SUMMARY OF COMMENTS APPLICABLE TO US HEALTH REFORM		
Location	**Key Words**	**Summary of Key Points**
IHS Site - Clinical	Youth, Extended (den, vis, etc), Expansion	• Impacts of unmet dental care on children's health • Lack of dental insurance coverage for children
IHS Site - Clinical	Lifestyle, Youth, Portability, Public Coverage, Prevention, Costs, Funding, Costs, Efficiency, Authorities, Entitlement	• Eliminate tax incentives to businesses that produce, promote products which contribute to unhealthy lifestyles. • Direct resources to health promotion/disease prevention and away from disease treatment. • Offer more school-based services and mandate health education/maintenance/disease management. • Decrease risk of fraud and, where found, impose severe penalties. Continue unannounced inspections of health facilities. • Allow veterans and poor to go to the nearest facility for medical care. Continue only VA hospitals affiliated with a university medical school. • Redirect resources to programs that contribute to healthy lifestyle. • Replace private health insurance with a public health trust funded by employees/employers giving a percentage of earnings. Design trust to impose personal responsibility for health. • Decrease clinician's time spent on GPRA activities. • Market healthy lifestyles. • Decrease exposure to media that promote unhealthy lifestyles.
IHS Site - Clinical	Medications, Costs, Costs, Partnership, Authorities	• Negotiate a single government-wide purchase agreement to get the best price for medical supplies, services, and pharmaceuticals.
IHS Site - Clinical	Public Health, Prevention, Public Health, Initiatives	• More emphasis on primary prevention activities, including more effective utilization of public health nurses. • IHS's Innovations in Planned Care could be an example of cost-effective, high quality health care for the rest of the nation. • Involve customers in building an accessible, acceptable and adaptable system of care.
IHS Site - Clinical	Public Health, Traditional, Infrastructure, Organization	• IHS is the model for US public health service because of wellness programs and the guaranteed access to care before reaching crisis/emergency level. 2) Consider models of national health care in other countries (Canada, England, Europe) for lessons learned. The US insurance-centered model has not worked. • Expand IHS services to include complimentary medicine (chiropractic, massage, acupuncture, traditional (Native)).
Tribal/Tribal Organization Site-clinic	Quality, EHR, Infrastructure,	• IHS could be a model or platform for delivery of care to the uninsured in the US. • Nashville Area Office needs: -a departmental operations for risk management, IT, Contract Health, and an infection control and

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		epidemiology department, -a Area level physician education and credentialing staff, -more organized nursing department with nurse executives and nursing education and credentialing staff, -coders and IT personnel at the service unit level, and - early standardized orientation/training on EHR for contractors and staff and programmed instruction for EHR users.
Tribal/Tribal Organization Site-clinic	Public Coverage, CHS, Quality, Collections, Efficiency, Revenues, Billing, Infrastructure, Workforce,	• UFMS does NOT work for managing hospital finances. Reimbursements are received AFTER care is rendered. UFMS prohibits paying bills until the "money is in the bank." • Direct more money to ancillary services and secretarial staff for health care providers. • Improve human resources functions to reduce recruitment/hiring time for providers. • US Reform: Model after France, Germany, etc and combine private insurance through employers but with government regulation of these companies. For those with no access to care, the government should be the single payer. • IHS is a good model of care for patients as a relatively cost effective and efficient model of a single payer system. • Improve the billing function. IHS under bills for services rendered.
IHS Site - Adm/Other	Chronic, Lifestyle, 3rd Party, Prevention, Collections, Limitations, Revenues, Billing, Authorities	• US and IHS reforms need to recognize the health education profession. • ADA will not approve bachelor-degreed health educators to become Certified Diabetes Educators (CDE) which prevents reimbursement of education services provided by health educators. • Educate patients to self manage diabetes could result in cost savings.
IHS Site - Clinical	CHS, Public Coverage, CHS, Costs, Funding, Efficiency, Patient Pays, Billing, Bureaucracy, HER, Infrastructure, Authorities	• Incentivize patient responsibility for health. • Reduce missed clinic appointments. • CHS budget is spent largely on substance abuse illness/injury. • Insurance company bureaucracy reduces cost efficiency gained by use of EHR. • A single payer system is most efficient in reducing healthcare costs. • Operate insurance companies as non-profit organizations, but if they continue as private industry, add a government-sponsored plan to provide competition. • Do not mandate people to purchase health insurance. • Ban disqualifying pre-existing conditions and "cherry-picking" patients.

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Tribal/Tribal Organization Site-clinic	Chronic, Communities, Public Coverage, Prevention, Efficiency, Waste, Initiatives,	• Consider a Community Health Program for US general population that provides home visits for monitoring patients and transportation services. • Decrease excess clinics visits, maximize essential care, and decrease hospitalizations through proper management of chronic health conditions.
Tribal/Tribal Organization Site-clinic	Costs	• Reform the U.S. judicial system (litigation). • Adopt national tort reform standards, like California. • Decrease health care system costs by cutting medical supply costs (laundry, band aids, and surgical instruments). • Stop blaming physicians for high medical costs.
IHS Site - Adm/Other	Limits, Prevention, Primary Care, Public Health, Quality, Costs, Funding, Limitations, Costs, Efficiency, Bureaucracy, EHR, Infrastructure, Initiatives, Organization, Workforce, Authorities	• Health care legislation should provide easy-to-understand costs versus benefits analysis for comparison purposes. • Identify long/short term funding for the health care system and how to address non-documented individuals, and encourage personal responsibility/accountability for health. • Health care reform legislation should prevent brain drain of health care professionals to other countries, and allow for continuous, proactive improvements. • Engage bipartisan input to formulate a sustainable health care reform solution. • Analyze Lessons Learned and adopt Best Practices of US and other countries' health care systems. • Pay health care providers based on better prevention measures (performance-based reward system) and provide economic incentives for innovative ways to deliver health care. • Establish locally staffed/supported Health Care Public Education Programs. Include prevention strategies in public education campaigns. • Cap profits of health care insurance/pharmaceutical/other healthcare related companies and compensation on malpractice lawsuits and other medical liability insurance costs. • Lower costs of medical/clinical professionals’ education. • Centralize, standardize, and streamline processes and procedures of health care systems to save time and money. • Find other ways to decrease health care administrative costs. • Encourage adaptation of electronic medical records to enhance portability, productivity, and efficiency. • Remove government bureaucratic hurdles to encourage synergy (collaboration, cooperation, coordination) between the public and private sectors.

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Tribe/Tribal Org	Lifestyle, Poor Health, CHS, Limits, Medications, Prevention, Primary Care, Public Health, Quality, Traditional, Costs, Funding, Limitations, Costs, Infrastructure, Initiatives, Authorities	• Support personal responsibility for health. • Provide adequate health care funding for Indians living on reservations. • Suggests FDA be more open to health benefits of cherries and nutritional supplements, recognize the health hazards of high fructose corn syrup, and stop the sale of tobacco (except use for Native American religious purposes). • Be more aggressive in shifting to a wellness model. • Remove limits on Americans' ability to import lower-priced prescription drugs. Place less focus on prescribing drugs and emphasize diet, exercise and nutritional supplementation. • Redirect IHS direct care and reprioritize CHS from funding treatments for preventable diseases to a strong wellness program. • Adopt the Health Equity approach. • The current system is resistant to change because of the initial costs involved.
HQ/Area Office	Communities, Public Health, 3rd Party, Public Health, Collections, Billing, Partnership, Workforce, Authorities	• Determine how AI/AN eligibility is to be reconciled with national health reform, how IHS public health services fit into reform, • If a federal health care insurance plan for the uninsured/underinsured emerges through the US health care reform effort, will IHS be allowed to collect/bill for services provided for M/M and private insurance? • Would the US health care reform benefit from consulting with the American public on either a national and/or regional level(s)? • Should health care reform include community health care advocates (like physician/health care extenders) for vulnerable communities in the U.S • Hold an internal IHS summit for employees to develop health care reform recommendations.
Tribe/Tribal Org	Behavior Health, Youth, IHS Eligibility, Prevention, Primary Care, Public Health, Funding, Infrastructure, Partnership, Workforce	• US health care reform that does not increase eligibility for referral care through an expansion of CHS or a total redesign of the payment for referral care will not adequately include AI/AN. • Linking our Health Information systems to other federal and state systems should be a priority. • Behavioral Health: Increase behavioral health providers at all levels, from counselors and social workers to psychiatrists specializing in child psych and other areas. Provide more funding for incentives for behavioral therapists and psychiatrists to practice in remote rural areas. Full funding for injury prevention programs and integration with clinical, behavioral, environmental and judicial systems should be undertaken.

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IHS Site - Clinical	Private Coverage, Public Coverage, Limits, Medications, Quality, Primary Care, Costs, Limitations, Costs, Efficiency, Patient Pays, Waste, Bureaucracy, HER, Infrastructure, Authorities	• US reforms: Enable Government to negotiate one best price for medications purchased by any government sponsored health program. • Reform malpractice by requiring a regional board of health professionals, legal and judicial members, and lay people to weed out frivolous claims. • Cap payment for immeasurable things (pain, suffering). Penalize those in the legal system who repeatedly bring frivolous suits. • Cut payments by 10% to prevent Medicare payment for over reimbursing for surgery and procedures. • Cut payments by 30-40% for surgical/procedure hospital reimbursements (those who do not freely admit medical and pediatric patients). • Expand loan repayment incentives for providers intending to go into primary care and work in underserved urban and rural areas or into government service. • Rethink and have a national discussion of cost effectiveness standards for various health interventions. Have highly secure, electronic medical health records for patients which can be accessed nationally. Payers could review the justification for certain procedures done. • IHS and other public health system reforms: Avoid bureaucratic red tape and incorporate successful private sector practices that are cost-effective, attract high-quality candidates, and provide good health care. Have a QA system that functions from both the top down/bottom up with a systematic process whereby unnecessary or highly complicated procedures/policy are revised, simplified, or eliminated in an ongoing basis. Change GPRA to streamline government processes. Have a high quality, well-funded, Beta-tested electronic health record system.
HQ/Area Office	Defined Benefits, Limitations, Costs, Infrastructure, Partnership, Sovereignty	• Inform decision makers that IHS is not an insurance plan. • Define an IHS benefit package comparable w/ other systems. • Improve IHS ability to identify costs and project future costs under different scenarios. • Quantify health outcomes. Better identify indicators of healthcare processes (when outcomes are difficult to measure). • Analyze needs, potential resources & impact of U.S. health care reform for different segments of AI/AN population - the uninsured, insured, and not covered by CHS. Collaborate w/ other groups that have similar challenges. • Emphasize unique aspects of AI/AN health - sovereignty, treaty obligations, remote locations, sovereign nations, treaty obligations, remote locations, increased disease burden, multi-

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		generational trauma. • Better align the priorities and processes within IHS to be responsive to mandates and incentives of U.S. Healthcare Reform plan. • Highlight and promote strengths of IHS -- E H R, telemedicine and primary care and (other) areas identified in U.S. Healthcare Reform discussions.
Tribe/Tribal Org	Funding, Entitlement, Sovereignty, Tribes	• Ensure national health care reform does not adversely impact the health care options for individual American Indians, trust obligations to tribes, tribal sovereignty, and funding to Tribal health care systems.
Tribal/Tribal Organization Site-clinic	IHS Eligibility, Funding, Expansion, Urban, Authorities	• Seeks to begin collective dialogue on IHS reform that supports Urban Indian health organizations, addresses the scope of Title V contracts, and minimizes the impact of State budget cuts in California.
HQ/Area Office	Collections, Authorities	• The closest thing this nation has to what is often thought of as single-payer is the U.S. Indian Health Service. Consider this model.
IHS Site - Clinical	Chronic, Defined Benefits, IHS Eligibility, Funding, Other Sources, Efficiency, Waste, Infrastructure, Authorities	• HCR may expand AI/AN enrollment in Medicaid and CHIP • HCR has not yet specified a standard benefits package (inc Medicaid) • Deem IHS "51st state" for Medicaid purposes with standard benefits for all • Full IHS participation in any "health insurance exchanges" • Include Tort reform • Need system-wide "global payment" system • Analyze any impacts on collections • Define uniform system-wide benefits package • Model transparency and reporting on Section 330 of CHCs • Patient-centered coordinated care in an efficient manner is critical to our future (chronic care initiative model) • Expand Infrastructure, telehealth, and EHR