the hospital closest to my home even though I can go to any hospital. 0 0 0 0 0
3. I like the new PBPP using community hospitals better than the former Pawnee Indian Hospital contract. 0 0 0 0 0
4. I am satisfied with the clinic hours at the local IHS clinic. 0 0 0 0 0
5. I know who to contact if I have questions concerning the PBPP. 0 0 0 0 0
6. I use my third party insurance more than the PBPP. 0 0 0 0 0
7. When I go to the clinic, non-Indians seem to have priority. 0 0 0 0 0
8. The new PBPP card makes it easier for me to receive hospital care closer to home. 0 0 0 0 0
9. I feel that I receive better care in private hospitals than the former Pawnee Indian Hospital. 0 0 0 0 0
10. The services covered by the PBPP cover most all hospital medical needs. 0 0 0 0 0
11. The services covered by the PBPP cover most all emergency room medical needs. 0 0 0 0 0

12. I would like to have the clinic open until 8:30 p.m. one evening a week. 0 0 0 0 0

13. I would like to have the clinic open Saturday morning from 9:00 a.m. until noon. 0 0 0 0 0

14. I am satisfied with the overall PBPP. 0 0 0 0 0

INFORMATION ABOUT YOUR USE OF PBPP

Directions: Read each question carefully and be sure to answer honestly and frankly. Your opinion is very important to a successful evaluation of the PBPP.

15. I live in ____________, in ____________, Oklahoma. (city/town) (county)

16. My age is ________ years old.

17. Are you currently employed? ___ yes ___ no ___ retired

18. Have you ever used the Pawnee Benefit Package Program? ___ yes ___ no

19. Would you use the program on a more regular basis if you understood it better? ___ yes ___ no

20. What would be most helpful to you in learning about the benefit program?
   ___ a. Workshop by tribe.
   ___ b. Individual explanations (conference with each user).
   ___ c. Written material with details.
   ___ d. Someone to explain the program when I have problems.
21. What would you recommend that the Indian Health Service do with the program?
   ___ a. Leave it as it is now.
   ___ b. Drop the program.
   ___ c. Make changes in how the program is administered (how payments are made and what is an approved expenditure).
   ___ d. Improve the existing medical services.
   ___ e. Reopen the hospital.
   ___ f. Other (please specify): ____________________________

22. Do you have health insurance other than the Pawnee Benefit Package Program?
   ___ yes   ___ no

23. If you answered "yes", what type of insurance do you have?
   ___ a. Group insurance through place of employment. ____________________________
   ___ b. Private policy insurance. ____________________________
   ___ c. Medicaid insurance benefits. ____________________________
   ___ d. Medicare insurance benefits. ____________________________
   ___ e. Other (please write the specific type of insurance): ____________________________

24. Were you covered by an insurance policy before accepting the Pawnee Benefit Package Program? ___ yes   ___ no

25. How did you hear about the Pawnee Benefit Package Program?
   ___ a. Community Health Representative (CHR)
   ___ b. Tribal official
   ___ c. Another tribal member
   ___ d. Newspaper article
   ___ e. Other (please specify): ____________________________

26. How many months have you had your identification card? ____________________________

27. When you signed up for a card, what kind of information did you receive?
   ___ a. Written material
   ___ b. Written material and a verbal explanation
   ___ c. A verbal explanation only
   ___ d. None

28. Is the program meeting all your health needs? ___ yes   ___ no
29. How well do you feel that you understand the program and how it works (how to get services, what will be paid for and how payment is made)?
   ___ a. I have no problems understanding the program.
   ___ b. I do not understand about emergencies.
   ___ c. I do not understand what is payable and what is not payable with this program.
   ___ d. I thought this program would pay for all of my health needs.
   ___ e. I thought that I did not need other insurance if I signed up for this program.
   ___ f. I do not understand anything about this program.
   ___ g. I have never used the program because I do not understand the way it works.

30. Has the Pawnee, White Eagle or Pawhuska Indian Clinic being closed on weekends been an inconvenience to you? _____ yes  _____ no

31. Have the number of doctors available to you at the Pawnee, White Eagle or Pawhuska Indian Clinic been an inconvenience or a problem to you? _____ yes  _____ no

32. Have you received all your necessary medication or prescriptions that you are entitled to under the PBPP program? _____ yes  _____ no  _____ no, haven't required medication.

33. Would you say that your health in general in comparison to others of your age is: (check one)
   ___ Excellent
   ___ Very Good
   ___ Good
   ___ Fair
   ___ Poor

34. Have you paid out-of-pocket for any health service, medications, or supplies in the past 30 days? _____ yes  _____ no

   If you answered "yes", please describe what type of services or supplies you paid for and approximately what it cost you. ___________________________________________
YOUR RECOMMENDATIONS

Please make comments that might help in the evaluation of this Pawnee Benefit Package Program. This is a good place to write about problems that you have had that were not included in this survey. Make suggestions for improvement. (Use the front and back of this sheet, if necessary.)

PLEASE RETURN THIS SURVEY IN THE ENVELOPE PROVIDED. THANK YOU FOR YOUR HELP!
HEALTH CARE QUESTIONNAIRE

PAWNEE BENEFIT PACKAGE PROGRAM (PBPP)

Directions: Read each question carefully and be sure to answer honestly and frankly. Your opinion is very important to a successful evaluation of the PBPP.

1. Do you have a PBPP I.D. card for each of your eligible family members?  
2. Have you read your copy of the PBPP booklet?  
3. Do you understand what the program can and cannot pay?  
4. Do you have a Third Party medical insurance?  
5. When you use your card in the future, will you go to the hospital closer to your home although you have the option of going to any hospital you choose?  
6. Although you have not used your I.D. card, would you prefer the Pawnee Indian Hospital to be reopened?  
7. Was the application for the PBPP I.D. card a problem for you to fill out?  
8. When you made application, did you have your Certificate of Degree of Indian Blood?  
9. Do you think the services covered by the PBPP cover most all emergency medical needs?  
10. Were you aware that only residents in the seven (7) county service area are eligible to receive the PBPP I.D. card?  
11. Do you know who to contact if you have any questions concerning the PBPP?

If there is a reason why you don't use the PBPP, please explain below. If you have any further comments, please express them below and on the back of this page, if necessary. Thank you for your help!

PLEASE RETURN THIS SURVEY IN THE ENVELOPE PROVIDED. THANK YOU FOR YOUR HELP!
February 12, 1985

Dear Health Care Provider:

The Indian Health Service is conducting an evaluation of the Pawnee Service Unit Benefit Health Package (PBPP) which includes the use of a patient identification card and an automated authorization/payment system. Our records indicate you have provided health care under this new program.

In an attempt to improve quality care to the Indian people and our relationship to our valued private health care provider, we would appreciate your comments on the attached subjects. With your input, we hope to continue improving the program.

Thank you for your service to the Indian people.

Sincerely,

James H. Rogers, Ph.D.
Consultant/Evaluator
Pawnee Benefit Package Program

Attachment
JHR/kj
HEALTH CARE QUESTIONNAIRE
PAWNEE BENEFIT PACKAGE PROGRAM (PBPP)

Directions: Read each question carefully and be sure to answer honestly and frankly. Your opinion is very important to a successful evaluation of the PBPP.

1. Do you like the PBPP using community hospitals better than the old contract health care system?
   Yes  No

2. Are you receiving reimbursement for service quicker under the new system versus the old contract health system?
   Yes  No

3. Do the cards and the Benefit Package system make it easier for you to understand what will or will not be paid?
   Yes  No

4. Does the PBPP improve your relationship with the Pawnee Service Unit?
   Yes  No

5. Does the PBPP improve your relationship with the Indian patient?
   Yes  No

6. If you had a choice, would you like to see the entire Indian Health Service Contract Health Program under the automated, I.D. card system?
   Yes  No

7. In your opinion, do you think that the PBPP would be better served if administered by a health group plan such as Blue Cross?
   Yes  No

Please use the space below and the back of this sheet to make any comments that you have regarding the PBPP. Thank you for your help!

PLEASE RETURN THIS SURVEY IN THE ENVELOPE PROVIDED. THANK YOU FOR YOUR HELP!
APPENDIX

ALCOHOLISM REHABILITATION TREATMENT

INFORMATION
ALCOHOLISM REHABILITATION CENTER

I. GENERAL INFORMATION

NAME OF FACILITY: Alcoholism Rehabilitation Center
FOUNDED: November 1981
ADDRESS: 14th & Hartford
Ponca City, Oklahoma 74601
PHONE: 405 765-0489
DIRECTOR: Jerry Vantine
OUTSIDE QUALITY EVALUATION: JCAH Accreditation

II. ADMISSION AND COST INFORMATION

CONTACT FOR ADMISSION: Alcoholism Rehabilitation Center
PHONE: 405 765-0489
DAYS/HOURS OF ADMISSION: 24 hours per day, every day; Pre-Admission Evaluation preferred, provided at no cost
TYPE OF PATIENT ADMITTED: Primary diagnosis of Alcoholism
TYPE OF PATIENT EXCLUDED: Persons under the age of 18. Persons with acute, primary psychiatric disorders. Persons that have concurrent medical difficulties.
FACILITY'S POLICY ON FORMER PATIENTS: Readmission is evaluated on an individual basis
ARE THERE ANY SPECIFIC LIMITATIONS:

Patients must be 18 years of age or older.

Must not have serious psychiatric disorders.

PROGRAM COSTS:

DETOXIFICATION

$1,150.00

INPATIENT PROGRAM

28-days includes Laboratory, X-ray, Medications, Psychological Testing & Physician Fees

$6,600.00

PRE-ADMISSION FINANCIAL ARRANGEMENTS:

Verified insurance preferred; private pay parties are asked for $500.00 deposit.

IS THERE THIRD PARTY REIMBURSEMENT?

Usually there is third party reimbursement from most group insurances which pay at 80% to 100%, depending on the group contract.

EXTENDED PAYMENTS PERMITTED?

The hospital business office will assist with extended payments for those qualifying.

III. DIAGNOSTIC/EVALUATION SERVICES

DOES PROGRAM PROVIDE GENERAL MEDICAL/PSYCHOLOGICAL SERVICES?

Yes

ARE DETOXIFICATION SERVICES MEDICALLY PERFORMED?

Yes

CAN THE SERVICE BE USED AS A SEPARATE SERVICE?

Yes

MUST ALL CLIENTS GO THROUGH DETOXIFICATION?

No, unless deemed necessary by Medical Director

AVERAGE LENGTH OF STAY FOR DETOX:

1 - 4 days

IS THIS CONSIDERED PART OF THE TOTAL IN-PATIENT TREATMENT PROGRAM

No

ARE THERE SEPARATE CHARGES?

Yes, as stated previously

PLEASE DESCRIBE COMPREHENSIVE DIAGNOSTIC/EVALUATION SERVICES AVAILABLE:

A comprehensive evaluation is performed during the first week of treatment. This evaluation consists of Psychological, Physical and Social Assessments.

IS THERE OFTEN A WAITING LIST?

Not Usually
IV. AVAILABLE SERVICE COMPONENTS

AVERAGE LENGTH OF STAY

28 days

PLEASE CHECK APPLICABLE SERVICES AVAILABLE:

<table>
<thead>
<tr>
<th>In-Patient</th>
<th>Out-Patient</th>
<th>Aftercare</th>
</tr>
</thead>
<tbody>
<tr>
<td>INDIVIDUAL COUNSELING</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>GROUP THERAPY/COUNSELING</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>BACK-TO-WORK CONFERENCE</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>RELAXATION THERAPY</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>ASSERTIVENESS TRAINING</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>INDIVIDUAL TREATMENT PLANNING</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>MEDICATION</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>MEDICAL MANAGEMENT</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>LECTURES</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>DISCUSSION MEETINGS</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>TAPES/MOVIES</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>ALCOHOL/DRUG EDUCATION</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>A.A. MEETINGS</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>N.A. MEETINGS</td>
<td>X</td>
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</tr>
<tr>
<td>LITERATURE</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>OTHER SKILLS TRAINING</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

V. PROGRAM

TREATMENT PHILOSOPHY:

Alcoholism is progressive and fatal if not arrested. The disease process is arrested through abstinence from mind-altering drugs, e.g. alcohol and other drugs. The quality of sobriety and probability of extended sobriety can be increased by introducing patients to appropriate self-help groups, i.e. A.A., as well as teaching life skills and providing counseling to aid in the implementation of those skills.

WHAT IS THE ROLE OF AA/NA IN THE TREATMENT PROGRAM

Participation in AA is integral to the program. Patients attend three AA meetings per week—one in-house, two outside. AA is a freestanding, autonomous group.

VI. MEDICATION POLICY AFTER DETOXIFICATION

IS THE USE OF SEDATIVE ANTI-ANXIETY DRUGS PERMITTED WHILE IN TREATMENT AND UNDER WHAT CIRCUMSTANCES?

These are used only during detoxification.

IS THE USE OF ANTI-Psychotic DRUGS LITHIUM, OR ANTI-DEPRESSANTS PERMITTED WHILE IN TREATMENT, AND UNDER WHAT CIRCUMSTANCES?

These type of drugs are used only when there are well-defined psychiatric indicators present to warrant their use; this is infrequent.
IS ANTABUSE USED? IF SO, UNDER WHAT CONDITIONS?

Infrequently. If a patient has had some success in the past with antabuse it may be considered, but such use is voluntary.

VII. FAMILY PROGRAMMING

IS FAMILY PROGRAMMING PROVIDED?
PLEASE DESCRIBE:

Every Saturday is Family Day. Patients and family members see films and hear lectures on the disease of alcoholism.

WHAT EFFORTS ARE MADE TO REACH AND INVOLVE THE FAMILY?

Counselors make contact with family members in an effort to involve family members in the treatment process.

MAY THE FAMILY BE TREATED WITHOUT THE ALCOHOLIC?

On an outpatient basis

IF TREATING BOTH FAMILY AND THE CHEMICALLY DEPENDENT PERSON, IS THIS DONE CONCURRENTLY?

Yes

VIII. OUTCARE

PLEASE DESCRIBE THE PHILOSOPHY OF THE OUTCARE PROGRAM:

Participation in outcare is critical to patients in integrating newly learned skills into daily living. It provides an important source of support, confrontation and feedback concerning life problems. Three aftercare meetings are available weekly.

IS THE LENGTH OF THE OUTCARE PROGRAM FIXED OR VARIABLE?

The Alcoholism Rehabilitation Center offers two years outcare at no additional cost.

WHAT SERVICES ARE PROVIDED AS PART OF OUTCARE?

Groups, individual counseling, alumni meetings and follow-up.

WHAT IS THE POLICY REGARDING DRINKING AND/OR USE OF MEDICATION IN OUTCARE?

Drinking and/or drug use during this period will be confronted. As long as a patient's behavior indicates an effort to remain sober they will be allowed to continue in the outcare program.

WHAT KIND OF FOLLOW-UP PROCEDURES ARE EMPLOYED?

Follow-up is conducted by personal contact telephone, or letter over a period of two years. This is done at intervals of 6 months, 12 months, 18 months and 24 months.
IX. STAFF

FROM WHAT DISCIPLINES DOES THE TREATMENT/COUNSELING STAFF DERIVE?
(Exclude Consultants)

M.D.
NURSING
ALCOHOLISM COUNSELORS

X. MISCELLANEOUS

ARE OTHER MEETINGS INHOUSE MANDATORY? Yes
ARE GROUP SESSIONS INHOUSE MANDATORY? Yes
ARE THERE OTHER MANDATORY PROGRAM ELEMENTS? Yes
WHAT STANDARD LITERATURE IS GIVEN TO PATIENTS? A.A. Big Book, 24-Hours a Day and various program materials.

XI. INTERFACE OF TREATMENT PROGRAM AND EMPLOYEE ASSISTANCE PROGRAMS

WHAT ARE THE PROGRAM'S EXPECTATIONS FROM REFERRING EMPLOYEE ASSISTANCE PROGRAMS? Willingness to provide behavioral data concerning employee's job performance; expectation of employer; monitoring employee's participation in outcare.

WHAT DOES PROGRAM ROUTINELY SUPPLY TO THE EAP? Progress reports on supervisory referrals.

ARE JOINT CONFERENCES ENCOURAGED AND UNDER WHAT CIRCUMSTANCES? Yes, during intake evaluation, during period of discharge planning, and as otherwise indicated by individual circumstances.
ST. JOHN - CORNELL
ALCOHOLISM AND CHEMICAL DEPENDENCY SERVICES

INFORMATION PACKET

I. GENERAL INFORMATION:

NAME OF FACILITY: St. John Medical Center
St. John-Cornell Alcoholism & Chemical Dependency Program

FOUNDED: November, 1977

ADDRESS: 1923 South Utica Avenue
Tulsa, Oklahoma 74104

PHONE: 918 - 744 2502

DIRECTOR: Thomas E. Bray 918 - 744 2668

OUTSIDE QUALITY EVALUATION: JCAH Accreditation

LICENSURE: State of Oklahoma

ACCESSIBILITY FROM:
Airport: 20 Min.  Train: 10 Min.

WILL FACILITY TRANSPORT PATIENTS FROM PUBLIC ACCESS? Yes, If Necessary.

II. ADMISSION AND COST INFORMATION:

CONTACT FOR ADMISSION
Unit Manager  Unit Clerk

PHONE:
Inpatient: 918 - 744 2502
Outpatient: 918 - 743 5845

DAYS/HOURS OF ADMISSION: 24 Hours/Day, Every Day; Pre-Admission Evaluation Preferred, Provided at No Cost.

TYPE OF PATIENT ADMITTED:
Primary Diagnosis Alcoholism or Drug Addiction/Abuse, With Willingness to Involve Significant Other/Family Member in Treatment Program.

TYPE OF PATIENT EXCLUDED:
Persons with Acute, Primary Psychiatric Disorders.

FACILITY'S POLICY ON FORMER PATIENTS:
Readmission is Evaluated on an Individual Basis.
ARE THERE ANY SPECIFIC LIMITATIONS IN REGARD TO:  

YES  NO  
1. AGE  X  
2. CATCHMENT AREA  X  
3. LEGAL ENTANGLEMENTS  X  
4. DRUG OF CHOICE  X  
5. MEDICAL PROBLEMS  X  
6. PSYCHIATRIC PROBLEMS  X  
7. MALE  X  
8. FEMALE  X  

IF YES, PLEASE EXPLAIN:  Must not have serious Psychiatric Disorders  

PROGRAM COSTS:  

ROOM & BOARD PER DAY:  
Detoxification days @ $288.00  
Rehabilitation days @ 200.00  

ANCILLARY SERVICES:  
X-Ray  47.00  
Psychological Testing and Evaluation:  123.00  
Lab Work  431.00  
* Recreational Therapy  19.00 per session  
* Biofeedback  36.50 per session  

MEDICAL/PHYSICIAN FEES:  
$100.00  

PSYCHOLOGICAL SERVICES:  
Charges for Licensed Psychologist for Individual Counseling:  62.50 per session  

PRE-ADMISSION FINANCIAL ARRANGEMENTS:  
Verified insurance preferred; private pay parties are asked for $2,000.00 deposit with arrangements for balance on dismissal.  

IS THERE THIRD PARTY REIMBURSEMENT?  
Usually there is third party reimbursement from most group insurances which pays 80% to 100%, depending on the group contract. Medicare accepted.  

EXTENDED PAYMENTS PERMITTED?  
Yes, prior to discharge by contacting Business Office.  

* Optional Services
III. DIAGNOSTIC/EVALUATION SERVICES

DOES PROGRAM PROVIDE GENERAL MEDICAL/PSYCHIATRIC SERVICES? 

YES

DIAGNOSTIC PROCEDURE

<table>
<thead>
<tr>
<th>IN-HOUSE</th>
<th>CONSULT/CONTRACT</th>
<th>ROUTINE</th>
</tr>
</thead>
<tbody>
<tr>
<td>HISTORY &amp; PHYSICAL</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>CHEST X-RAY</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>EKG</td>
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<tr>
<td>EEG</td>
<td>X</td>
<td>X</td>
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<tr>
<td>T.B. SCREEN</td>
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</tr>
<tr>
<td>SEROLOGY</td>
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<td>X</td>
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<tr>
<td>CBC</td>
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<tr>
<td>BLOOD SUGAR</td>
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<td>X</td>
</tr>
<tr>
<td>ELECTROLYTES</td>
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<td>X</td>
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<tr>
<td>LIVER FUNCTION</td>
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</tr>
<tr>
<td>DRUG SCREEN</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>PSYCHOLOGICAL TESTING</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>PSYCHIATRIC EVALUATION</td>
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<td>X</td>
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</table>

ARE DETOXIFICATION SERVICES MEDICALLY PERFORMED? 

YES

CAN THE SERVICE BE USED AS A SEPARATE SERVICE? 

YES

MUST ALL CLIENTS GO THROUGH DETOXIFICATION? 

YES

AVERAGE LENGTH OF STAY FOR DETOX: 

1-3 days

IS THIS CONSIDERED PART OF THE TOTAL TREATMENT PROGRAM? 

Yes, however will be evaluated on an Individual Basis.

ARE THERE SEPARATE CHARGES? 

Yes, as stated previously.

PLEASE DESCRIBE COMPREHENSIVE DIAGNOSTIC/EVALUATION SERVICES AVAILABLE: 

A Comprehensive Evaluation is performed during the first ten days of treatment. This evaluation consists of intellectual, psychological, physical, and social assessments.

IS THERE OFTEN A WAITING LIST? 

Not usually.
IV. AVAILABLE SERVICE COMPONENTS:

AVERAGE LENGTH OF STAY:
- Alcohol Patients: 30 Days
- Drug Abusers: 45 Days

PLEASE CHECK APPLICABLE SERVICES AVAILABLE:

<table>
<thead>
<tr>
<th>Service Component</th>
<th>IN-PT</th>
<th>OUT-PT</th>
<th>FAMILY</th>
<th>AFTERCARE</th>
</tr>
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<tbody>
<tr>
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<td>X</td>
<td>X</td>
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</tr>
<tr>
<td>GROUP THERAPY/COUNSELING</td>
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<tr>
<td>MARRIAGE COUNSELING</td>
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<tr>
<td>BACK-TO-WORK CONFERENCE</td>
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<td>OCCUPATIONAL THERAPY</td>
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<td>BIOFEEDBACK</td>
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<td>RELAXATION TRAINING</td>
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<tr>
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<td>PAIN MANAGEMENT ORIENTATION/TRAINING</td>
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<td>INDIVIDUAL TREATMENT PLANNING</td>
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<tr>
<td>MEDICATION</td>
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<tr>
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<tr>
<td>DISCUSSION MEETINGS</td>
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<td>TAPES/MOVIES</td>
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<tr>
<td>A.A. MEETINGS</td>
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<td>A.A. STEP LECTURES</td>
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<tr>
<td>N.A. MEETINGS</td>
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</tr>
<tr>
<td>LITERATURE</td>
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<tr>
<td>AL-ANON MEETINGS</td>
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<tr>
<td>ALATEEN MEETINGS</td>
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<td></td>
<td>X</td>
</tr>
<tr>
<td>OTHER SKILLS TRAINING</td>
<td>X</td>
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</tr>
</tbody>
</table>
V. PROGRAM

TREATMENT PHILOSOPHY:

The only appropriate treatment goal for the Chemically Dependent patient is abstinence from alcohol/drugs.

WHAT ARE THE PROGRAM'S VIEWS OF ABSTINENCE?

The quality of sobriety and probability of extended sobriety can be increased by introducing patients to appropriate self-help groups, i.e., AA or NA, as well as teaching life skills and providing counseling to aid in the implementation of those skills.

WHAT IS THE POLICY ON DRINKING OR UNAUTHORIZED MEDICATION USE DURING TREATMENT?

While drinking or unauthorized medication use during treatment are grounds for discharge, each case is individually considered by the clinical staff.

WHAT IS THE ROLE OF AA/NA IN THE TREATMENT PROGRAM?

Participation in AA and/or NA is integral to the program. Patients attend five AA meetings per week - in-house and outside. Al-Anon is available once per week in-house. In-house AA, NA and Al-Anon are freestanding, autonomous groups.

VI. MEDICATION POLICY AFTER DETOXIFICATION

IS THE USE OF SEDATIVE ANTI-ANXIETY DRUGS PERMITTED WHILE IN TREATMENT AND UNDER WHAT CIRCUMSTANCES?

These are used only during detoxification and to a limited extent during the first week of treatment. None are permitted after that time.

IS THERE USE OF ANTI-Psychotic DRUGS, LITHUH, OR ANTI-DEPRESSANTS PERMITTED WHILE IN TREATMENT, AND UNDER WHAT CIRCUMSTANCES?

The above drugs are used only when there are well-defined psychiatric indicators present to warrant their use; this is infrequent.

IS ANTABUSE USED? IF SO, UNDER WHAT CONDITIONS?

Infrequently. If a patient has had some success in the past with Antabuse it may be considered, but such use is voluntary.
VII. FAMILY PROGRAMMING

IS FAMILY PROGRAMMING PROVIDED?
PLEASE DESCRIBE.

Yes, within 5 days of admission.
Family, Marital, Co-joint Family Groups Weekly.
Also, Children's Program Weekly.

WHAT EFFORTS ARE MADE TO REACH
AND INVOLVE THE FAMILY?

Each Family will be Contacted within 5 Days
After Admission.

MAY THE FAMILY BE TREATED
WITHOUT THE ALCOHOLIC?

Yes, On an Outpatient Basis.

IF TREATING BOTH FAMILY AND THE
CHEMICALLY DEPENDENT PERSON,
IS THIS DONE CONCURRENTLY?

Yes.

VIII. AFTERCARE

PLEASE DESCRIBE THE PHILOSOPHY
OF THE AFTERCARE PROGRAM:

Participation in Aftercare is critical to
patients in integrating newly learned skills
into daily living. It provides an important
source of support, confrontation, and feedback concerning life problems. There are
15 groups to choose from for scheduling
purposes.

IS THE LENGTH OF THE AFTERCARE
PROGRAM FIXED OR VARIABLE?

Variable; One Year provided but may be
longer if needed at no cost.

WHAT SERVICES ARE PROVIDED AS
PART OF AFTERCARE?

Group sessions weekly, individual counseling
as needed and constant support system in case
of crisis situation.

WHAT IS THE POLICY REGARDING
DRINKING AND/OR USE OF MEDICATION IN AFTERCARE?

Drinking and/or medication use during this
period will be confronted. As long as the
patient's behavior indicates effort to remain sober and they are not disruptive,
they will be allowed to continue in the
AFTERCARE PROGRAM.

WHAT KIND OF FOLLOW-UP
PROCEDURES ARE EMPLOYED?

Follow-up will be by phone, letter and off-
site visits when necessary for as long as
the person is putting forth the effort on
their own behalf.
IX. STAFF

FROM WHAT DISCIPLINES DOES THE TREATMENT/COUNSELING STAFF DERIVE?
(EXCLUDE CONSULTANTS).

<table>
<thead>
<tr>
<th>Discipline</th>
<th>YES</th>
<th>NO</th>
<th>FULL-TIME</th>
<th>PART-TIME</th>
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<tr>
<td>M.D.</td>
<td>X</td>
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<td>2</td>
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<tr>
<td>NURSING</td>
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<td></td>
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<td>3</td>
</tr>
<tr>
<td>ALCOHOLISM COUNSELORS</td>
<td>X</td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>PSYCHIATRISTS</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PSYCHOLOGISTS</td>
<td>X</td>
<td>X</td>
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<td></td>
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<tr>
<td>SOCIAL WORKERS</td>
<td>X</td>
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<td></td>
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<tr>
<td>OCCUPATIONAL REHAB.</td>
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<tr>
<td>OTHER MENTAL HEALTH (FAMILY THERAPIST)</td>
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<td>X</td>
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<td></td>
</tr>
<tr>
<td>OTHER ADVANCED DEGREES Ed.D.</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

X. MISCELLANEOUS

ARE AA/NA INHOUSE MEETINGS MANDATORY? Yes, unless specifically requests to go to Outside meeting with Sponsor.

ARE AA/NA MEETINGS IN THE COMMUNITY MANDATORY? Yes.

ARE OTHER MEETINGS INHOUSE MANDATORY? Yes, "Bridging the Gap".

ARE GROUP SESSIONS INHOUSE MANDATORY? Yes.

ARE PATIENTS EXPECTED TO DO A 4TH AND 5TH STEP WHILE IN TREATMENT? No; However it is suggested they find a Sponsor before leaving treatment.

ARE THERE OTHER MANDATORY PROGRAM ELEMENTS? No.

WHAT STANDARD LITERATURE IS GIVEN TO PATIENTS? Treatment Program Work Book, AA Big Book.

WHAT IS THE POLICY REGARDING PHONE CALLS AND VISITATION? Restricted to unscheduled time and to Immediate Family for the first week, unless specific arrangements are made upon admission.
XI. INTERFACE OF TREATMENT PROGRAM AND EMPLOYEE ASSISTANCE PROGRAMS

WHAT ARE THE PROGRAMS EXPECTATIONS FROM REFERRING EMPLOYEE ASSISTANCE PROGRAMS?

We Recommend a Company Representative visit with Counselor and Patient in the 2nd & 4th weeks of treatment with back-to-work conference involving Supervisor, Union Steward (if appropriate), Personnel Manager, and/or Labor Relations Representative. The purpose of the Conference is to re-establish a good working relationship and understanding by all parties concerned as to the disease concept, Organizational policies & work rules, importance of Aftercare, and the role each person plays in the recovery process.

WHAT DOES THE PROGRAM ROUTINELY SUPPLY TO THE EAP?

With the Patient's consent, progress in treatment and possible recommendations to the Employer as it relates to specific patient recovery needs.

ARE JOINT CONFERENCES ENCOURAGED AND UNDER WHAT CIRCUMSTANCES?

As stated above, Joint Conferences are recommended during both the 2nd & 4th week, particularly the 4th week, if the patient is resistant to treatment. The Company may be asked to encourage the patient's participation as it may affect the patient's position in the Company.
ESTIMATED COST FOR TREATMENT

HOSPITAL CHARGES

<table>
<thead>
<tr>
<th>Service</th>
<th>Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avg. 3 days of Detoxification</td>
<td>$864.00</td>
</tr>
<tr>
<td>Avg. 27 days of Treatment Program</td>
<td>$5,400.00</td>
</tr>
<tr>
<td>X-Rays, Laboratory, Medications and Physician Fees</td>
<td>$578.00</td>
</tr>
<tr>
<td>Psychological Testing &amp; Evaluation</td>
<td>$123.00</td>
</tr>
<tr>
<td><strong>Total Estimated Hospital Billing</strong></td>
<td><strong>$6,965.00</strong></td>
</tr>
</tbody>
</table>

IN ADDITION TO THE ABOVE CHARGES, THE FOLLOWING ITEMS ARE OPTIONAL:

<table>
<thead>
<tr>
<th>Service</th>
<th>Quantity</th>
<th>Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biofeedback Training</td>
<td>8 sessions @ $36.50 per session</td>
<td>$292.00</td>
</tr>
<tr>
<td>Recreational Therapy</td>
<td>10 sessions @ $19.00 per session</td>
<td>$190.00</td>
</tr>
<tr>
<td>Extended Psychological Supervision</td>
<td>@ $62.50 per session</td>
<td></td>
</tr>
</tbody>
</table>

SUMMARY

BASED ON AVERAGE PATIENT CHARGES FOR FISCAL YEAR 1984 FOR A 30-DAY INPATIENT TREATMENT, THE ESTIMATED COST WOULD BE: $6,965.00
I

INFORMATION SHEET
STAFF AND PROGRAM
BROOKWOOD RECOVERY CENTER-TULSA

PRESENT STAFF:

Administrative:

Executive Director
Assistant Administrator

Medical:

Medical Director

Nursing Coordinator (R.N.)
Registered Nurses
Licensed Practical Nurses
Treatment Aide

Counseling:

Clinical Director

Alcoholism and Drug Counselors
Family Counselors
Intake and Crisis Line Counselor
Interventionist

Other Support Personnel:

Consulting Psychologist
Consulting Psychiatrist
Pastoral Consultant

Judy Person
Mason R. Lyons M.D.

Jerry Cooke, M.S.W., C.A.D.C.
James Moore, P.H.D.
Reverend Keith Cupples

INPATIENT PROGRAM:

The Brookwood program follows the Johnson Institute disease model of alcoholism. The program is based on the fundamental concepts developed by Alcoholics Anonymous and its related organizations, Al-Anon and Alateen. The core of our treatment philosophy is that the power to stay sober resides in a group, rather than an individual. Alcoholism is an addiction, and the craving to drink is parallel to the most basic instincts and drives, rendering willpower alone helpless and causing the alcoholic to be permanently disabled and incurable. Rehabilitation, to be successful, must provide a totally new lifestyle.

Therapy and insight, however powerful, cannot equal the power of a peer group. Involvement, assumption of responsibility, and caring/sharing with the total group helps the patient to sublimate the will and relieve the craving to drink. This effort and involvement must be continuous and ongoing in order to constantly replenish the power of the group and the strength of the individual.

Recognizing that the family members have the same pattern of problems, psychological, social, and spiritual, and the same feeling of isolation,aloneness, self-pity, despair, cynicism, and confusion, the family receives instruction and therapy concurrently with the patient. Such involvement includes a change in the
way of life for them, as well. The family gets sick together and must get well together.

Finally the period of intensive therapy and controlled environment is insufficient to obtain permanent, lasting results without further reinforcement. Hence, the development of the Continuing Care program, which maintains contact and strengthens the participation in the principles of therapy and in the Alcoholic Anonymous program while affording the patient and family an opportunity to work through any problems arising after discharge. This is an integral part of a successful program.

The program itself is essentially a 2 year series of physical, psychological and emotional treatments, the most intensive phase of which is the initial inpatient stay.

The program begins with medical detoxification, followed by inpatient rehabilitation, which together cover 28 to 42 days, depending upon the substance of abuse. The first phase of the patient's recovery can be summarized as follows:

1-Each patient is given a physical examination by the Medical Director within 24 hours from admittance.

2-Each patient is assigned a primary Alcoholism and Drug Counselor and a Family Counselor.

3-Each patient is given a battery of psychological tests which are evaluated by the Consulting Psychologist.

4-All patients attend at least one formal 1-hour didactic session per day, dealing with various aspects of alcoholism and recovery.

5-Each group meets in a professionally directed counseling session for at least 1 1/4 hours twice daily, six (6) days per week.

6-Individual counseling is scheduled by counselors as needed.

7-Family group counseling of approximately 4 hours is held weekly at convenient times, and each family participates in an intensive family week of therapy.

8-Individual family counseling is scheduled as needed.

9-Where deemed therapeutic, inpatient interventions are done early in a patient's stay.

10-The basic program provides for a minimum of 35 hours per week of formalized individual, group, and family counseling, and is supplemented by vocational, employment, and social services as needed.
11-Following the first phase of the comprehensive program (detoxification), patients attend nightly AA meetings in outside community AA groups five nights a week and attend AA meetings held on the unit the other two. NA meetings may be substituted in the case of drugs other than alcohol.

12-Temporary AA/NA sponsors or contacts are obtained for each patient.

13-A back-to-work conference is held, whenever applicable, with each patient and his or her employer.

14-A going-home conference is held with each patient and his or her family.

15-Each patient works with the Pastoral Consultant to do a 4th and 5th Step by the end of inpatient treatment or during Continuing Care.

16-Pastoral Consultant is on the unit a part of each week to consult with patients as needed.

Brookwood’s Continuing Care program is 2 years in length. The patients meet weekly with Continuing Care Counselors, with the first hour of each meeting often focusing upon a lecture on one of the topics shown below, and the other hour or hour and half devoted to separate patient and family sessions of group therapy.

1. Parallel Growth and Emotional Independence
2. How to Change—(Pick a Slogan)
3. Sponsorship and Johari’s Window
4. Principles Before Personalities
5. Why Am I Afraid? (Film Clip)
6. Levels of Communication and Rules
7. 4th Step Workshop
8. Forgiveness and 5th Step
9. Recovery and Beyond
10. 6th and 7th Step Workshops
11. Value Clarification
12. Love and Caring/Sharing (What It Is and What It Is Isn’t)

The program has been designed according to the principles and traditions of Alcoholics Anonymous due to its established effectiveness in fostering longterm patient recovery. The accent of the program is on producing people who get sober and stay sober, and returning sober, productive employees to their work.

EVALUATIONS

Evaluations are done by the Clinical Director by appointment.

INTERVENTIONS

A 2-week Intervention and Education class runs continuously on the unit; Classes are each Thursday afternoon, 2-4 p.m., and each Thursday night, 7-9 p.m. There is no charge for these classes, they are provided as a community service.

Counselors are also available for helping people prepare for and do a formal intervention, following the Johnson Institute model of intervention.

Brookwood and its employees consider CONFIDENTIALITY of utmost importance to quality patient care.