University of New Mexico
UNM Digital Repository

Native Health Database Full Text

Health Sciences Center Archives and Special Collections

1989

Assessment of Strategies to Promote Cost and Management Efficiencies in Tribal and Contract Health Service Programs

Support Services International, Inc.

Follow this and additional works at: https://digitalrepository.unm.edu/nhd

Recommended Citation

Support Services, Inc. Assessment of strategies to promote cost and management efficiencies in tribal programs. Indian Health Service, Staff Office of Planning, Evaluation and Research, Rockville, MD 20857 (E-89). 1989

This Article is brought to you for free and open access by the Health Sciences Center Archives and Special Collections at UNM Digital Repository. It has been accepted for inclusion in Native Health Database Full Text by an authorized administrator of UNM Digital Repository. For more information, please contact disc@unm.edu.

9700409

INDIAN HEALTH SERVICE

Volume II
FINAL REPORT
Appendices

Assessment of Strategies to Promote Cost and Managment Efficiencies in Tribal and Contract Health Service Programs

December 1989

Department of Health and Human Services
Public Health Service
Indian Health Service
Office of Planning, Evaluation and Legislation
Division of Program Evaluation and Policy Analysis

Volume II
FINAL REPORT

Assessment of Strategies to Promote Cost and Management Efficiencies in Tribal and Contract Health Service Programs

Appendices

Task Order No. 236-88-0505

Submitted to:

Department of Health and Human Services
Public Health Service
Indian Health Service
Office of Planning Evaluation and Legislation

Project Director: Ramona Ornelas

Submitted by:

Support Services, Inc.
8609 Second Avenue, Suite 506
Silver Spring, MD 20910-3362
(301) 587-9000

APPENDIX A
SITE VISIT REPORTS

1) Mashantucket Pequot
2) Devils Lake Sioux
3) Puget Sound Service Unit
4) Taholah Service Unit

MASHANTUCKET PEQUOT SITE VISIT REPORT

Task Order No. 236-88-0505

Submitted to:

Department of Health and Human Services
Public Health Service
Indian Health Service

Submitted by:

SUPPORT SERVICES, INC.
REMOTE PROCESSING MANAGEMENT • NATIVE AMERICAN RESOURCES
8609 Second Avenue, Suite 506 Silver Spring, MD 20910-3362
(301) 587-9000

TABLE OF CONTENTS

MASHANTUCKET PEQUOT SITE VISIT REPORT

1.0 INTRODUCTION

Under contract with the Indian Health Service (IHS) and the Health Care Financing Administration (HCFA), Support Services, Inc. (SSI) studied four sites to assess strategies for management and cost efficiencies in health care delivery. The sites, designated by IHS, were the Mashantucket Pequot Health Department (MPHD), Connecticut: the Ft. Totten Clinic, Devils Lake Sioux Reservation, North Dakota; the Puget Sound Service Area, and the Taholah Clinic, Quinalt Reservation, Washington. This report presents the findings of the Mashantucket Pequot site visit.

1.1 Background

The Indian Health Service (IHS) is the federal agency responsible for providing health care to American Indians and Alaska Natives. IHS provides health care directly through hospitals, clinics and pharmacies; through tribally operated programs, with services provided at tribal clinics or purchased from area providers through Contract Health Services (CHS), or through a combination of direct and contract care.

The Mashantucket Pequot Health Department (MPHD) is a tribally operated program under Public Law 93-638 (Indian Self-Determination and Educational Assistance Act). MPHD provides primary health care through its clinic, and purchases all physician, dental, pharmaceutical and inpatient services from area providers. The MPHD currently serves 350 of the approximately 850 eligible Native Americans living in New London County, Connecticut.

Due to a growing population with increasing health care needs, and rising health care costs, the MPHD has been forced to defer services previously provided. In FY 1988, MPHD was able to draw on reserve funds to cover costs incurred in excess of its CHS budget. That reserve has been exhausted, and the MPHD can reimburse only for top priority, urgent and emergency services.

1.2 Study Objectives

The purpose of this site visit was to collect information to help the Mashantucket Pequot to assess alternative health care systems to determine which are the most appropriate for the service population, and which will enable the program to provide needed contract health services with the financial resources available. It is expected that the selected alternatives will transfer from the IHS to the Tribe all responsibility to manage tribal health care in a cost efficient manner. Thus, the recommended alternatives must demonstrate a commitment and ability to promote tribal self-determination through the development of management capabilities.

This study analyzes the health status of the population served, the MPHD services, and assesses alternative health care delivery and management systems to determine which best meet the health care needs of the population. Health care alternatives include current program modifications, negotiation of competitive contracts with health care providers, development of a limited pharmacy program, certification as a Rural Health Clinic, purchase of select services through Health Maintenance Organizations (HMOs), and certification of the MPHD as a Competitive Medical Plan (CMP). These health care alternatives are analyzed in terms of their impact on quality of care and cost of services, and their reliability and capability.

1.3 Tribal Feasibility Studies

Based on a concern for the provision of high quality health care, as well budgetary constraints, the MPHD is assessing alternative methods of delivering and managing health care. In 1987, with a grant from IHS, the MPHD sponsored an HMO feasibility study. This study examined the Connecticut market for health care services, and initially determined that a tribally operated HMO with a state-wide client base was feasible. After further study, the Tribe determined that an HMO was not practical because of a state capitalization requirement of $1,000,000 and an uncertain market. The tribe is currently conducting a CMP feasibility analysis (discussed in Section 5.4).

2.0 HEALTH SERVICES AND UTILIZATION RATES

This section identifies the range and frequency of use of existing services provided by the MPHD, and the providers to whom patients are referred. This data defines the needed services, and identifies problem areas in health care delivery.

2.1 Mashantucket Pequot Health Department

The MPHD Clinic provides basic primary health care and referrals to area health care providers for 350 patients. The MPHD emphasizes mental health, maternal and child care, nutrition and preventive health education. The program also identifies patients eligible for alternate health care resources, provides utilization control through identification of the most appropriate health care resources available to a patient, and reviews claims for accuracy. Generally, the MPHD provides a triage and utilization management function that is quite similar to utilization review programs provided by some HMOs and Preferred Provider Organizations (PPOs).

The MPHD operation, staffing costs, and patient treatment expenses are covered by IHS, The FY 1989 CHS budget is $315,549. In those cases for which physician, hospital, dental and outside mental health care is needed, the MPHD issues a Purchase Order to obligate CHS funds for the care. Providers submit their bills to the MPHD after having recovered from primary payors--private or employee insurance, and Medicaid or Medicare, depending on patient coverage and eligibility.

2.1.1 MPHD Programs

With a staff of seven, the MPHD operates several programs. While the majority of the services are provided at the Clinic, the Community Health Nurse, and Community Outreach Workers regularly make home visits to patients unwilling or unable to come in to the Clinic.

Health promotion and disease prevention are major focuses of the MPHD programs. The MPHD provides informational material designed to encourage patients to come in and either meet with staff or be exposed to health information. Staff conduct informal seminars and meetings for school children and adults, and sponsor a program to train "peer counselors" in preventing substance abuse. In addition to providing regular blood and screening tests (blood pressure, TB screening, cholesterol, blood sugar, vision tests, etc.), the staff work with patients, at home and at the clinic, to monitor medications, diet and lifestyle. A Community Outreach Worker also makes home visits to educate patients on auto safety.

- The alcohol program focuses primarily on health education; however the Community Health Nurse/Alcohol Coordinator also provides counseling services and crisis intervention.

- The MPHD has implemented a Community Injury Control Program to reduce traffic accident injuries to infants. This program focuses on education and loans car safety seats to the parents of newborns.

- Working closely with the Tribal Manager, the MPHD also coordinates environmental health programs consisting primarily of water testing for fluoride and minerals and home radon testing.

2.1.2 Staffing

The MPHD staff include: the Health Director, (responsible for planning, management, staffing, administration, budget and coordination of MPHD programs); the Nurse Supervisor, (who provides health screening, primary care and health education); the Community Health Nurse/Alcohol Coordinator, (whose primary responsibility is mental health, and alcohol and substance abuse counseling and program coordination); two Community Outreach Workers; (who work with patients in supervision of medications, preventive health and health education, and assist in providing transportation when necessary); the Health Secretary, (who assists in administration and management of programs); and the Contract Health Administrator, (who coordinates and oversees relations with area providers, assists in the identification of alternate resources, and manages collection and payment of provider claims).

2.1.3 MPHD Facility

The MPHD occupies an attractive new building centrally located on the Mashantucket Pequot Reservation. The facility includes a large central area designed for easy access, several offices and cubicals used by the Nurse and Outreach Workers, and an examining room which appears to be infrequently used except for counseling.

Although there is no public transportation in the area, distances between the residences of most patients and the Clinic are not great, and MPHD staff do not believe that access is an issue for most patients. For those who can or do not drive, the MPHD provides transportation.

2.1.4 MPHD Utilization

The MPHD Clinic is not heavily utilized by eligible patients -- only 350 of 850 eligible persons are currently using its services. Many patients prefer to be seen in their homes rather than at the Clinic. Clinic staff report seeing about 200 patients monthly for referral, treatment, counseling or to provide transportation, with many patients making repeat visits for mental health counseling (MPHD Monthly Nursing Report, 1988).

The MPHD staff cite confidentially as the key issue in low Clinic utilization. The user population is small, and may be known by, or even related to staff; therefore, patients are hesitant to come in for mental health counseling, or for treatment of illnesses that are socially sensitive, such as sexually transmitted diseases. Because of its central location, and the fact that it is an open facility with only one entrance used, the Clinic does not afford much privacy. Lack of knowledge about the services offered by the MPHD among eligible patients, and the lack of a defined set of benefits were also cited as reasons for low usage.

2.1.5 Quality Assurance and Utilization Review

The MPHD has quality assurance (QA) and utilization review procedures in place. Through careful tracking of patients and patient records, the MPHD monitors providers to assure that their treatment is appropriate and timely. By requiring that patient referrals be made by MPHD staff (except in emergency cases), the MPHD assures that patients are referred to the appropriate providers.

2.2 Provider Referrals

Patients needing physician or dental care are referred to one of over 20 physicians or physician groups, four dentists or dental associates, three hospitals, three pharmacies and one optometrist located in the area. Figure 1 indicates the apportionment of funds among providers.

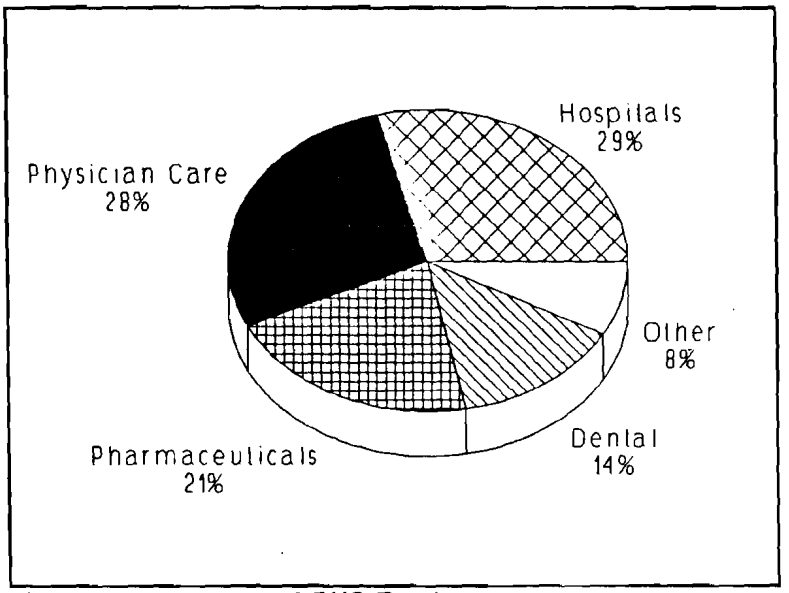

Figure 1. Allocation of CHS Funds
(Mashantucket Pequot Annual Report, 1988)

Clients are referred to area health care professionals for the following care: dental (over 30 percent), pediatrics (20 percent), family practice (over 30 percent of patients), OB-GYN, optometry, and orthopedics.

Generally, providers are selected on the basis of their willingness to work with the MPHD and its patients, provider relationship with patients, their willingness to accept Medicaid and Blue Cross/Blue Shield (BCBS) patients, their geographic location, and their commitment to quality service.

While the MPHD does have contracts with some providers, the contract is not a prerequisite to CHS coverage for patient costs. The contract in place does not establish a fixed or firm negotiated fee, and the MPHD is paying the market rate fee-for-service. The contract also includes a provision requiring drugs to be priced in accordance with the Federal Maximum Allowable Cost (MAC). The MAC provision did not appear to be strictly enforced, and the MPHD is studying alternative methods of procuring pharmaceuticals. At the time of the site visit, the MPHD Director was in the process of renegotiating provider contracts.

Access to providers is an issue for some Medicaid and BCBS patients. An increasing number of providers refuse to treat these patients because of the low reimbursement rates and delays in payment.

2.3 Hospital Services

The MPHD purchases inpatient care from three area hospitals. Comprehensive inpatient services are obtained at the William W. Backus Hospital (39 patients admitted in FY 1988), Lawrence and Memorial Hospital (36 patients admitted in FY 1988), and Yale New Haven Hospital (seven patients admitted in FY 1988).

While Backus is the hospital preferred by the MPHD staff, nearly half of the CHS physicians are affiliated with, and admit their patients to, Memorial Hospital. The MPHD believes that the average length of stay at Backus is shorter than at Memorial, and the quality of care is better. Yale New Haven Hospital is used only for specialty care.

In FY 1988, 82 MPHD patients were admitted to hospitals and the average length of stay was 2.5 days (Nashville Area Office, and IHS Office of Program Statistics, FY 1988.) The average length of stay at Backus Hospital for all patients is over 5.6 days. Total hospital expenses reimbursed by the MPHD in FY 1988 were $76,607.42, for an average cost per day of $368.30.

Under Connecticut law, hospitals may offer discounted services only to HMOs. Legislation has been proposed to close the HMO exception, and require all parties to pay a comparable rate for hospital admissions and services. Treatment of Medicaid patients is charged at the Diagnostic Related Group (DRG) rate. The MPHD currently reimburses hospitals at the DRG rate.

2.3.1 Inpatient Mental Health and Detoxification

The MPHD has insufficient funds to cover the needed inpatient mental health and detoxification treatment. Treatment at private facilities costs as much as $12,000 per patient, with most private insurance having a cap at $5,000. The state hospital usually has a waiting list of up to six months, is several hours from where patients reside, and is strongly disliked by patients who usually refuse treatment there. As a result, patients in need of care are not receiving treatment. In FY 1988, six clients were in residential care, and the number needing such care has not decreased.

Backus Hospital is considering expanding its inpatient mental health services for alcohol and drug detoxification and treatment. The hospital anticipates that such a program might cost $500 per day/per patient. However, hospital administrators indicated that they might be willing to enter into an agreement with MPHD at a considerable savings. Additionally, Backus Hospital is more conveniently located than is the state facility, and more patients may volunteer to be treated there.

2.4 Summary Of Health Services and Utilization Rates

MPHD patients are currently receiving a wide range of services, in their homes, at the Clinic, and through area providers. In addition to urgent and emergency care, the health department provides extensive primary and preventive care, health education, mental health, alcohol and drug counseling. These programs are tailored to the needs of the population

served, and are working towards establishing patient relationships based on trust and confidence.

Inpatient care is sought primarily for child birth and neonatal care, and outpatient care mainly for dental, pediatrics and OB-GYN. The MPHD is used most frequently for mental health counseling.

3.0 HEALTH STATUS ANALYSIS

Two types of health status information were collected during the site visit: 1) quantitative data that identifies specific diagnoses, and 2) qualitative information that identifies underlying health care issues--such as prevalent stress or alcoholism. This information was analyzed to identify basic health treatment needs and highlight unusual health conditions.

According to the MPHD, the health status of the service population is approaching the same level as that of non-Indians in the area. Generally, health status has improved significantly in the past four years, allowing the MPHD to shift its emphasis from emergency room treatment, to preventive care and health education. Children are up-to-date on their immunizations, and patients receive routine physical exams on a regular basis.

In spite of such improvements, the MPHD has identified several areas of growing concern. Alcohol and drug abuse are prevalent, and are believed to be a factor in 80-90 percent of illnesses and accidents--most notably diabetes, high risk pregnancies, spouse and child abuse, and traffic accidents. Work related stress is also increasing, and impacts heavily on the general health status.

3.1 Mental Health

Mental Health--including alcoholism and drug abuse, stress, long-term behavioral problems and learning impairments--has been identified as an issue central to the well-being of the service population. While alcohol abuse is the most visible mental health problem, MPHD staff trace histories of mental health care needs beginning in childhood. Several elementary school children suffer from learning disabilities, and adolescents attempt suicide, drop out of school and become involved in alcoholism and drug abuse. Many causes are identified, including the family cycle of alcohol dependency, fluctuating incomes, perceived isolation from the surrounding community, a lack of reservation based activities for children and "reservation life" in general.

Every MPHD staff person interviewed identified mental health services, and alcohol and drug abuse prevention counseling as the most needed services, and the area where present services are most inadequate. Because inpatient psychiatric care is prohibitively expensive, and is at times unavailable due to a scarcity of beds, the MPHD relies heavily on out-patient counseling. Aside from the services provided by the staff Community Health Nurse and Community Outreach Workers, the MPHD is able to afford little psychological or psychiatric care.

3.1.1 Alcohol and Drug Abuse

Alcohol and drug abuse have been identified as the major reservation health problem. While data on the incidence of alcoholism is not available, MPHD staff indicate that as much as 90-95 percent of the adult population is adversely impacted by alcohol and/or drugs.

The MPHD has staff to provide counseling, and limited funds to purchase out- and inpatient care in urgent and emergency situations. However, the program's effectiveness is hampered by patient resistance to treatment, and issues of confidentiality. While the Tribal leadership recognizes alcoholism and drug abuse as an important issue, several persons interviewed expressed the belief that it is a personal, rather than a tribal or MPHD matter.

3.2 Ambulatory Health Status

Among ambulatory CHS services, dental care, family practice, OB-GYN, pediatrics, neurology, or orthopedics are the most often visited providers, with 290 patients receiving care from providers in these fields. Diabetes represents another major health care need. Although health maintenance and health education services provided at the MPHD Clinic decreases reliance on contract physicians, regular physician check-ups are necessary. The MPHD also reports three cases of cervical cancer and/or cancers related to sexually transmitted diseases. These cases require high cost treatments and medications.

While long-term professional outpatient mental health care is needed, such treatment is very costly (as much as $85 per session), and is seldom adequately covered by insurance. Thus, MPHD staff are the primary providers, and devote much time of their to mental health care.

3.3 Inpatient Health Status

High risk pregnancies, caesarean sections, accidents, cancer treatment and inpatient detoxification represent the bulk of hospital services purchased through the MPHD. Over 82 patients (25 percent of the patient population) were admitted to hospitals in 1988. The rate of hospitalization is considerably higher than the national average.

With the exception of a high rate of caesarean sections (8 of the last 10 pregnancies), the MPHD believes that its inpatient usage is average. The high caesarean rate is attributed to early and high risk pregnancies, rather than to hospital or physician abuse.

3.4 Births and Deaths

Since 1984, 51 children have been born to MPHD patients or their spouses. Two of these births were premature, and two were low weight (under 2500 grams). The MPHD is projecting an increase in the birthrate, and has five current high risk pregnancies. High risk pregnancies, premature and low weight births are among the highest cost cases covered by CHS. The cost of treating high risk pregnancies is often as much as $10,000 for the birth and neonatal care alone.

Because the program is new, and serves a small population, few deaths (3) have been recorded, and no statistical or mortality patterns established.

3.5 Dental Care

Dental care is one of the most frequently used medical services, with a third of the service population having received dental care in FY 1988. Funds for dental care are restricted, and the MPHD is no longer able to provide contract funds for routine dental care.

3.6 Summary of Health Status

Information on the overall health status of the patient population has conflicting implications. While Health Department staff report that health conditions are not bad, and are not worse than those in the community, they also cite a high alcoholism rate and a high rate of caesarean sections. Data collected by IHS indicate birth weights above those of the national average, higher rates of hospitalization, but shorter hospital stays.

- In the three year period between 1984 and 1986, two of 37 (5.5 percent) of tribal live birth weights were low (under 2500 grams). In the general population, 6.7 percent of live births were low weight for 1984, and for Indians and Alaska Natives the percent of low weight births was 6.1% for 1983-1985. (IHS Chart Series Book, and IHS Office of Program Statistics)

- According to the Office of Technology Assessment (OTA) health care study, the average rate of hospitalization at all U.S. nonmetropolitan hospitals was 15.9 percent (1982), and the average stay was 7.5 days in 1983. The average length of stay in IHS hospitals was 4.9 days in 1984. The hospitalization rates of the MPHD service population was 25 percent, while the average length of stay per admission was 2.5 days.

Several other factors not reflected in health statistics are areas of growing concern. These include prevalent alcohol and drug abuse, and stress related complaints. Additionally, the incidence of high risk pregnancies, and numerous caesarean births indicate underlying health problems that need to be considered in program planning.

4.0 MARKET ANALYSIS

To identify and assess appropriate health care delivery systems, it is first necessary to understand the health care needs and utilization patterns of the current and potential patient base, and to predict changes in the market population. This information will be used to determine what services patients need and are receiving. These services, in turn, will be a key factor in comparing the costs and advantages of alternative health care providers.

4.1 Demographic Data

Demographic data defines the actual and potential market for health services, in terms of its current and future size, and identifies future health care needs. The demographic data collected during the site visit provides information on key characteristics of the market, such as age and sex distribution, income and insurance coverage.

The exact number and characteristics of Mashantucket Pequot Tribe eligible for Contract Health Services (CHS) are difficult to determine because of growth and migration to the area. The Mashantucket Pequot Tribe received Federal recognition in 1983, and have since been actively pursuing new membership among descendants of Mashantucket (Western) Pequots listed on the 1900 and 1910 Census. In addition to cultural and social attractions, the Tribe offers housing and employment opportunities to its members. The reservation population has more than doubled since 1984, when 105 were listed on reservation rolls. The off-reservation membership is also growing rapidly due to attraction of seasonal workers to standard of living and employment rates higher than in surrounding areas. Many such persons, if members of Federally recognized tribes, are eligible for MPHD services. Thus, the IHS eligible population may increase rapidly in the near future, and fluctuates from year to year.

4.1.1 Population Data

According to IHS figures, 865 New London residents are eligible for health care services through the MPHD. (1988 IHS estimate based on 1980 census figures--which takes into account growth from births only). The Tribe estimates that the eligible population may be close to 1,200, counting new tribal members and those moving into the county for employment (HMO Feasibility Project, A Report from the Mashantucket Tribe, 1988).

Based on projected births, IHS estimated that the eligible population will grow to 1,062 in the year 2001, 1,089 in 2050, and to 1,178 in the year 2010. The number of persons using health services will probably increase at a greater rate than the eligible population as a predominately young population reaches child bearing age, and as more people utilize the services available through the MPHD.

4.1.2 Age Distribution

Age distribution is used as a predictor of near- and long-term health care needs. For example, the MPHD reports that the majority of patients are 16 or younger, and few are 65 or older. Figure 2 illustrates the distribution of the population by age.

Fifteen is the median age of the service population, and three fourths of the population has reached, or will soon be entering, adolescence and child bearing age. High-risk pregnancies and infant care represent most of the MPHD's high-cost cases, and staff have identified an increasing need for mental health services as children enter adolescence.

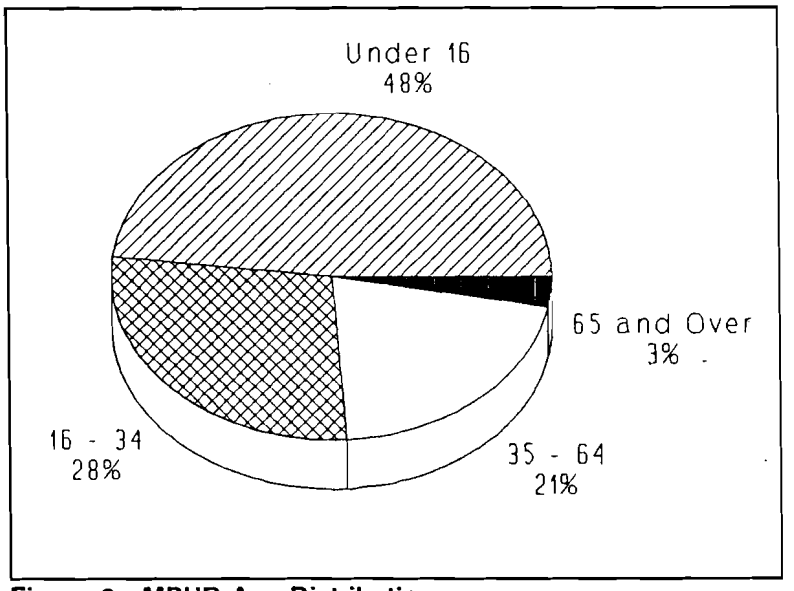

Figure 2. MPHD Age Distribution

Detailed information on age was collected only for the 126 persons living on the Mashantucket Pequot reservation. IHS does not maintain age distribution data for the eligible New London County population; thus, projections are made from the reservation population, and from observations made by the MPHD staff.

4.1.3 Sex Distribution

Sex distribution is another predictor of near- and long-term health care needs, in terms of gender related conditions--primarily those relating to pregnancy and childbirth. Data on sex distribution was collected only for reservation residents. The population is almost evenly divided between men and women, and with the exception of pregnancy and childbirth, the health care needs of male and female MPHD patients are similar. However, pediatrics and OB-GYN represent the majority of health care services sought, as well as the greatest expenses incurred by the MPHD.

4.1.4 Income Distribution and Employment

Tribal members living in or near poverty are those who rely most heavily on tribal health care services. At the same time, many low income patients are eligible for assistance from other sources, such as AFDC or Medicaid.

The average Mashantucket Pequot household income is $29,000, with an average family size of 3.5. About 70 percent of the of client population are employed, or are covered by employee insurance. Approximately 28 percent of the eligible population are below the poverty level and eight percent of the patients are eligible for Medicaid. Three percent of the population are eligible for Medicare. IHS funds are the sole coverage for about 20 percent of the patients seen at the MPHD Clinic.

4.1.5 Insurance

Many MPHD patients with private insurance are employees of the Mashantucket Pequot Tribe, and work for the tribal government, or tribal industries. Tribal employee insurance is provided through a self-insurance fund sponsored by United South Eastern Tribes (USET). This fund, administered by BCBS of Tennessee pays at fee levels based on Tennessee standards--with benefits paid at a significantly lower rate than the fees charged in Connecticut. For FY 1988, the insurance plan reimbursed at a rate of about 40-45 percent of the fees charged by providers.

Because private insurance is the primary payor, CHS funds pay only the amount that is not covered by the alternate payor. Thus, for those patients covered by tribal insurance, CHS funds are contributing 55-60 percent of health care costs incurred by tribal employees.

4.2 Service Population

In FY 1988, the patient population was comprised of members of ten tribes, and less than one-third were members of the Mashantucket Pequot tribe. Figure 3 illustrates the population distribution.

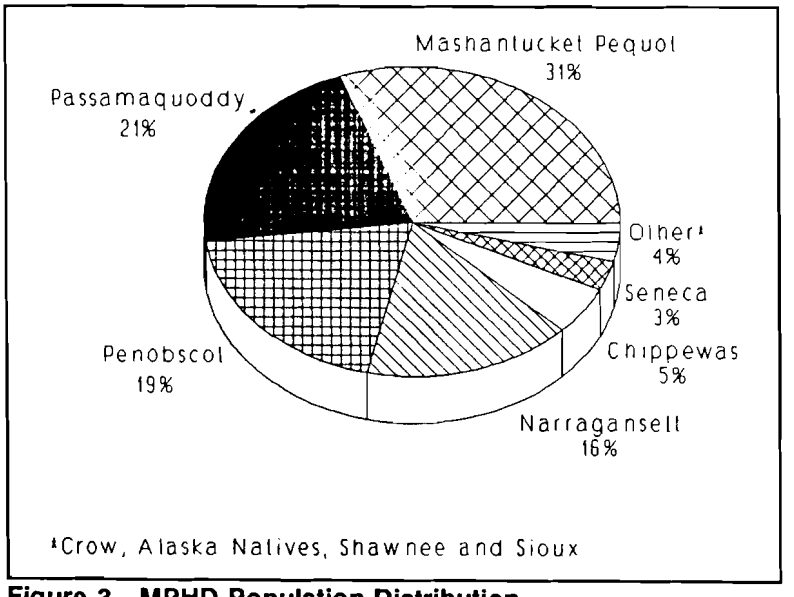

Figure 3. MPHD Population Distribution

4.3 Other Markets

Under 40 percent of the eligible population in New London County are currently using MPHD services. Other Native Americans living in the area may comprise a viable market for services. The MPHD has an informal agreement with other tribes in the area, but no firm agreements regarding coordination of services.

Prior to implementing a program to attract some of those eligible patients not currently using MPHD services, staff should explore funding and eligibility issues. One important concern is whether IHS funds will significantly increase the patient population. Another factor is determining patient eligibility, as well as identification of patients covered by alternate sources of coverage. Because the MPHD is oriented towards primary health care and located on the reservation, it is unlikely that non-Indians will seek health care at the Clinic.

5.0 ASSESSING ALTERNATIVES

In purchasing services, the MPHD has the benefit of a large pool of health professionals and medical facilities in the nearby area from which to choose, and can concentrate on negotiating agreements with the highest quality and most cost-efficient providers. However, to achieve significant discounts, the MPHD must offer incentives. Such incentives may include prompt, or more timely payment of claims, and a concentrated pool of patients. The MPHD may also consider purchasing access to a provider network, discount and utilization management program.

Alternatives which rely on a large infusion of capital, or a rapidly increasing population base should be analyzed in light of the likelihood of attracting a large number of new patients.

5.1 Program Flexibility and Range of Services

The size of the service population is important in that a relatively small increase in the number of clients may have a significant impact on the ability of the health department to meet client needs. For example, 30 new clients represents a 10 percent increase in total clients, with the possibility of introducing new health care needs and unanticipated costs. The potential for change necessitates a high degree of flexibility and adaptability in any alternative considered.

Currently, the MPHD is able to provide or procure a wide range of services, such as environmental health, alcohol counseling, and orthopedic surgery as funds are available. In assessing alternatives, it is necessary to assure that needed services will not be lost, nor unnecessary expenses incurred in implementing the program. For example, HMOs and PPOs probably cannot provide the same degree of home counseling as is presently available to patients.

In summary, alternative health care systems for this Tribe must be flexible both in terms of serving a changing population, and in providing, and arranging for the provision of comprehensive health care services.

Likewise, when considering the development of new programs, such as an HMO or Competitive Medical Plan (CMP), it is important that the health care benefits be weighed against the potential risks and costs, and the capabilities of the MPHD staff be considered

in planning changes. The threshold questions in the feasibility assessment of alternative health care systems are:

- Will the alternative improve health care services, and how will the patient population be impacted?
- Is the alternative cost efficient, and can the program afford the expense?
- What state and federal regulations apply?
- Does the MPHD have the administrative, record keeping and management capacity to monitor the program?
- What are the risks in adopting the alternative?
- What steps are required to implement the alternative?

5.2 Recommended Program Modifications

Because the funds are limited, and the MPHD staff is small, this study recommends program modifications designed to enhance existing services, rather than major changes in the administration and delivery of health care.

The following recommended modifications can be considered and implemented independently, or in combination, without disruption to patient health care services, or risk to the continuity of the primary care services currently provided by the MPHD.

5.2.1 Mental Health Services

The MPHD may consider entering into a affiliation agreement with Backus Hospital, under which the hospital will provide detoxification treatment. Backus is considering the possibility of developing a residential alcohol and drug treatment program, but expressed uncertainty over the size of the market for such services. Given that the MPHD is presently purchasing detoxification treatment (to the extent funds are available) from private facilities at a premium rate, Backus may be able to provide more accessible services at an advantageous cost.

Beneficial aspects of affiliation to provide mental health care are that the MPHD can design of the program to increase continuity of care and meet cultural needs. With involvement of MPHD staff in the inpatient care period, staff will be better prepared for, and patients more receptive to follow-up treatment. Additionally, the mental health program can overcome cultural impediments to treatment, such as the lack of family visitation privileges at the state facility.

A mental health program in which the MPHD participates is likely to improve overall health care, and may be cost efficient. Whether or not the MPHD can afford such a

program will depend largely on the degree of support from Backus. The next step in assessing such a program is to begin negotiations with Backus administrators.

5.2.2 Negotiated Agreements: Physicians and Dentists

The reservation's location affords the MPHD latitude in selecting from among area providers and enables the program to request competitive bids. The MPHD has already identified and is using several area physicians and hospitals, and should concentrate on these in negotiating competitive agreements.

Because of the number of patients it represents, the MPHD has leverage in negotiating agreements with providers. The MPHD should require physicians and dentists to submit, and adhere to a schedule of fees, discounted on the basis of the number of patients referred. A factor in negotiating with providers will be the MPHD's ability to improve turnaround time in processing claims, which is presently 60-120 days. A discount in charges for prompt payment is customary among many providers, and timely payment combined with preferred referrals is a strong incentive to negotiate favorable rates.

More aggressive negotiation of provider contracts need not have any impact on health care delivery, could be accomplished at little cost and has the potential of considerable savings to the program. In FY 1988, the MPHD spent over $112,000 in dental and physician care.

A 20 percent discount would have saved the program over $22,000, funds that could then be allocated towards other needed services. There are no risks associated where providers are involved in the contract negotiations, there are no risks associated with this procedure.

5.2.3 Negotiated Agreements: Pharmaceutical

The MPHD standard contract includes a clause requiring drugs to be distributed in accordance with the federal Maximum Allowable Cost (MAC), as enacted in 1975. If applied more aggressively, this clause could accomplish considerable cost savings for the MPHD. In FY 1988, the program spent over 20 percent of its budget on pharmaceuticals. Enforcing the MAC clause has the potential to achieve cost savings without an adverse impact on health care or risk to patient or program. State and federal regulations do not prohibit such contract agreements, and the state may have a MAC formally in place.

5.2.4 Certification as a Rural Clinic

The MPHD does not provide the kind of services which can be billed to insurers. The cost of the basic primary care services provided by the Clinic are not recoverable from private insurance, and recovery from Medicaid is possible only through certification under the Rural Health Clinic Services Act of 1977 (Public Law 95-210).

Under the Rural Health Clinic Act, clinics providing primary outpatient services through a physician, physician's assistant or nurse practitioner may recover an all inclusive rate per visit. Coverage for the following services is included in the Rural Clinic program: routine medical or surgical treatment provided by a physician, physician's assistant or nurse

practitioner, and services incidental to their treatment; home nursing care where provided by a registered nurse (RN) or licensed practical nurse (LPN); outpatient maternity services where provided by a nurse midwife; and diagnosis and treatment.

Certification also requires that a limited range of laboratory tests be offered by the clinic--some of which are already being provided.

The certification program is managed by the IHS Nashville Area Office, Alternate Resources Program, which is encouraging clinics to consider certification, and can provide assistance in the application process. Independent of certification, the program also provides information and training materials to assist clinics identify persons eligible for alternate resource coverage.

With nearly 10 percent of its patient population known to be eligible for Medicaid, and others who may be eligible depending on seasonal employment, the MPHD should consider applying for certification as a Rural Clinic. To be eligible for certification, the Clinic need only have a part-time physician's assistant or nurse practitioner on staff, and increase the scope of its services to include the required tests. Certification would enable the MPHD to be reimbursed directly for Medicaid patients, and some of the increased services would also be billable to private insurance. Through billing for some of its patients, the MPHD would free-up funds to use in enhancing services. Another benefit to internalizing a limited range of services are the savings by not purchasing such services from outside providers.

The first step in an evaluation of the benefits and costs of certification is to determine how frequently, and at what cost, additional services could be internalized. The second step is to assess the costs involved in implementing the plan: increased staff, staff training, equipment and supplies. Finally, the evaluation should appraise the risks involved in becoming a Rural Clinic, such as disruption of patient-physician relationships, patient acceptance and use of the program, ability of staff to administer the program, process claims and maintain data, and financial failure of the program. Information and application forms can be obtained from the Alternate Resources Program.

5.2.5 On-Site Pharmacy

The MPHD has considered the possibility of operating a small pharmacy on the reservation. Because of the range of drugs that are prescribed on a routine basis, their short shelf-life, and cost, a service population of over 1000 is needed to make even a limited pharmacy operation cost-efficient. However, the MPHD may consider purchasing over the counter and prescription drugs which are prescribed with great frequency. If purchased in bulk, pharmaceuticals can be obtained at significant discount.

To identify frequently prescribed drugs, the MPHD should review patient prescriptions over the past year. A review of prescriptions will also enable the MPHD to identify patients who are prescribed medications by several providers without coordination, or potential abuses of the system, such as where barbiturates or anti-depressants are being frequently prescribed.

Prior to a full-scale study of the risks and benefits of implementing a limited pharmacy program, the MPHD should determine what staff changes would be required to dispense pharmaceuticals, and what state and federal laws apply. Further analysis should examine the costs of a pharmacy program, including staffing and staff training, purchase, storage and dispensing costs, administrative and record-keeping requirements.

5.2.6 Provider Network and Utilization Services

HMOs and PPOs are increasingly willing to "unbundle" their benefit packages, to sell select services to groups. Under such a plan, the MPHD may be able to purchase benefits such as access to HMOs provider network, discounts, and utilization review programs at a fixed per capita or group rate. By purchasing access to the provider network and discounts, the MPHD may be able to take advantage of the HMO or PPO's ambulatory and hospital discounts, while remaining responsible for the actual patient costs.

While the MPHD already has some utilization procedures in place through its referral and patient voucher system, the bargaining power of an HMO or PPO enables it to enforce a broader scope utilization control. Such restrictions would be advantageous to the MPHD in areas where costly procedures are being performed more frequently than is customary--as in the case of caesarean sections. Utilization review procedures may include procedures may include:

- Pre-admission certification for inpatient medical procedures, to determine the appropriate treatments, norm lengths of stay, and inform physicians and hospital of agreed costs. Where applicable, pre-admission certification also provides cost savings by requiring that diagnostic tests and pre-admission tests be performed on an outpatient basis

- Concurrent utilization review, to assure that patients are hospitalized only as long as necessary and that only needed services are performed

- Periodic review of hospitalization patterns where physicians and/or hospitals have an above norm number of high cost cases. Because hospitalization and related services are among the highest cost health care, concurrent utilization review focuses on the following five areas:

    - Was hospitalization necessary?
    - Was the treatment customary for the diagnosis?
    - Were the frequency and duration of the treatment appropriate?
    - Was the length of stay appropriate?
    - Could an alternative treatment setting have been used?

- Claims auditing to identify/inaccurate or unnecessary charges, and to resolve discrepancies.

The Colonial Individual Practice Association, an HMO with participation of 80-90 percent of the physicians in the New London area has indicated a willingness to consider unbundling its services. Other PPOs in the area may also be willing to sell select services.

To evaluate the benefits of purchasing services from an established HMO or PPO, the MPHD should determine the value of the discount offered, relative to the cost of buying the service. Additionally, the stability of the HMO or PPO should also be assessed to assure continuity of service.

5.2.6 Summary

While the recommended program modifications listed above are not without costs and risks, a preliminary analysis suggests that the costs are be outweighed by the savings, and justified by improvements or increase in services, and the risks managed through monitoring.

5.3 Marketing of Services

The MPHD QA and utilization control procedures are effective and cost efficient, and may be marketable to other health care providers or insurers in the region. With enhancement of its administrative and data collection procedures, and an increase in the scope of its utilization control programs, the MPHD may be in position to implement a program to market select administrative functions.

Possible purchasers of these services might include state social service departments, federal agencies such as the Department of Defense, or area PPOs. Such a program would require significant staff training, complete automation and improved data collection procedures.

One preliminary issue that arises in the assessment of such a program is whether or not its implementation would be funded by IHS. Deciding factors include the likelihood that the program would improve health services to eligible patients, whether the MPHD has the ability to manage such a program, a thorough assessment of the risks, and a fiscally sound management plan.

5.4 Competitive Medical Plan (CMP) Assessment

The MPHD has considered several alternative systems of health care delivery, and has conducted HMO and CMP feasibility assessments. Because of the service population size needed to support an HMO, and because of the state capitalization requirement, the MPHD is no longer considering the HMO option, but is proceeding with the CMP analysis.

Some of the CMP objectives are:

- to give the MPHD access to Medicare rates for hospital admissions,
- to increase the likelihood that community providers will contract with the MPHD,

- to provide a vehicle for seeking Champus and other contracts as a preferred contractor for claims processing and related services.

While the stated objectives may be achieved by the formation of a CMP, the MPHD plan does not meet preliminary Health Care Financing Administration (HCFA) regulations governing CMP eligibility, nor does it address the costs of implementing the plan, or the risks involved. Three legislative requirements not met by the plan as presented during the site visit are: insolvency protection and compensation requirements (42 CFR Section 417.407 (c) (5), and 417.407 (2).), and the qualifying condition requiring eligible organizations to "deliver a specified comprehensive range...of services" (417.10 (a)).

- HCFA has interpreted the insolvency protection clause to mean that the CMP must demonstrate that it has arrangements in place to cover at least two months of health care expenses in the event it becomes insolvent. As far as IHS eligible patients are concerned, the MPHD can guarantee payments only to the extent funds are allocated, at that time. While the Area IHS Office has in the past met costs obligated beyond the Service Unit obligation, such funds are not guaranteed, and are usually limited to urgent and emergency care. To the extent the MPHD CMP plan anticipates providing services to persons not eligible for IHS funds, provisions for insolvency protection have not yet been demonstrated.

- The compensation clause requires that the "entity receives compensation for health care services it provides to enrolled members on a periodic, prepaid capitation basis regardless of the frequency, extent, or kind of services provided to any member." (417.407 (c) (2)). If the funds received from IHS are classified as "compensation", compensation is based on frequency and kind of services offered.

- The MPHD does not now provide a fixed or "specified range" of services. Beyond primary health care, some basic services such as diabetes treatment, and urgent and emergency care, services are provided as funds are available.

In addition to the issues raised by the controlling legislation, the CMP plan does not include a risk and benefit analysis, in which cost savings, program administration costs and licensing requirements are analyzed.

Prior to seeking IHS funding, the CMP feasibility analysis should identify how health care will be improved under the plan, and what MPHD programs will be affected. If there is no impact on the quality or range of health care services, then a benefit through cost savings must be demonstrated. As presented during the site visit, the CMP plan addressed none of these threshold issues.

6.0 SUMMARY

Alternatives in health care delivery systems for the Mashantucket are limited by two factors:

1) the small size of the service population, and the broad scope of needed health care services, and

2) limited funds.

This report assessed a variety of alternative health care systems for the Tribe, including the formation of an HMO or CMP, the purchase of services, certification as a Rural Clinic, and modifications to existing MPHD programs. Review of the data collected during the study indicates that the most viable alternatives are certification as a Rural Clinic, program modifications to better utilize resources, or the purchase of select services.

Information collected during the site visit indicate that the largest health issue facing the service population is mental health and alcoholism. It appears that this critical need is not being met by the MPHD. Thus, alternatives implemented in the future need to make provisions to meet the needs in this area.

Certification as a Rural Clinic will enable the MPHD to recover health care costs in some areas, so that resources may be reallocated. The recommended program modifications will enable the MPHD more effectively negotiate with providers, to obtain services at a lower cost, or to increase the range of services provided.

DEVILS LAKE SIOUX
SITE VISIT REPORT

Task Order No. 236-88-0505

Submitted to:

Department of Health and Human Services
Public Health Service
Indian Health Service

Submitted by:

SUPPORT SERVICES, INC.

REMOTE PROCESSING MANAGEMENT • NATIVE AMERICAN RESOURCES
8609 Second Avenue, Suite 506 Silver Spring, MD 20910-3362
(301) 587-9000

TABLE OF CONTENTS

LIST OF FIGURES

DEVILS LAKE SIOUX SITE VISIT REPORT

1.0 INTRODUCTION

Under contract with the Indian Health Service (IHS),[1] Support Services, Inc. (SSI) studied four sites to assess strategies for management and cost efficiencies in health care delivery. The sites, designated by IHS, were the Devils Lake Sioux and Ft. Totten Clinic, North Dakota; the Mashantucket Pequot Health Department, Connecticut; and the Puget Sound Service Area, and the Taholah Clinic, Quinalt Reservation, Washington. This report presents the findings of the Devils Lake Sioux site visit conducted in February, 1989.

1.1 Background

The IHS is the federal agency responsible for providing health care to American Indians and Alaska Natives. The IHS provides health care in hospitals, clinics and pharmacies; through tribally managed programs, with services provided at tribal clinics or purchased from area providers through Contract Health Service (CHS) funds; or through a combination of both.

Health care at the Devils Lake Reservation is provided by IHS staff at the Ft. Totten Health Center clinic, through CHS providers, and through health programs managed by Devils Lake Sioux Tribe under Public Law 93-638 (Indian Self-Determination and Educational Assistance Act). The Ft. Totten Health Center (IHS Clinic) provides basic medical and dental care, minor surgery, and purchases specialty and inpatient care from area providers. The Tribal Health Service Program (Tribal Program) provides environmental health monitoring, preventive care, health education and transportation services. The health programs serve a resident population of about 4,500, of whom 3,600 are members of the Devils Lake Sioux Tribe. The Clinic reports open files for 8,000-9,000 patients seen within the last five years. Key management issues for the IHS Clinic are the shortage of on-site physicians, space, staffing, and funds. Because of the low levels of needed resources, the IHS Clinic services are limited to emergency and intervention care. Primary management concerns for the Tribal Programs are the shortage of funds and manpower.

[1]Equal funding for this project was provided by the Office of the Secretary, Department of Health and Human Services.

While the overall health status in the area has improved significantly over the past eight years, Ft. Totten has one of the highest rates of "years of potential life lost" (YPLL) in the nation, and among Native American communities. Similarly, the infant mortality rate for the Ft. Totten Service Area is almost twice that of all races in the U.S.; and for Native Americans.

1.2 Study Objectives

The purpose of this site visit is to collect information to help the Devils Lake Sioux assess alternative health care systems in order to determine which systems best address the needs of the service population.

The alternative health care system must enable the program to provide needed direct and contract health services with the financial resources available, and to coordinate health care resources needed to provide a high quality of health care.

This study analyzes the health status of the population served, the services presently provided by the IHS Clinic, CHS services, and Tribal Programs, and assesses a range of alternative health care systems and management techniques. Health care alternatives assessed in this project include program modifications, development of joint venture programs, coordination and integration of health programs and resources, and the formation of a Health Maintenance Organization (HMO). These health care alternatives are analyzed in terms of their impact on quality of care and cost of services, and their relative cost efficiency.

1.3 Health Care Decision Making Process

A critical factor in this study is that no central tribal body is responsible for health care planning and decision making. In addition, those that are involved in the process do not always work in concert. The Tribal Health Board (Health Board) is the body formally charged with health care policy formation and implementation; however, the Tribal Government may override the Health Board. There is often poor communication among the IHS Clinic, Tribal Programs, and the Health Board. Thus, sometimes staffing and resource allocation decisions seem to be influenced by political factors, rather than on the basis of competence.

1.4 Tribal Feasibility Studies

The medical crisis caused by the shortage of physicians on-site at the IHS Clinic, and the pressing need for an improvement in health care (as evidenced by the high mortality rate) have prompted the Health Board to consider alternative methods of health care delivery. Consequently, the Chairman of the Health Board conducted a policy study to determine if a tribally-operated HMO was feasible and would attract providers to the area. No HMO or PPO currently operates in the region. The study did not examine the specific health care needs of the population, the financial aspects of starting and operating an HMO, or applicable state or federal legislation. The Health Board has since decided not to pursue this option.

2.0 HEALTH SERVICES AND UTILIZATION RATES

This section identifies the range and frequency of use of health care services. The IHS Clinic provides basic ambulatory care, and purchases specialty and inpatient care with CHS funds. The Tribal Program provides disease prevention and health education services. The scope of services delivered through these programs, and the rates at which they are used, reflect the health care needs, and problem areas in health care delivery.

2.1 Ft. Totten Health Center (IHS Clinic)

The IHS Clinic provides comprehensive ambulatory health care during work hours, on weekdays. Services include general health care on an appointment or walk-in basis, diabetes treatment, prenatal and well child care, testing and laboratory services, minor surgery, orthopedics, audiology, and some preventive care and health education. The tribal Health Department emphasizes mental health, maternal and child care, nutrition and preventive health education. For specialty care and inpatient treatment, patients are referred to area providers, or to other IHS facilities, most frequently the IHS facility in Belcort. The program also identifies patients eligible for alternate health care, and submits claims for treatment of Medicaid patients.

The IHS Clinic also identifies patients eligible for alternate resources, with an emphasis on Medicaid. Approximately 350 (under 10 percent) patients are enrolled in Medicaid. Reimbursements on behalf of Medicaid patients are between $300,000 and $400,000 annually. While patient eligibility is checked, patients are not aggressively encouraged to enroll in Medicaid, and the IHS Clinic does not have procedures to assist patients in

enrollment. With 45 percent of the patient population unemployed, Medicaid eligibility and enrollment should be higher than 10 percent.

2.1.1 Clinic Programs

The IHS Clinic operates several programs, with a current staff of 26. In addition to the regular Clinic staff, specialists provide services on a consultant basis. Services provided by the clinic include:

- The general health program provides comprehensive health care, including diagnosis and treatment of most illnesses, minor surgery (e.g., sutures and cyst removal), X-rays, fracture setting and cast removal, physical and respiratory therapy, and immunizations and inoculations.

- The laboratory provides basic services including hematology, urinalysis, chemistry, serology and bacteriology. The laboratory also performs routine testing (e.g., chlamydia trachomatis, etc.), since the program can perform such tests at a considerable savings.

- The Radiology Program provides X-rays, ultrasound services, and is planning to expand its services to include OCG studies, spleen and liver scans.

- The Nursing Program provides prenatal and child care, immunizations, preventive health, and health education with emphasis on dealing with a high number of high-risk pregnancies and premature births. The program also has a "psychological/ economic" component that monitors mental health and provides counseling and screening. The staff work with infants and children with mental or physical impairments, alcohol and drug abusers, patients suffering from hypertension, those involved in child abuse, neglect, domestic violence, suicidal patients, and the unemployed. In addition to IHS funds, the Nursing Program receives assistance and resources from the North Dakota Maternal Child Health Program (MCH), and has in the past received state and federal grants.

- The pharmacy provides most of the medications prescribed to patients on an outpatient basis. Over 7,500 prescriptions are filled annually.

- The Dental Program provides routine dental care on-site, with some surgery laboratory and emergency care referred to area providers. Because of staff time and budget limitations, the dental program focuses on interventive rather than

preventive measures. The program does work with the Reservation elementary school and the Women, Infants, and Children (WIC) program to provide fluoride treatments and some disease prevention activities.

- The Mental Health/Social Services program provides counseling on a priority basis. This program is greatly over-burdened, and focuses only on crisis intervention. Although the suicide rate is high, there is no contingency plan to deal with suicidal patients, such as a primary contact person, nor is there a 24 hour hot-line program established to address situations that arise when the Clinic is closed. Presently, the social worker is called in for all crisis situations. Staff expressed concern that under the current work-load, the program would lose its current, or any future mental health worker, to "burn-out".

- The Diabetes Program works in coordination with Tribal Health Programs. This program provides health monitoring and screening services, preventive care and health education.

- The MCH Program provides general primary health care, with an emphasis on immunizations, prenatal and well-baby care, nutrition, preventive care, and health education.

- The WIC Program focuses on prenatal and neonatal care, nutrition, and family health.

2.1.2 IHS Clinic Funding

The IHS Clinic has two budgets; one for direct care, which includes operation and administrative and operation costs, and another for CHS. The total IHS Clinic FY 1989 is $ 2,195,466, including funds recovered on behalf of Medicaid patients. Figure 1 below illustrates the allocation of budget funds.

In 1988, the Clinic received a grant from the National Heart, Lung and Blood Institute to study cardiovascular disease. The grant provided funds to provide physical exams, health risk appraisals, cholesterol level monitoring, and extensive health education.

Several Clinic programs are funded by the State, or through a combination of state and IHS funding. These programs include the Diabetes Program (joint state and IHS), the MCH, and WIC programs, both state funded.

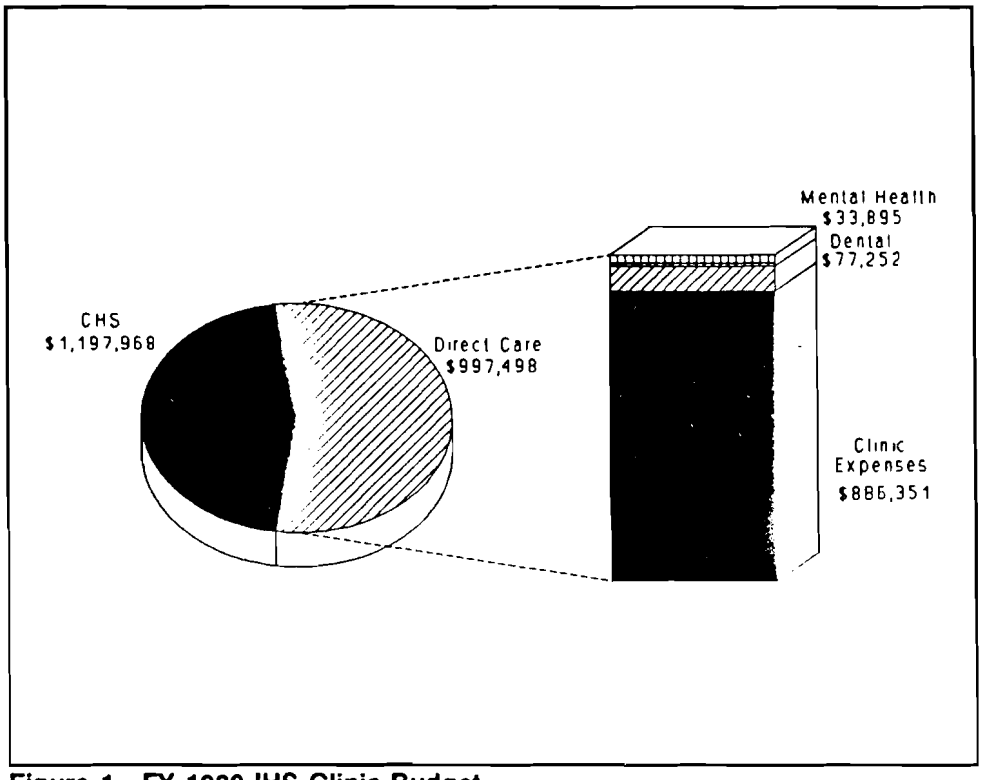

Figure 1. FY 1989 IHS Clinic Budget

2.1.3 Staffing

The IHS Clinic staff model includes 34 staff positions, nine of which were vacant at the time of the site visit. Clinic and CHS services are managed and coordinated by the Health Systems Administrator. Most other staff members work under a specific program, but work together in screening and treating patients. With over five years experience with the patient population, the Physicians Assistant is the primary health care provider. Other staff include: the Clinical Pharmacist, who manages the pharmacy and is also the Clinic Director, two medical technologists and a tribal medical technician who work in the laboratory, and a dental officer, a certified dental assistant and one tribal CHR dental assistant. The Mental Health Program is staffed by a social worker, one consulting psychologist who works one day every other week and a psychiatrist who sees patients for six hours every three weeks. The Diabetes Program is staffed by two licensed practical nurses (LPN) and one nurse practitioner, and the MCH program is staffed by one licensed practical nurse and one registered nurse.

The IHS Clinic has no resident physician, although its staffing plan calls for three (for the past six or seven years, the IHS Clinic has had no more that two physicians at a time). In addition, Clinic operations are impeded by vacancies in several provider and support staff

positions. The Health Services Administrator has explored programs to attract physicians to the IHS Clinic. He estimates that providing a base salary of $130,000 would be sufficient to secure a physician; however, the rural environment and the lack of hospital privileges are also major obstacles. When the IHS Clinic does not have a permanent on-site physician, care is provided by physicians flown in for two week periods.

At the time of the site visit, the IHS Clinic was receiving the services of eight visiting physicians, funded by both IHS and the National Health Service Corps. Most of these physicians are flown in once a month, and provide about half a day to patient treatment. Services provided under this plan include pediatrics, pediatric neurology, pediatric cardiology, OB-GYN, endocrinology, audiology, and cardiology. Clinic staff report that the part day allocated to patient care is not sufficient to meet patient needs.

A surgery team from Belcort visits the Clinic every six weeks to perform minor surgery including suturing and lacerations, and setting and removing casts. On most visits, the team is available to see patients for only three hours.

Difficulty in filling positions and a high turn-over rate undermine the Clinic's effort to provide high quality care. Patients complain of having to repeat their medical case histories often, and difficulty in establishing a relationship with their providers. The Clinic, in turn, has trouble in attracting some of those patients who are seriously in need of medical care. The number of vacancies, and an increased reliance on short-term or temporary staff, have disrupted continuity in patient care. Consequently, the staff is over-worked, and have difficulties implementing procedures to control patient utilization of contract services.

A draw-back to the visiting physician system is that while patient needs often cannot wait, they do not surface simply because the staff is on-site. Thus, frequently there are more patients than can be treated in the visiting physician's allotted time, or there are not enough patients to efficiently use the physician's time.

2.1.4 IHS Clinic and Tribal Health Program Facilities

The IHS Clinic and Tribal Health Programs are housed in one wing of the Tribal Headquarters. While centrally located for those living in the town of Ft. Totten, it is nearly 40 miles from the most distant points on the Reservation. Consequently, transportation provided by the Tribal Health Program is often used. Both the Clinic and the Tribal Program are in need of additional space for storage, patient waiting rooms, and treatment or counseling space.

2.1.5 IHS Clinic utilization

Most patient care is provided at the Clinic, with cases referred out only when on-site treatment is not possible. The Clinic is heavily utilized by eligible patients, with nearly 27,000 visits yearly. About 60 percent of these visits are to primary care providers: physician, physicians assistant, pediatric nurse, nurse midwife and nurse practitioner. The IHS Clinic staff also occasionally perform emergency or trauma treatment related to traffic accidents on the reservation.

Clinic staff expressed concern over low utilization of Clinic services among the reservation's older population. Patients who live in remote areas, or have had little exposure to Clinic services are hesitant to participate. Also, some patients avoid using the IHS Clinic by "saving their symptoms" until evenings or weekends when the IHS Clinic is not open, and then use emergency room or private physician services. Low utilization of services, and the preference for off-site providers underscore the need for continuity and trust in the patient-Clinic relationship.

2.1.6 Quality Assurance and Utilization Review

The IHS Clinic has an extensive internal quality assurance (QA) program. In addition to patient surveys, each Clinic program has established service objectives, and indicators by which to measure how well the program is meeting its objectives. Regular patient surveys indicate general satisfaction with services provided at the Clinic; however, the Clinic does not have any procedures to evaluate area physicians, clinics or hospital.

Despite the effective utilization control procedures in place, the Clinic is unable to enforce them because of the shortage of staff. The procedures limit use of contract health care to urgent and emergency care by treating patients on-site whenever possible, and by requiring patients to get prior approval for contract health care, or notifying the IHS Clinic within 72 hours of receiving after hours or emergency treatment. Because of extensive use of the hospital emergency room after hours, the IHS Clinic implemented a "call-in" program, operational during hours when the clinic was closed. Under the program, patients could call in and speak to one of the physicians, or physician assistant, to receive an immediate assessment of their condition, or a referral to a provider or emergency room. The call-in program was successful in reducing emergency room utilization, but was dropped when the Clinic's physician staff was reduced to one. Since the termination of the call-in program, emergency room use has increased greatly. Emergency room treatment costs between $100 and $150, as much as four times a routine physician visit. Data on the rate of emergency room usage were unavailable.

2.2 Contract Health Services

Where the IHS Clinic is unable to provide direct care, it either refers or transports patients to other IHS facilities, or refers them to private physicians, clinics, and hospitals in the town of Devils Lake, 10 miles distant, or in other towns as distant as 140 miles. Because CHS funds are limited, only top priority--urgent and emergency cases are referred.

Access to providers is an issue for the Devils Lake Sioux, geographically and culturally. The IHS Clinic and the town of Ft. Totten are 10 miles from the town of Devils Lake; thus, some Reservation residents must travel 40 to 50 miles to reach Devils Lake. Some specialized inpatient care, such as cardiology, is purchased from Grand Forks, over 90 miles away, with patients frequently transported by air. Many on the Reservation do not own working or reliable cars; thus, transportation services provided by the Tribal Health Programs are heavily used. While the IHS Clinic reports a good working relationship with providers, individuals express a strong distaste for going into Devils Lake. Historically, relations between the Town and Reservation have not been good, and it appears that when possible, the two groups function separately and independently.

2.2.1 Physician Referrals

Specialized physician care is purchased from private providers on a fee-for-service basis. In FY 1987, the number of outpatient visits was 1,972, with an annual increase of about 20 percent. In FY 1988, the total amount of CHS funds spent on outpatient services was over $500,000. In spite of the number of patient referrals, the relationship between the IHS Clinic and area providers appears strained, with little professional exchange between the town medical professionals and the Reservation. Because the number of assessable providers is limited, the IHS Clinic has not been able to aggressively pursue contracts that strictly regulate the cost of patient care. The IHS Clinic has not established a program to invite area physicians to see patients at the clinic, nor does the clinic encourage its own physicians to become affiliated with the hospital.

Patients are most frequently referred to private providers for the following conditions: accidents, poisoning and violence, respiratory diseases, diseases of the skin and subcutaneous tissue and symptoms of ill defined conditions. Generally, providers are selected on the basis of their willingness to work with the Clinic patients. Data on the break-down of physician charges by diagnosis or provider was unavailable.

2.2.2 Hospital Services

Inpatient services are those administered to patients admitted to a hospital or other residential facility. The IHS Clinic purchases all of their inpatient care from off-site sources. In 1986, 94 percent of impatient care was purchased from private hospitals, with about 80 percent of that at Mercy Hospital. Under six percent of inpatient care was provided by other IHS hospitals--primarily at the IHS hospital in Belcort. The total budget for hospital services in FY 1988 was $761,667.

The IHS Clinic has a contract with Mercy Hospital, under which services are provided at no more than the Diagnostic Related Group (DRG) rate. This contract was entered into only after a prolonged dispute with the Hospital, in which the Hospital was boycotted--and patients sent elsewhere, at great expense and inconvenience. Reservation patients represent a significant portion of the client base (between 30 and 40 percent); therefore, Hospital administrators may be willing to expand the range of their cooperative arrangements with the Clinic.

In FY 1987, 290 IHS Clinic patients were admitted to inpatient facilities, a sharp decrease from preceding three years, in which over 400 patients were admitted annually. The average length of stay was under 4.5 days, with the leading causes of hospitalization being diseases of the respiratory system, complications of pregnancy, childbirth, and puerperium, injuries, and poisonings.

Mercy Hospital, a non-profit venture, is the only inpatient facility in the town of Devils Lake. The hospital has 110 beds, and operates only 55, with an occupancy rate of 17 percent to 35 percent. According to hospital administrators, Clinic referrals represent between 25 percent and 35 percent of hospital admissions. In 1988, the hospital had a bottom line profit of four percent, but this year expects to break even, due to an increased number of Medicaid patients. Hospital profits come mainly from emergency room and outpatient services.

2.3 Tribal Health Programs

Seven health programs are operated by the Tribe, with over-sight provided by the Tribal Health Board. The tribal programs address a broad scope of health care needs, including preventive care, health education, environmental health, transportation and community services, and alcohol and drug abuse treatment (chemical dependency). The tribal programs also host several clinics, including a well baby clinic, and an audiology and optometry program. Tribal programs operate 8:00 a.m. to 4:30 p.m. on weekdays.

Despite the fact that tribal programs augment those provided by the IHS Clinic, and in spite of their close proximity, there is little direct coordination of services between all programs. With the exception of the Diabetes Program (Clinic-operated) and the Health Education Program (tribally-operated), and the Clinic laboratory, the tribal and Clinic programs do not share staff or expertise, space or resources, and there are no established procedures to share information on patient health needs or health status. An example of the gap between clinic and tribal health programs is that the tribal programs are not described in the informative brochure distributed by the IHS Clinic, and the tribal programs do not have funds to produce their own materials. Thus, patients do not have a complete reference to consult regarding the availability of health services.

The Tribal Programs do not have an official program-wide director, which results in disputes over leadership, resources, and objectives. However, the Director of the Tribal Health Administration program appears to be assuming leadership responsibility for the other programs. While the Health Board is the formal decision making body, some programs report directly to the Tribal Council.

- The Tribal Health Administration Program has focused its efforts on unifying and monitoring all tribal health programs. Activities include provision of unity and continuity of health services; community input; and where possible, identification of tribal members capable of filling health care positions, or interested in being trained to do so. The Tribal Health Administration program has one staff person.

- The Chemical Dependency Program is designed to meet what are identified as the Reservation's most pressing problems--alcoholism and drug abuse. Because there are no voluntary inpatient facilities in the area, and because funds for contract counseling are severely limited, the Chemical Dependency Program is heavily used. An indication of the degree of the alcohol problem is that over 25 people were admitted to inpatient treatment under court order in the first one and one half months of 1989. With a small building adjacent to the Tribal Headquarters, and a full time staff of six, the Director does not believe that the Chemical Dependency Program is adequate to meet the Reservation needs. While the program is "on-par" with those provided to the general public, primary residential care, a half-way house, and a separate program for youth are needed. According to staff, the program could fill twelve to twenty beds in an inpatient program.

  With separate funding from the state Indian Affairs Commission, the Chemical Dependency program sponsors daily alcohol and chemical dependency programs for elementary school children.

- The Environmental Health Program investigates and evaluates environmental health hazards, provides community education on the effect of poor environmental conditions on health, and recommends solutions to the Tribal Government, which is responsible for environmental health decisions. The program has one staff member whose specific duties include testing and monitoring of water quality and waste disposal systems, studying and addressing road conditions leading to frequent traffic accidents, and administering a vector control program (control of dogs, rodents, insects, etc.).

- The Health Education Program was designed to provide information to a widely dispersed population with a low level of "health awareness." The program conducts workshops, classes, and hosts an annual health fair, with all Tribal programs (health and otherwise) and elementary teachers participating. The program distributes printed and audio-visual information on child health, prenatal care, stress management, alcohol and substance abuse and other health care topics. The education program works closely with the Clinic diabetes program to provide basic health care and preventive information.

- The Community Health Representatives Program (CHR) was designed primarily to serve three needs: integrate traditional, and community based health care with the services provided by the Tribe and by IHS, provide home care and strengthen home-based, individual and preventive care, and serve as a "primary first responder" in cases of emergency. Most of the eight member staff are trained in Emergency Medical Treatment. Many other duties have been discontinued due to the lack of transportation in the community. Staff members report that they are able to fulfill some of their other duties, such as explaining medical procedures, and providing preventive information while transporting patients.

- The Community Health Nurse Program (CHN) is the Reservation's primary home health care provider, and also provides immunizations for those living far from Ft. Totten. The CHN program is funded distinctly from the other Tribal Health Programs, with salaries provided through the Public Health Corps. The Tribal Health Programs cover CHN operating costs, and the Tribe, on occasion, assists in funding special projects.

- The Laboratory program is operated in conjunction with the Clinic Laboratory program. The program sponsors one Medical Technician who works in the Clinic laboratory.

Data on utilization rates were unavailable.

2.3.1 Tribal Health Program Budget

The Tribal Health Program has an IHS funded budget of $452,100 for FY 1989. The funds are allocated as indicated in Figure 2.

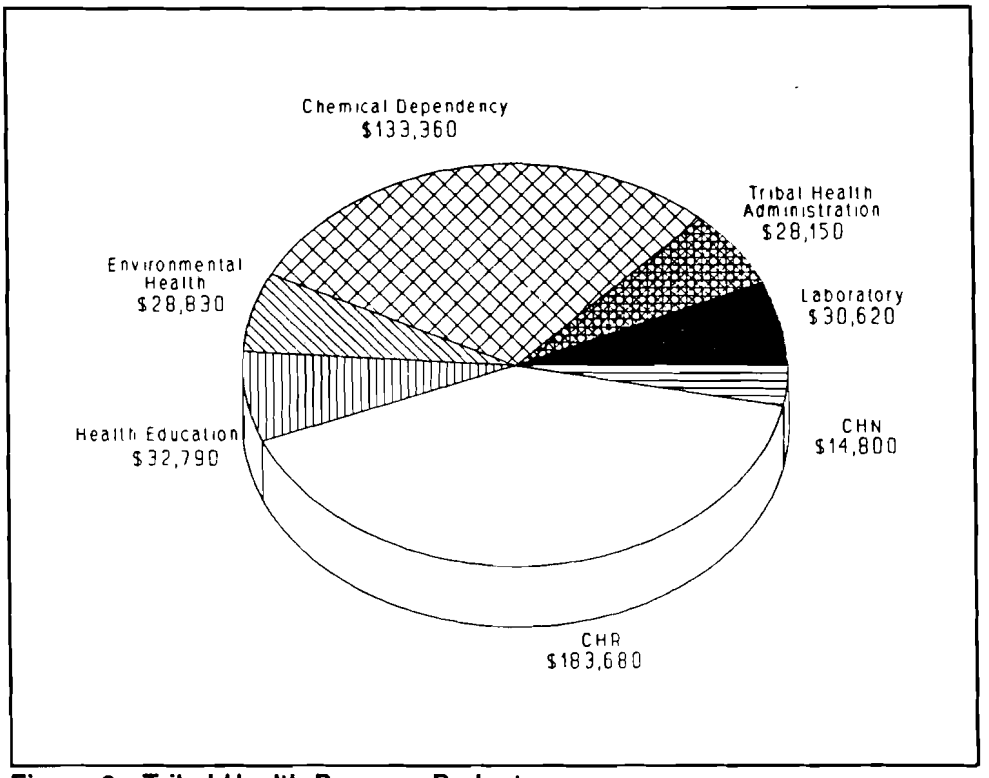

Figure 2. Tribal Health Program Budget

2.4 Intermediate Care and Family Services

The Tribe funds several health related services, including St. Judes home for the elderly, and a Family Services Program. St. Judes provides basic intermediate care to about 20 older tribal members, with an annual budget of $200,000. Development of Family Services Program is underway. The program is expected to include some social service counseling, with an emphasis on family stability, youth education, and alcohol abuse prevention.

2.5 Summary of Health Services and Utilization Rates

Comprehensive health care services are provided to patients through a variety of services. All of the available services are heavily used, and each program stressed a need for additional staff, additional space, or both. While each program is well managed, and is served by a dedicated staff, there appears to be insufficient coordination between programs. The lack of coordination between services not only undermines the continuity of patient treatment, but also escalates use of the more expensive alternatives: private providers and the hospital emergency room. Patients needing health care cannot consult a single source to determine which program to contact, and may, as a result, simply use the emergency room. The Clinic and the Tribal Health Programs operate during the same work day hours--leaving patients uncovered during peak accident times--in the evenings and on weekends, and thus inadvertently encouraging use of the emergency room.

3.0 HEALTH STATUS ANALYSIS

This section reports quantitative information on the health status of the eligible and current service population. This information is analyzed to identify basic health treatment needs and highlight unusual health conditions, and patterns of morbidity. Two types of information were collected during the site visit: quantitative data that identifies specific diagnoses, and qualitative information that identifies underlying health care issues--such as prevalent stress, or alcoholism.

As indicated in mortality rates, the health status of the service population is significantly worse than that of the general population, and is low compared to other IHS service areas. The major causes of death are traffic accidents, diseases of the heart and diabetes. In terms of the YPLL, rates for the Ft. Totten service population are high, (Years of Potential Life Lost, Aberdeen Area Indian Health Service, 1988). The crude infant mortality rate for the Ft. Totten Service Area is similarly high (Mortality Charts, Aberdeen Area Indian Health Service, 1988). YPLL and infant mortality rates are illustrated in Figure 3.a and Figure 3.b below.

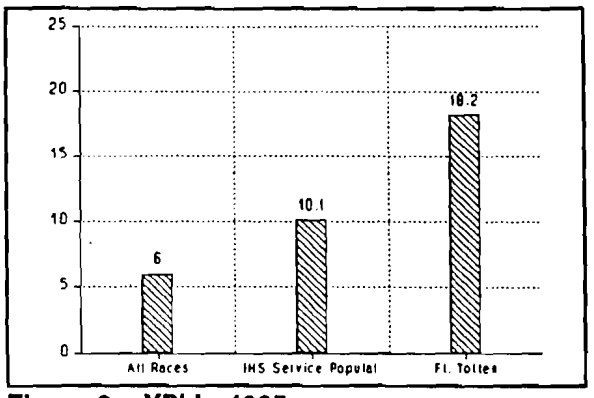

Figure 3a. YPLL, 1985

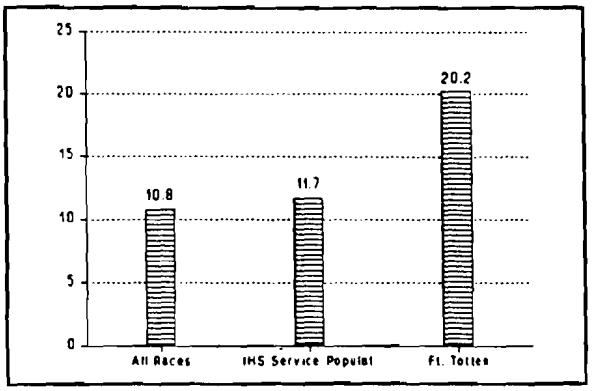

Figure 3b. Crude Infant Mortality 1985 - 1986

Balancing these indicators is the fact that the number of outpatient visits for serious illness is not unusually high, and the rate of hospitalization is low, and has recently decreased.

3.1. Ambulatory Health Status

The broad range of conditions treated in an ambulatory setting emphasizes the need for comprehensive care, as is presently provided. The conditions for which outpatient treatment is sought are illustrated in Figure 4.

Patients suffering from hypertension account for more visits than their numbers would suggest. While the total number of patient visits for the disease is high (840) the total number of patients is low (59) (Aberdeen Area Profile, Indian Health Service, 1988).

The health care needs served through the Tribal Health Program underscore some of the fundamental causes of illness among the patient population. Among adults and young adults, alcohol is cited as a factor in most traffic accidents, and in many of the deaths caused by diseases of the heart, and diabetes. The impact of alcohol on health is not well documented because it is seldom the primary cause of death, or the most direct cause of illness. However, Clinic and Tribal Health Program staff interviewed listed alcohol as the underlying cause of 90-95 percent of illness and death. Other underlying causes of poor health relate to poverty and low employment: stress, homicides and family violence, and poor nutrition all contribute to a low health status. The high rate of infant mortality is in part caused by the number of teenage pregnancies, compounded by alcoholism and poor nutrition.

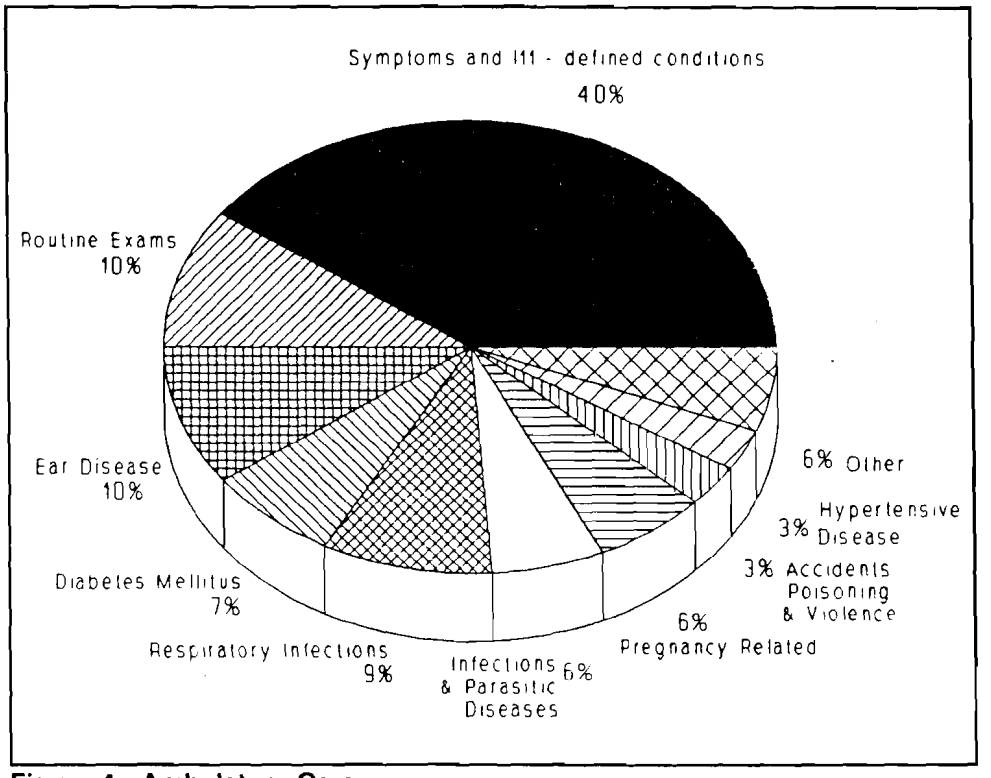

Figure 4. Ambulatory Care

3.2 Inpatient Health Status

The inpatient admission rate for the Devils Lake Sioux service population is lower than the Aberdeen Area norm. In FY 1987, 290 patients out of a population of 3,957 were admitted to the hospital, for an admission rate of 7.3 percent. In the same period, the number of admissions for the Aberdeen Area was 13,732, out of a population of 89,135, for an admission rate of 15.4 percent. At an average of about 5.5 days stay per admission, the length of hospitalization is close to the national average. The major causes for admission are illustrated in Figure 5.

3.3 Summary of Health Status

Mortality data, including the crude infant mortality rate, and YPLL rate for the Devils Lake Sioux service population suggest that the general health status is poorer than that of the surrounding area; however, utilization of ambulatory and inpatient services is lower for the service population than it is for the Aberdeen Area. This disparity suggests the service population has unmet ambulatory care needs. Another area of health concern is teenage

mothers, who may be alcohol or drug abusers, and are less likely to seek and follow through medical treatment.

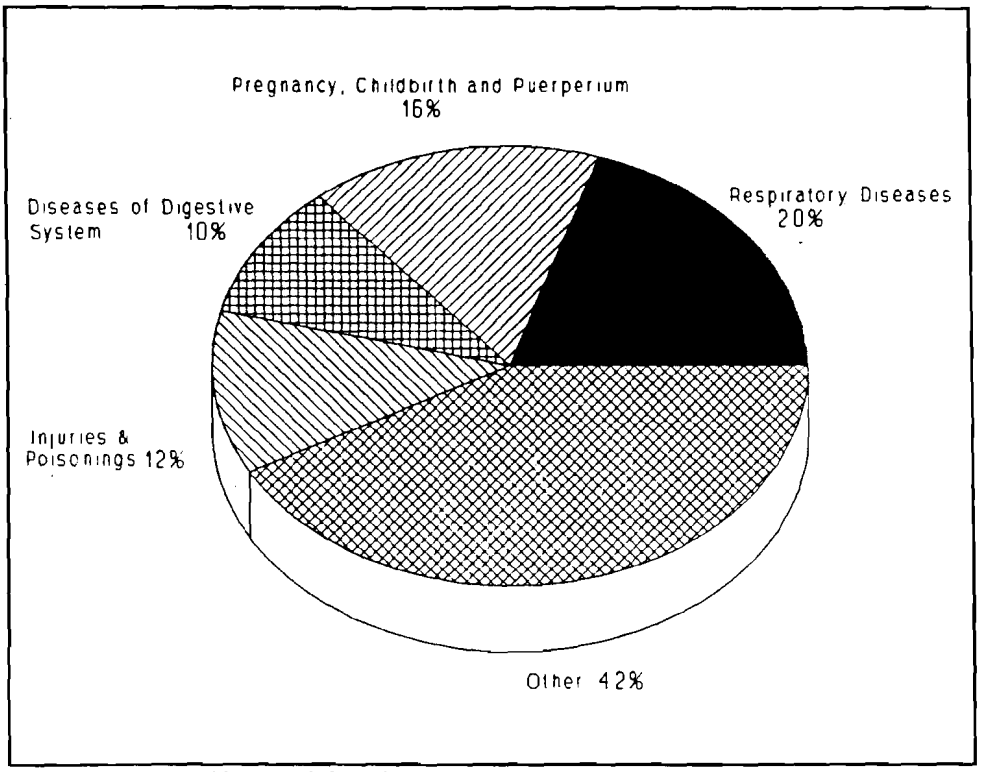

Figure 5. 1988 Hospital Admissions

4.0 MARKET ANALYSIS

To identify and assess appropriate health care delivery systems, it is first necessary to understand the health care needs and utilization patterns of the current and potential patient base, and to predict changes in the market population. This information will be used to determine what services patients need and are receiving. These services, in turn, will be a key factor in comparing the costs and advantages of alternative health care providers.

4.1 Demographic Data

Demographic data defines the actual and potential market for health services, in terms of its current and future size, and identifies future health care needs. The demographic data collected during the site visit data segment the market by key characteristics of the market, such as age and sex distribution, income and insurance coverage.

4.1.1 Population Data

The number of IHS eligible patients living on the reservation was 3,456 in FY 1987, and the Clinic Systems Administrator estimates the current active population at 4,500, with between 8,000 and 9,000 open files (number of patients using the clinic within the past five years). The difference in figures is attributed to by the temporary or seasonal movement of eligible persons who come to the area seeking employment. According to IHS figures, the IHS eligible population is expected to grow to 3,875 in 1990.

4.1.2 Age Distribution

Age distribution is used as a predictor of near- and long-term health care needs. Many Clinic patients are 16 and under, which suggests a near term increase in the need for childbirth and infant care services, and counseling for adolescents. Age distribution is illustrated in Figure 6.

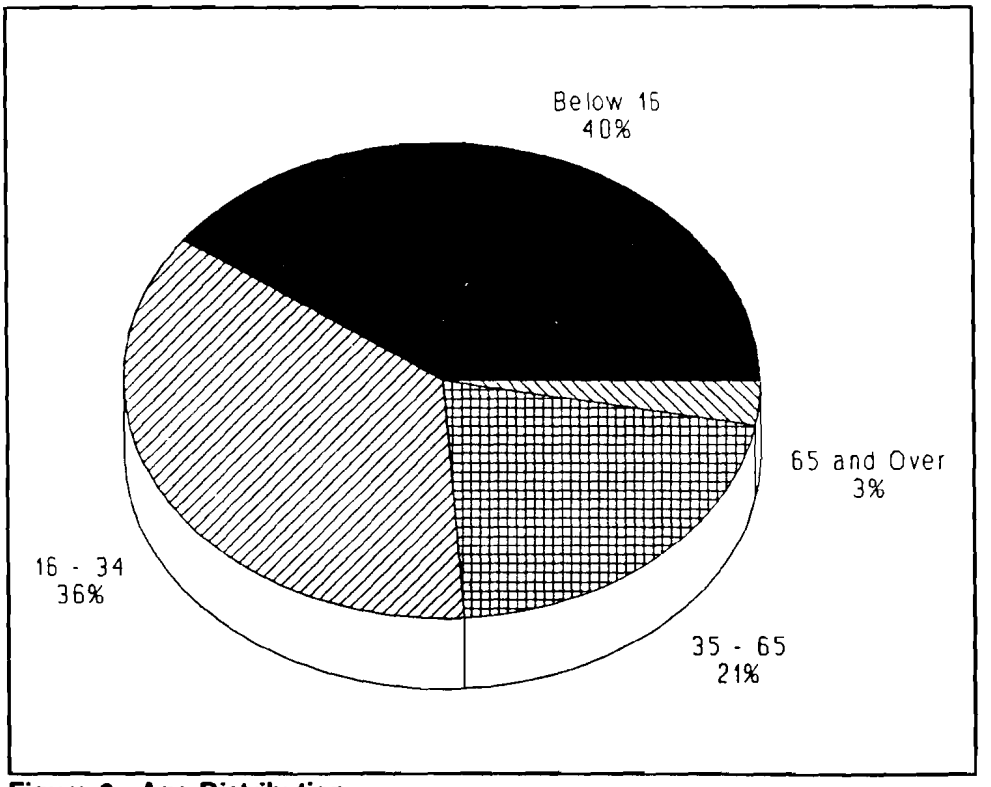

Figure 6. Age Distribution

Detailed age data was available only for the 3,609 Devils Lake Sioux Tribal members living on or near the Reservation. One area of health concern centers around maternal and child care, and conditions relating to high-risk pregnancies, especially where patients are diabetics. With high-risk pregnancies and infant care representing one of the most frequent causes of hospitalization, health programs continue to address care for pregnant women and infants.

Patients 45 and older account for over 20 percent of total ambulatory patient visits. The most frequent health care needs of this population are diabetes, diseases of the respiratory system, hypertensive disease, and health care in these areas will be a growing long-term issue.

4.1.3 Sex Distribution

Sex distribution is another predictor of near- and long-term health care needs, in terms of gender related conditions--primarily those relating to pregnancy and childbirth, and accidents. The population is nearly evenly divided between men and women; however, more women than men use the health services on a regular basis. For the conditions which bring patients to the health services most frequently, the health care needs of men and women are similar. The exception to this pattern is the second leading cause of hospital admissions: complications of pregnancy and childbirth. Other than the need for care in this area, the population's sex distribution should have little impact on health care needs in the near- and long term.

4.1.4 Income Distribution and Employment

Tribal members living in or near poverty are those who rely most heavily on subsidized or tribal health care services. At the same time, many low income patients are eligible for assistance from other sources, such as AFDC or Medicaid.

Unemployment on the Reservation is high, at about 45 percent for FY 1988, and is expected to increase in FY 1989. There are few opportunities for employment on the reservation, and many who are employed work for the Tribe, or for one of the tribal enterprises. The number eligible for state assistance fluctuates, due to part time and seasonal employment, and because of occasional dispersement of Tribal funds. About 30 percent of the of patient population is covered by employee insurance, and approximately 10 percent of the eligible population has been identified as eligible for Medicaid. IHS funds are the sole coverage for nearly 50 percent of the patients seen at the Health Department Clinic.

4.1.5 Insurance

About 20 percent of the patients treated through the Clinic are employees of the tribal industries, and are covered under a standard employee plan with approximately 80 percent coverage for patient treatment costs. The total annual cost of employee insurance is close to $1,500,000, and amounts to approximately $2,700 per employee. About 65 percent of tribal enterprise employees are Native Americans, and the amount spent to cover IHS eligible patients is over $970,000. At a small additional cost, employees can elect family insurance. Where eligible patients receive care covered by CHS, IHS becomes the secondary payor.

4.3 Other Markets

Although the town of Devils Lake has over 10,000 inhabitants, it is unlikely that these individuals would purchase any of their health care through a tribal or reservation based health care program. A Reservation based program would not be geographically convenient, and historically, relations between the town and the Reservation have not been good.

5.0 HEALTH CARE ALTERNATIVES

In purchasing services, the IHS Clinic has the benefit of comprising a large segment of the local health care market, but is at a disadvantage in that there are a limited number of health care providers, and the opportunities for achieving significant discounts are restricted. However, through effective management and control of private provider and emergency room usage, negotiated agreements with area providers, and coordination of existing health care programs, savings can be achieved.

In assessing program modifications and the development of new programs, it is important to weigh potential health care benefits against potential risks and costs. Threshold questions in the assessment of alternatives include:

- Will the alternative improve health care services?
- Is the alternative cost efficient, and can the program afford the implementation and maintenance expense?

- What state and federal regulations apply?
- Do the existing programs have the administrative and management capacity to operate the program?
- What are the risks in adopting the alternative? Can the risks be managed?
- What steps are required to implement the alternative?

Where these issues cannot be addressed, the alternative cannot be evaluated. The recommendations that follow require further analysis prior to implementation; however, preliminary analysis suggests that they satisfy the basic requirements set out above.

5.1 Coordination of Resources

Health care is presently provided through three main sources--the IHS Clinic, CHS care, and through tribal health programs. The cost of these services, when combined with the contribution of the Tribe through its operation of St. Judes, and the insurance coverage provided by tribal industries, is close to $4,000,000, or approximately $880 per patient.

While the funds committed to health care are significant, the lack of coordination of resources undermines the ability of health programs to provide, and to buy, consistently high quality health care. Each program functions independently; with coordination, the quality and scope of health care could be much improved.

Programs that are not now integrated, but that might benefit from pooled resources include the Clinic's Mental Health program, and the Chemical Dependence program, and WIC and MCH programs with the services provided by the Community Health Representatives.

The IHS Clinic and Tribal Health Programs could also benefit one another, and their patients by staggering their hours of operation. Under the present system, both programs operate between the hours of 8 a.m. and 4:30 p.m., leaving patients uncovered on weekends and evenings.

5.2 Program Modifications

The following staffing modifications could be implemented without major disruptions in patient care. While the changes are not without costs and risks, a preliminary analysis

suggests that the costs may be outweighed by the savings, justified by an increase in, or improvement in services, and the risks managed through monitoring.

5.2.1 Hospital Privileges

To offer the IHS Clinic physician broader practice opportunities, and to decrease inpatient treatment costs, the program should explore the possibility of obtaining hospital privileges at Mercy Hospital. Such an arrangement would benefit not only the physician, but would also help the Clinic to control CHS expenditures. Presently, all patients admitted to the hospital are under the care of a CHS physician. With hospital privileges, the Clinic physician could provide some of that care, at a significant savings.

In order to have hospital privileges at Mercy Hospital, the physician must be "on-call" for a limited period each month. Mercy Hospital staff reported that several years ago, one Clinic physician had fulfilled this obligation, without apparent hardship, and had maintained hospital privileges. The costs of implementing such a program are minimal, and the benefits to patient health care are significant. The cost savings under such a program can be determined by comparing the cost of CHS physician payments for inpatient care to that of providing the same care through a staff physician.

5.2.2 Physician Affiliation Agreements

Given the difficulty in employing and retaining a staff physician, and the lack of continuity in providing health care through visiting physicians, the IHS Clinic should consider entering into agreements with local physicians to provide patient care on-site. If this is not possible, the Clinic may approach area providers to determine their willingness to participate in an after-hours "call in" program.

In order to determine the costs of providing care through affiliation agreements, the Clinic would have to analyze its records to determine the physician costs of providing care on-site, and work with area providers to ascertain whether they would be willing and able to provide the same care at a cost efficient rate. An agreement between physician and Clinic would specify treatment rates, and would require the providers to work within the Clinic's assurance guidelines and utilization review procedures.

5.2.3 Reduction in Emergency Room Use

With between $100 and $150 allocated for each emergency room visit, the Clinic should analyze causes, and treatments to determine whether a call-in program could efficiently be operated using area providers. Factors that need to be examined to determine the feasibility of such a program include the frequency and cost of emergency room treatment, and the number of cases that could be treated on-site during clinic hours.

Another method for reducing emergency room costs is to encourage the hospital to provide an alternative to such treatment. This may be accomplished by contracting with the hospital to require the referral of patients to other, less costly providers when a true emergency is not involved. Under the present system, many patients go into the emergency room with minor ailments, such as colds and minor cuts. These patients could be effectively treated by staff physicians outside of the emergency room, on a walk-in clinic basis. As incentive to develop or implement such a program, the Clinic might agree to refer all, or the bulk of its CHS patients to the emergency room alternative.

5.2.4 Identification of Alternate Resources

While the clinic recovers substantial funds through Medicaid, many potential recipients are not being identified. The IHS Clinic should implement more forceful identification and enrollment procedures, requiring patients either to enroll for Medicaid, or demonstrate that they are ineligible. In addition, the clinic should consider assisting patients in filling out the Medicaid application, which is long and difficult for some.

5.3 Mental Health Joint Venture

The staff in each IHS Clinic and Tribal Health Program identified a strong need for increased prevention services in the areas of mental health, alcohol, and drug abuse. Because of limited funding and their small staffs, the programs intended to provide mental health and alcoholism counseling are unable to meet their patient demands. Long term care is also impeded by the fact that there are no local inpatient programs, and aside from the tribal program, no cost-efficient day treatment programs.

Mercy Hospital has identified a need for mental health services within the community of Devils Lake, and indicated an interest in entering into a joint venture with the Tribe to serve this need. Although limited resources have not permitted the Mental Health and Chemical Dependency programs to fulfill all patient needs, the staff of each program has gained valuable experience in the field, and might be better able to meet patient needs in

a different forum. To assess whether a joint venture to provide mental health services would be cost efficient, the Tribe needs to address the following issues:

- What are the Tribe's direct (salaries, facilities, transportation, etc.) and indirect costs (referrals, hospitalization, alcohol related accidents and illnesses)?

- What are the costs (establishment, maintenance) of entering into a joint venture of this nature?

- What are the Tribal capabilities in this field? Is this a program in which Tribal members or employees can have an active part?

- What are the community needs? Are these needs being met elsewhere? What services can the community afford?

In considering potential participation in a joint venture, the Tribe must evaluate the impact of the venture on cost, access and quality:

- Will the aggregate cost of the joint venture be lower than costs now incurred in mental health treatment? Is there an opportunity for profit?

- Does the joint venture create access to services which are not now readily available?

- Will providers be attracted by the professional opportunities in, and features of, the venture?

- Does the venture increase the quality of services? Is provider accountability increased?

Each of the factors listed above impacts upon the appropriateness and viability of a joint venture program. While this review has outlined the issues involved in a program to provide mental health services, there may be other health care services in which a joint venture is appropriate.

5.4 Coordinating Tribal Enterprise Insurance

Approximately 400 IHS Clinic and Health Program patients are covered by tribal enterprise insurance. Under the present system, there is no program to coordinate the health services provided to these patients. Insured patients are not encouraged to use the Clinic, yet when a patient uses approved CHS or emergency room services, the Clinic is responsible for the portion of the bill unpaid by the insurer. According to the Personnel Manager of the Devils Lake Manufacturing Corporation, employees frequently use the hospital emergency room for minor injuries, rather than the Clinic. There are copayment or deductible forgiveness incentives built into the insurance plan to encourage use of cost efficient resources, such as the Clinic.

Utilization review and cost containment could be accomplished in an informal partnership between the tribal enterprises, the IHS Clinic and Health Programs. Under such a program, tribal enterprises would find part of the cost of a utilization review call-in or triage program, in which patients were directed to the most appropriate health care service.

Utilization Review is typically performed by a trained registered nurse (RN), with backup provided by a physician. Ideally, these services are provided from a local base, by someone with knowledge of the community, and who is known, and trusted by patients. Using HMO experience as a guide, Utilization Review programs usually require one RN to serve about 5,000 patients. Commercially available software includes management, and record keeping programs to assist in the administration of Utilization Review. Including salaries and software, the cost of an Utilization Review program should not exceed $100,000.

5.5 HMO Feasibility

The Tribal Health Board conducted a policy study of the possibility of forming a tribal HMO to provide health care service to both the Native American and general population. The study identified two core health care objectives: the need to provide continuity in comprehensive health care services, and the need to attract physicians to the area. As envisioned, the HMO would replace only those services now provided through the Clinic and CHS services, and would leave the Tribal Programs intact. The study did not analyze the costs, regulations, benefits or risks in forming an HMO. Several factors limit the feasibility of a tribal HMO at this time: an inadequate patient population size, limited start-up funds, extensive service demands, and the lack of providers. To be economically viable, an HMO needs a minimum patient population of between 8,000 and 10,000. With fewer patients, the program cannot provide services, or cover administrative and

management expenses in a cost efficient manner. The combined health care programs currently serve about 4,500 patients. It is unlikely that a tribal-based program would be able to double that number drawing from the general population.

The Health Board did not address the issue of whether an HMO could provide services at a cost equal to, or lower than, the rate at which they are already being provided. In addition to the operating expenses, the costs of implementing an HMO program are significant, including organization and staffing, market testing and marketing, and patient education. In addition, the application process requires considerable professional analysis of costs, financial stability, management capabilities, and market projections.

Given the potential funding for the HMO, and considering the probable market size, the HMO plan did not identify how the program would attract or retain the needed staff.

6.0 SUMMARY

At a time when the Tribe plans to take more direct control of, and to coordinate its health services, the lack of continuity in physician care is of great concern. Until permanent on-site physicians are employed, the IHS Clinic should focus on developing more advantageous relationships with area providers, to bring town physicians to the Reservation to provide care. In the long term, local physicians may be able to provide high quality care at a more cost-efficient rate than under the present system. Mercy Hospital and area physicians can also be used to help control utilization rates, and reduce reliance on emergency room services.

Health care could be improved through the better coordination of health care services. The fractionalization of services is, in part, due to the lack of a comprehensive health plan, or single decision making body, with detailed knowledge of, and authority over all programs. While the Health Board is intended to serve this function, it has not been successful in that it lacks the cooperation of individual program directors or administrators. The Tribe may consider reforming the Health Board to include program directors, staff, council members and private providers, and vest in this board the final authority over all health care policy decisions. The duties of the Board should include the integration of services and the allocation of resources to areas of highest priority.

While the formation of an HMO is not economically feasible, the Tribe may consider entering into the health care market through a joint venture with the hospital to provide mental health services. Prior to entering into such an agreement, the Tribe should conduct a thorough analysis of the benefits and risks of a joint venture.

PUGET SOUND SERVICE AREA
SITE VISIT REPORT

Task Order No. 236-88-0505

Submitted to:

Department of Health and Human Services
Public Health Service
Indian Health Service

Submitted by:

Support Services, Inc.
8609 Second Avenue, Suite 506
Silver Spring, MD 20910-3362
(301) 587-9000

PUGET SOUND SERVICE AREA
SITE VISIT REPORT

Task Order No. 236-88-0505

Submitted to:

Department of Health and Human Services
Public Health Service
Indian Health Service

Submitted by:

TABLE OF CONTENTS

LIST OF FIGURES