INDIAN HEALTH SERVICE/CALIFORNIA AREA OFFICE
TRIBAL ADVISORY COMMITTEE MEETING
November 14, 2012

EXECUTIVE SUMMARY

CATAC Members:		**Region Represented:**
Mr. John Green	Absent	Northern
Mr. Stacy Dixon	Present	Northern
Mr. Peter Masten Jr.	Present	Northern
Mr. Michael Thom (a)	Present	Northern
Ms. Bonnie Hale	Absent	East Central
Mr. Robert Marquez	Present	East Central
Mr. David Moose	Absent	East Central
Mr. Silver Galleto	Present	West Central
Mr. Nelson Pinola	Absent	West Central
Ms. Crista Ray	Present	West Central
Mr. Chris Devers	Present	Southern
Mr. Johnny Hernandez	Present	Southern
Ms. Teresa Sanchez (a)	Present	Southern

All are primary representatives unless noted; alternates denoted with an (a).

IHS Staff In attendance:

Ms. Margo Kerrigan	Director, IHS California Area Office
Dr. Charles Magruder	Chief Medical Officer
Ed Fluette	Associate Director, Office of Environmental Health and Engineering
Jeanne Smith	Acting Associate Director, Office of Management Support
Mr. Travis Coleman	Acting Indian Self-Determination Program Manager

The California Area Tribal Advisory Committee (CATAC) meeting began at 8AM on November 14 in the California Room at the Holiday Inn Capitol Plaza, 300 J Street, Sacramento, California 95814. In addition to the attendees listed above, the meeting was open to California healthcare program directors and attended by additional Indian Health Service (IHS) staff.

Ms. Kerrigan opened the meeting by acknowledging the following groups of attendees: Indian healthcare program directors, CATAC members, and representatives to national IHS and HHS workgroups. She then introduced the new IHS/CAO Chief Medical Officer (CMO), Dr. Charles Magruder. Dr. Magruder brings a wealth of experience to the IHS/CAO, having worked with the Air Force, the Centers for Disease Control and

Prevention (CDC), overseas in Iraq, and as a County Health Program Officer. He graduated with a Bachelor's Degree from the University of Kansas and a Master's Degree from Harvard University. He graduated from University of Kansas Medical School and has a number of licenses. He has produced many peer-reviewed publications and has many security clearances. IHS/CAO carefully recruited for this position in order to find a CMO who is committed to the Area Office. Ms. Kerrigan asked the group to recognize Mr. Magruder. She also noted that Dr. Sprenger, the Acting CMO, who retired as the IHS/CAO CMO on December 30, 2011, will continue his work towards two youth regional treatment centers (YRTCs) in the California Area.

Mr. Chris Devers led the group in prayer.

Ms. Kerrigan provided an introduction to the first agenda topic by noting that California has never had a hospital/medical center. Four years ago, the Innova Group was asked to replicate a study from the Northwest Indian Health Board. The study looked at regional medical centers that would provide ambulatory surgery and specialty care (not emergency rooms or intended for delivering babies). These regional medical centers are intended for routine medical activities (e.g. cardiology, endocrinology). The IHS/CAO expanded the study after reviewing the first draft. The expanded study looked at the number of regional health centers that would be relevant to California's tribal population. The future of the study depends on the goals of the present group (tribal officials and healthcare program directors). First, the group needs a common vision of what the services would look statewide, for the total Area. The Innova Group has been asked to evaluate a range of 2-4 medical centers. They will present their analysis of this, which include a study of the population and a study of the market share the facilities could support in an urban area. This project is in its infancy. When appropriate, the Area Director will ask each recognized tribe to identify the number of facilities they want (one vote per tribe). This is a complex process, and will require a large sum of resources, but would eventually save contract health services (CHS) resources.

Feasibility of Constructing regional medical centers and specialty care/ambulatory surgical centers in California:

Mr. Anthony Laird and Mr. Kent Tarbet presented on behalf of the Innova Group. Mr. Laird provided a background of the Innova Group. The group was hired by Ms. Kerrigan, on behalf of the IHS/CAO. Mr. Laird proceeded to describe the current project and then the concept, as demonstrated in the Billings Area. The Innova Group provided six maps of three scenarios of regional care at 4, 3, or 2 locations. Attendee asked the group to identify which facilities were tribal and which were federal when describing the concept.

Attendee requested the presentation, but Ms. Kerrigan said that because the report is still in progress, only the maps can be distributed. The final report will be issued to all California tribes.

Attendee asked for clarification on the primary service areas (PSA). Mr. Laird said they generally use a 30 minute driving distance to identify PSAs, but this also depends on the area. When identifying PSAs, the group considers how far a patient is willing to drive. They also consider if there is an alternative within a driving time that is acceptable.

Attendee asked if CHS resources would fund these facilities, and the answer was no.

Attendee asked about the role of the contract health service delivery area (CHSDA) in this project. The Innova Group said this concept was developed for the state, so they do not have all the answers for the federal government.
Attendee noted that in rural areas, the clinics must provide transportation service. This should be considered. The Innova Group said they factor this into the conversation by assuming that not everyone will use these facilities once they are built. In many cases, the user population is higher than the service population.

Attendee asked if the Innova Group looks at capacity over all (native or non-native). The Innova Group said they did not look at empty beds in all facilities, but they did make the assumption that a percentage would choose a different facility.

Attendee asked if the Innova Group has completed an analysis with the Resource & Patient Management System (RPMS) used by clinics in the IHS/California Area, such as specific diagnostics to see the type of care that is needed. What is in the building is what is important, not just that there is a building. Mr. Tarbet clarified that the utilization rate is based on California tribal clinics, and should pick up the health disparities in this population compared to the general population.

Attendee noted that if they drive an hour and a half to one of these facilities, their family would have nowhere to stay. The facilities should focus on establishing suitable lobbies or waiting rooms. The Innova Group said that may be the next step. The current model does not consider families of the patients.

Mr. Ed Fluette noted that there has been a turnover of California healthcare program directors and wanted to inform all attendees that the IHS/CAO houses the master plan, which includes every health program except for Redding Rancheria. Mr. Rick Wermers keeps the master copies and can send an electronic copy to anyone who is interested.

Attendee asked how emergencies are factored into this project. The Innova Group said patients with an emergency would still visit a local hospital. There would not be emergencies in the regional center. If the emergency translates to acute care, the patient could be transferred to the regional center.

Attendee asked for clarification on the “direct service population”. The Innova Group said “users” include anyone who has ever shown up in a clinic’s system. Conversely, the “service population” includes all natives in the community. Ideally, the service population and the census population are the same.

Attendee asked about the ultimate purpose of the regional health centers. The Innova Group said the ultimate purpose may be to stretch CHS dollars.

Attendee noted that their clinic serves non-CHS patients and this project will take a lot of time and money. A seventh option would be to have no facility, and instead increase CHS resources. The Innova Group admitted that there is a seventh option, but clarified that these regional health centers would not strip any current CHS dollars.
Attendee asked if these facilities would include psychiatric hospital beds. Mr. Laird said they are hard to obtain and are not included in this concept.

Attendee asked for the percentage of California's native population that will be served with these scenarios. For outpatient and inpatient care, each of these scenarios serves about 90%. This is more accurately answered by specialty care provider visits addressed. The number of specialty care provider visits change in each scenario.

Attendee asked if the model is based on a conservative user population rather than census data. The Innova Group confirmed this.

Attendee asked if this project was based on 2005 data, or current data. The Innova Group said they used 2005 data, but projected future data with the assumption that some services are offered already at some clinics, but this may change.

Attendee asked what standards are used. The Innova Group used workloads from RPMS.

Attendee asked how a big organization such as Sutter Medical Foundation would proceed with this project. The Innova Group said they would do the same analysis, but this project only looks at the native population.

Attendee asked how unmet need is considered into this project. The Innova Group said unmet needs will remain the same. The percentages in the model do not represent the need. Dr. Sprenger clarified that the remaining percentage could be addressed using the CHS funds that are saved by utilizing these regional centers.

Attendee asked if patients with new coverage would still be considered in this scenario, or if there is an assumption that they would find local care. The Innova Group said the assumption is they would use these regional centers.

Attendee asked how the Innova Group calculated the cost per square foot. Mr. Tarbet said they used $400/sq. ft. Attendee said IHS facilities cost much more than that, and these numbers are too low. These costs also do not consider the cost to recruit. The attendee said the information on salaries.com is an understatement of today's market, and suggested the Innova Group look at that again. For example, salaries.com lists psychiatrists at $50,000, but should really be $200-300,000. The Innova Group explained that the relationship stays the same throughout the model, so you can see the magnitude between each scenario regardless. Although, the model uses 2010 costs, inflation can be factored into the final report. Ms. Kerrigan clarified that these numbers are for planning

purposes. This project is not looking at actual costs, just magnitude. The IHS/CAO would have to go to Congress for the actual funds. The Innova Group added that the cost of the land is not included.

Attendee asked if the request would be for a three year funding cycle, meaning the project would not start until 2015 or 2016. Attendee also asked if this would affect the YRTC. Ms. Kerrigan said the priority is the YRTCs.
Attendee said this project successfully outlines how many facilities are needed. Unfortunately, these facilities would still not assist isolated areas with no facilities and no ability to drive long distances for care. There are still a lot of people who do not use Indian facilities because they do not believe in them or IHS. For these reasons, this will be a tough decision for tribal leaders. Mr. Tarbet said this is why all Indian healthcare facilities cannot have a hospital; rather, we must analyze the usefulness of a number of regional facilities.

Attendee expressed interest in seeing this model refined to include information from all Indian clinics regarding the specialty care they already provide. This may affect the model and the cost basis of this whole structure. Attendee expressed satisfaction with the model overall, but believes that extra step is needed.

Ms. Kerrigan once again clarified that this study is not complete. The final report will include the tribal consultation results. At the time the study was designed, she just wanted to give the tribes as much information as possible so they could choose to go to Congress and request funds for this. Since there is currently a Democratic Congress and President, tribes should use this opportunity to request what they want for the California Area. This is a long process, as is seen with the YRTCs, but that is not a valid reason to not try to initiate this. Tribes can choose to put it in the budget request and see where it goes. Another option is for the California Area to request a demonstration project, as is being done with the Puget Sound Service Unit. This presentation is meant to inform all as to what the California Area can justify and what we should ask for from Congress.

Attendee noted that the tribes previously asked for a hospital. Ms. Kerrigan said that request was sent to the Area Office and the Area Office cannot make this happen. The IHS/CAO must still reconcile the unmet need calculations.

Attendee said he is not sold on this concept since the model has taken 10 months to create already, and there is still much more to do. In addition, the eastern tribes already have a hospital with Cherokee and less than 3% of their inpatients come from tribes outside of their CHSDA. Travel is a primary concern. Plus, providers at IHS facilities are often not as great as other nearby hospitals. Since there is a shortage of providers, it will be difficult to recruit quality providers to these regional facilities. This approach may not be cost beneficial compared to alternatives. Ms. Kerrigan said the purpose of this session is not to make a decision, but to review the current analysis. There will be tribal consultation to make the decision.

Attendee noted that the California Area consists of over 100 tribes and they should all be considered as well as the future of healthcare. Attendee said this is a lot of information for one meeting.

Dr. Sprenger asked if the Innova Group considered the effect of telemedicine. Mr. Laird said this is included as specialty care in this concept.

Overall, the Innova Group found that consolidation of 1-2 clinics outweighs 2-4 clinics, when considering both cost and quality of services.

Attendee said the decision will ultimately be based on money and the deciders will be Congress. It would be helpful to know the total cost for planning, implementation, and operational costs (1-20 years) versus the alternative. The alternative should be keeping tribal patients at local facilities. This analysis will build the case for extra CHS funding

Ms. Kerrigan said funds for tribal healthcare programs are not seeing any growth. The funding is going towards facilities. The California Area may never see an increase for the CHS budget. The California Area may be more likely to obtain funding for a new facility. However, there is a process to obtain new facilities. Currently, this study is incomplete. Once there is an executive summary of the study, it will be sent out to all California tribal officials. Each stage of the facility development process will require a request for funding from Congress, just as with the YRTCs.

Attendee questioned whether the demand will increase once a regional facility is built when there is a large population not using the current facilities. Further, the attendee asked why funding can be increased to build these regional facilities, but not at the local level. The Innova Group said they were looking at which resources best address demand, and the demand was seen to stay the same regardless. These regional centers are by referral only. If the user population or demand is going to increase, that will only happen if user counts increase at the primary service unit level. It is projected in the model that user populations will increase.

Attendee said this is a great tool for strategic planning over the next ten years. However, attendee again urged that the specialty care numbers are considered. Another option is to advocate for Medicare-like rates for specialists in order to better use CHS dollars.

Attendee addressed the seventh scenario discussed earlier and asked why the tribes should not lobby for increasing funding for the local facilities. Ms. Kerrigan explained that the CHS program has not changed in over 35-40 years. Tribes can try to lobby Congress for more CHS funds, but the IHS has never seen this happen. Ms. Kerrigan suggests requesting both. Attendee noted that not all facilities will benefit, such as the rural facilities. Attendee encourages lobbying for the seventh option.

Attendee asked whether patients who refuse to use these facilities because they do not have transportation to them would not be able to use CHS. After all, CHS is the care of last resort. Ms. Kerrigan said transportation costs could be considered for further

analysis. The Innova Group said patients will have to drive regardless, but the study considers how far they are going to drive. The question is how these regional medical centers will compete with the private sector for those patients that have a choice.

Attendee suggests California become a demonstration project and show unmet need that way. Congress likes demonstration projects and saving money, and this would do both. Attendee asked for pictures in order for tribes to see what these regional facilities would look like in comparison to what is already available. Tribal leadership will also need to see what specialized care will be available in these facilities, and where Indian people have been receiving this care. Hopefully, referred patients have been coming back to their primary clinic. The study should look at CHS referral patterns. The study should also make clear that these are not hospitals.

Attendee said Congress and the Senate will likely not agree to any of these scenarios in the near future. At least all of the current CHS funding will remain the same in any of these scenarios. The attendee also noted that the presentation was hard to follow, so it should be simplified even more. Hard copies would also be helpful.

Attendee asked about the accuracy of the Innova Group's projections, since they have completed a number of these reports. The Innova Group does not track the percentage of accuracy, but they have many return customers. Mr. Laird added that the cost of land varies wildly so it is hard to make accurate predictions. That is why land was not included in this initial stage. The attendee said he looks forward to tribal consultation.

Attendee said 27 years ago a hospital was designated for southern California, and asked how this concept is different. The tribes did not want the hospital. Patients with medical problems will not drive long distances, passing other hospitals, to go to a regional health center. Although this study looks at numbers, in a practical sense, this concept does not work in the California Area. Alternatively, if four facilities are requested, they will not get funded. The YRTCs are not even fully funded now. This model is not going to work.

Mr. Fluette said this is only the first day the IHS/CAO has requested this input. Either we do nothing or we find out if it is a possibility. Tribes cannot advocate for the seventh option unless there is a study like this one. The Innova Group has been working with IHS for a number of years, and they are well-respected throughout IHS. The Portland Area IHS is a few years ahead of the California Area. This study will provide our Area with a starting point.

The group was dismissed at 12pm for lunch. The CATAC members reconvened at 1pm separate from the healthcare program directors.

Review Executive Summary – June 21, 2012:

Ms. Kerrigan thanked Travis Coleman and Rachel Pulverman for their work with the Executive Summary so the tribes know what the CATAC is discussing. She then

reviewed the agenda for the afternoon. All agreed to approve the Executive Summary from June 21, 2012.

Ms. Kerrigan opened a roundtable discussion on the feasibility study discussed in the morning:

- Mr. Chris Devers said it was interesting. He remembered having talked about this before. He asked if IHS/HQ has offered funding for it. Ms. Kerrigan said this study was completed with IHS/CAO funds, for a total of $165,000. Mr. Hernandez asked if that was the cost of the study as of today, and if additional funding will be needed for it. Ms. Kerrigan said that is the total cost, spanning two separate fiscal years. Mr. Devers said he is still unsure about using 2005 data for this study. The Resource & Patient Management System (RPMS) is available to extract data, but some California facilities use different systems. Ms. Kerrigan noted that 4- 5 facilities do not use RPMS. Those facilities are trying to develop a graphical user interface (GUI) with RPMS, but this has not happened yet. Mr. Devers asked if the data from those facilities is incorporated into the analysis. Ms. Kerrigan said they are currently not included, but can be added in addition to using more recent data.
- Mr. Johnny Hernandez encouraged immediate tribal consultation so tribes are involved in the whole operation from the start. This concept includes a lot of travelling for patients and travel is already hard for them. This is a tough situation because all California tribes must be considered. Congress needs to see something, even if they say no. Also, the reason the hospital did not work previously is because the northern tribes were fighting with the southern tribes. Now that the tribes are able to work together, new ideas should be pursued.
- Mr. Robert Marquez said this study demonstrates an option, and it is nice to see something different. Since this is dependent on government funding, accurate data collection is key. It would be helpful if more recent data was used.
- Mr. Michael Thom likes the idea of having a hospital because all of the CHS funds will come back into IHS. For example, Tucson's one federal facility earns more money than the entire state of California. He will encourage his tribal council to support it.
- Mr. Pete Masten believes today's presentation was aimed at the wrong group. Tribal members should have been involved in the original direction with the Innova Group. Today, no handouts were provided so they cannot go home and complete their own evaluations. The trend of healthcare is to expand services. This study also did not account for the various clinics in the state that already provide specialty services. If nothing else, this project is a tool to show Congress how the California Area has tried to reduce contract health costs and demonstrate what is needed for additional CHS funds.
- Ms. Dominica Valencia said tribal clinics do not have access to professionalism or specialty care and CHS allows for specialty services outside of the system. This project will provide a facility to send patients. Many hospitals do not allow tribes to practice traditional medicine, and these regional facilities would. Mr. Devers said it is still unclear what is being proposed. This study does not propose a hospital, and patients cannot just walk through the doors.

- Mr. Silver Galleto said this was a lot of information today and a lot to digest. He ideally wants four facilities, but his fear is that it will not happen. Tribes must consider what Congress will appropriate and how everyone can benefit from it. It would be great if the facilities could gain simple approval, but this has not been seen with the YRTCs.
- Ms. Crista Ray likes the concept, and thinks it is a win-win. She was not sure why there were so many negative comments. For clarification, she asked if this affects CHS funds, and Ms. Kerrigan said no. This will enhance what is already provided. Ms. Ray thinks she has a good grasp on the information and does not think it is a bad idea. This is a way to meet unmet need. This helps urban natives that are in bigger areas. If they could utilize this for their specialty care, that would be good use of CHS funds. Mr. Galleto said that when you push it to an urban location, it is difficult for others to get there. They both agreed it would bring more money into the state. Ms. Ray asked how to better advocate for this from Congress. Ms. Kerrigan said the first step is tribal consultation, once the data is available and the model is completed. Once tribes are in agreement on which plan to resume, requests must be made to Congress to authorize facilities, funding for purchase of the land, funding for design, funding for purchase, and funding for staffing. This is labor intensive, but the other U.S. tribes are doing this every single day. The consultation will eventually be part of the final report. Ms. Kerrigan said she asked the Innova Group to develop an executive summary and list talking points associated with each model. She said this this is a complex strategy, but the California Area will be on the heels of the Portland Area IHS demonstration project being funded. Once Congress funds the Portland Area IHS, that sets a precedent. Since Congress already agrees with the concept, the California Area will not need to convince them. There are no hospitals in the Portland Area IHS so they are also 100% dependent on CHS. The bigger tribes have a combination of outpatient and inpatient facilities plus contract health. The facilities get the funding, but the little tribal contractors are still funded at only 50% level of need. Mr. Galleto asked if tribes could lobby alongside the Portland Area IHS and push the concepts together. Ms. Kerrigan said they may have already lobbied to Congress, but Mr. Galleto suggested they still try to join them. Ms. Kerrigan further clarified that this project is not ready to launch as it is now. She is looking for input on how to tweak it so that everyone is interested. The study requires more recent data, more information on local specialty care that is available at local tribal healthcare programs and in the vicinity, and data on CHS referral patterns. The preparatory work is not complete.
- Ms. Kerrigan asked for Mr. Stacy Dixon's opinion on this as a funding possibility. He said if they pass the budget, this is a possibility, but it is hard to say what the outcome will be for the next year. The concept sounds good to get something going. He said they have been pushing for the YRTCs for a long time. His concern is that they are on the Nevada border, but they cannot go to Reno even though it is closer and easier to get to because of their status with Medicare and Medicaid. Ms. Kerrigan said it was not her intent to start pushing this. Tribes should still push for the YRTCs while this concept is being finalized. Mr. Dixon said it is good to at least get this on the table and look at the pros and cons.

Feedback from tribal leaders must still be considered. Reaching out right now is a good idea, and so is consultation.

- Ms. Jackie Wise Spirit said this is a lot of information to comprehend, especially with all of the current budget problems. It may be a good idea in the future, especially since the California Area is always being left behind.
- Ms. Teresa Sanchez said she does not see how it is going to benefit California as a whole since California tribes are so spread out. The project needs a lot of refining to benefit everyone. Mr. Dixon agreed that the location will be important and there are many options. Northern California is so rural that it is hard to establish a facility that has all of the needed care. For the eastern and western tribes, the commute will be hard.

Dr. Sprenger commented that there are a few things that the Innova Group addressed, but may need more focus. First, this project would allow for development of medical experts within the IHS system. These experts could use telemedicine to provide consultations in the field as well. It is also nice for a doctor to have someone they can call within their own system. In addition, CHS funding and third party funding (e.g. Medi-cal, private insurance) could be recouped. Those third party funds could be used for enhancing care in tribal clinics.

Ms. Kerrigan concluded this topic by explaining that she wanted to show the amount of analysis that has already gone into this. She will send out the completed analysis for tribal consultation. Hopefully at the annual Tribal Consultation in March 2013, this topic can be discussed as a finished product. She thanked the group for their input.

Youth Regional Treatment Centers North and South updates:

Ms. Kerrigan asked for YRTC updates from Mr. Gary Ball, Staff Architect, and Mr. Steven Zerebecki, YRTC Planner:

- Mr. Ball reported on the status of the southern YRTC. The IHS/CAO has signed a contract with an architect for the southern property. The kick-off meeting occurred in October with the architect and the team at IHS/CAO. The follow-up meeting occurred alongside a site visit. At this point, the architect is preparing conceptual ideas on where buildings might work on the site. That meeting will occur on November 29 at IHS/CAO.

  Mr. Devers referenced his comment at the last meeting regarding incorporating southern tribes when establishing the design of the facility. Ms. Kerrigan said IHS/CAO will involve and look for tribal input in the design plan, which is just now starting. Mr. Devers encourages them to involve tribes earlier, rather than later. This should include what direction the building faces, for spiritual reasons, for example. Ms. Kerrigan asked how the IHS/CAO should work with southern tribes on this. Mr. Devers suggested sending an invitation to tribal chairmen with the dates the CAO will be down there and requesting a pre-meeting. Ms. Kerrigan asked if they should meet with the Southern California Tribal

Chairmen's Association. Mr. Devers explained that association only consists of 17 individuals, and more tribes should be involved. Ms. Kerrigan said she is willing to present to the southern tribes with Mr. Ball and Mr. Zerebecki, but will need logistics for a full consultation. Mr. Ball explained the current timeline, having scheduled a meeting on December 19 and January 4. By January, the CAO is hoping to see concepts. Site concepts are to be completed by December 19, so it would be helpful to meet with the southern tribes before then. Mr. Hernandez insisted that southern tribes have been forgotten again, even though these facilities are supposed to be for them. The timeline should be pushed back to include southern tribes in the process. Ms. Kerrigan agreed, but said she is unavailable in December so it shall be pushed back until January. Mr. Ball said adding time to the 441-day timeline is not a problem and asked how much time they need to schedule a meeting.

ACTION ITEM:

Mr. Ball agreed to send the southern YRTC schedule to Mr. Devers and Mr. Hernandez so they can discuss upcoming meeting dates with southern tribes.

- Mr. Zerebecki reported on the status of the northern YRTC. Since the last CATAC meeting, D-Q volunteered to revert back property in Yolo County near Davis. The property has changed title and is in the name of the federal government. Due diligence studies have completed, and one drainage issue was identified. Since it is still feasible to build on the site, this will be mitigated. The issue may result in building a berm around the site or raising the foundation. Since the road has not been maintained, clearing it out will be part of the improving the drainage issue. IHS requested that IHS/HQ approve the acquisition of the land. They are reviewing it and should wrap-up soon. Since no obstacles have been identified, this could occur at any time. It is only a formality to sign over the property to the IHS. Then, the IHS Director will announce acquisition of the property, and Ms. Kerrigan will forward that to all tribally elected officials and schedule a designation of the land. All CATAC members and tribal representatives will be invited to this celebration.

Ms. Kerrigan said the minimum amount of land needed for a YRTC was determined to be 10 acres. Since the southern YRTC will consist of 20 acres and the northern YRTC will consist of 12 acres, both packages are nice.

Mr. Devers said he visited Spokane and they have a great program there. He knew someone on the land who opposed it, but insists they are his best neighbors to this day.

Ms. Kerrigan concluded this topic by acknowledging that there is continued progress on the YRTCs, even though it is sometimes slow. In addition, the IHS Director has indicated she would like to come out for the groundbreaking.

California Representatives to National IHS and HHS Workgroup List and Reports:

ACTION ITEM:

Travis will email forms to be used by representatives to national IHS and HHS workgroups.

Contract Support Cost (CSC) Workgroup: Representatives: Ms. Mary Benedict and Ms. Michelle Hayward (not present)

Ms. Benedict noted that this is not an IHS-approved presentation. Since the Ramah case was won, the workgroup has not met. There have been changes to the policy, but they have not been finalized so she does not know when they will be distributed to tribes. On September 24, the IHS Director sent a letter to all tribal leaders. Ms. Benedict urges the IHS to change its practices because she was not informed that the data was due. The numbers were also not sent back to tribes to ensure accuracy. The Area Office Report is due on November 15. She requested that Ms. Kerrigan review the process and how it can be improved so tribes have time to look at the reports before they are submitted to IHS/HQ.

Mr. Devers asked who is currently on the workgroup and working on the changes. Ms. Benedict said there are representatives from each area, and all are tribal. Randy Grinnell was appointed as federal chair of the workgroup because the meeting has been cancelled by the tribal side for a while. The group still has not met for months. There has been no regrouping since the lawsuit favored the tribes.

IHS National Behavioral Health Workgroup (BHWG): Representatives: Mr. Robert Marquez and Mr. Michael Thom

Mr. Marquez reported that there have been three meetings so far (two face-to-face and one teleconference), and he has attended one of the face-to-face sessions and the one teleconference. The latest topic has been the funding formula. There are some concerns with areas of funding. Alaska seems to have an advantage because they have current data. The primary issue when in regards to funding is providing current data. In Alaska, all clinics are part of one data collection system, and this is not the case in California. The funding formula is made up of these three categories: user population, poverty level, and disease prevalence. According to RPMS, California currently has 80,438 active users. This is the number used to measure performance. The workgroup is analyzing whether this formula is still working or if it should be changed for fairness of distribution. On top of this, there is a limited amount of money in this pool. Originally, $10 million was allocated for MSPI and $6 million was allocated for DVPI projects. Currently, there is only $5 million for MSPI and $7 million for DVPI projects. This is highly competitive, and only two California tribes received direct funding. There is one tribe in another Area that only received $2,000, and you cannot do much with that for Methamphetamine. We must consider how to increase these numbers. The answer is data collection, and encouraging non-RPMS tribes to submit information. Since tribes

are not required to submit this information, we can only ask for it. In addition to funding, three pilot programs have been extended for two years. There are some new tribes that are not doing as well as they should be, and it is hard to justify this initiative while they are struggling. There is skepticism from government on this. A lot of this funding is being used for technical assistance as opposed to direct support. This is an ongoing argument between new sites and sites that have been doing this. Currently, the funding is distributed to IHS Areas, and they decide to which tribes to give the funding. Self-governance tribes should not be required to follow this procedure. This year, there was a decision to only fund programs who currently receive these funds. Next year, the workgroup will decide whether to open it up to RFPs and if it should be a three-year contract or a contract to be renewed every year. So far, workgroup members have voted for three year contracts. After all, the first year is to start the project, and the remaining two years are spent working to sustain it. Since there is a need for this funding, the workgroup submitted a request for an increase of funding for both initiatives. The next meeting is scheduled for January. Once the progress reports are submitted in January for the current programs, the workgroup will decide who will be funded. Next year, there will only be two face-to-face meetings and four conference calls in order to save money.

ACTION ITEM:

Mr. Marquez will send the funding increase lobbying resolution to all CATAC members.

IHS Contract Health Services (CHS) Workgroup: Representatives: Mr. Johnny Hernandez and Mr. Chris Devers

Mr. Hernandez reported that there is little progress with the workgroup as everyone is still fighting for more funding. There have been five conference calls. At the last meeting in Denver, IHS was trying to force prevention funds to be taken out of CHS funds. The workgroup resisted this. Right now, the workgroup is revising the manual. The biggest concern is funding, no one know what is going to happen with the budget. Everyone is hoping CHS will be a separate line item, but this is almost impossible with the current state of Congress. The next meeting is scheduled for January 23-24 in Denver, at which time the manual will be finalized. Then, the workgroup will look at the formula and see if that will be changed. Mr. Hernandez asked if the CATAC members had seen the CHS Manual, and agreed to bring copies for everyone at the next CATAC Meeting. Some of the manual was written in the 1960s.

Ms. Kerrigan clarified that the issue of using CHS funds for prevention was an edict for federally-run hospitals only. Mr. Hernandez was unaware of this, and believes the changes to CHS will benefit the federally-run facilities.

Mr. Masten asked who is responsible for revising manual, and Mr. Hernandez said IHS is responsible for this. Mr. Masten wants to ensure that maintaining the current CHS funds is a priority for California to protect. Mr. Masten asked if the updated manual will change the formula and asked who is working on this. Mr. Hernandez said there are

seven individuals on the workgroup (two from Navajo, two from Montana, one from Oklahoma, one from Oregon, and one from New Mexico).

ACTION ITEM:

Mr. Hernandez will bring copies of CHS Manual for all CATAC members at next meeting.

Tribal Leaders Diabetes Committee (TLDC): Representatives: Ms. Rosemary Nelson (not present) and Ms. Dominica Valencia

Ms. Valencia read a report created by Ms. Nelson and provided to all CATAC members. Ms. Valencia stressed the importance of the TLC program and warned that the Diabetes program would be terminated if the SDPI does not pass. Mr. Hernandez referenced his time on the STAC and said they would vote on which boards to keep and which boards to terminate. Mr. Dixon confirmed that they still do this for all national boards, but he is not sure how they are currently prioritized. Ms. Valencia said tribes can send a letter of support before the end of the month to urge the passing of the SDPI. Tribes are urged to contact their congressmen as well. Mr. Hernandez asked for a sample letter to send, and Ms. Valencia said a template is available on the TLDC website. There are currently ten individuals on the committee and all are just focused on getting this passed. Then, the California representatives will start to fight for California to make sure we get our share.

IHS Facilities Appropriation Advisory Board (FAAB): No Representatives

Ms. Kerrigan said she asked for recommendations for the FAAB from tribes about four months ago, but only received one response from CRIHB. Nelson Pinola recommended Kerry Gragg, CRIHB Tribal Facilities Engineer and former IHS employee, but he does not fit the criteria. She asked Mr. Pinola to be California's representative instead and include Mr. Gragg as the technical representative. Mr. Pinola has not yet agreed.

HHS Secretary's Tribal Advisory Committee (STAC): Representatives: Mr. Stacy Dixon and Ms. Elaine Fink (not present)

Mr. Dixon provided a packet to each CATAC member about what transpired at the meeting on September 11-12. The most important issues are addressed at the bottom of page 5; these are the recommendations from the STAC to Secretary Sebelius:

- Establish a definitive listing of CHEF-covered services
- Introduce options that would allow CHS programs to choose to be reimbursed at 100% once a case is completed or receive a 50% advance payment
- Determine if the 50% advance payment is an effective mechanism for encouraging applicants to submit completed paperwork quickly
- Determine if the CHEF program should provide a higher percentage in advance or set aside funds to cover the remaining 50% (based on the estimated total cost)
- Identify approaches that better distinguish true unmet need catastrophic cases currently not submitted for reimbursement due to the depletion of funds in the

CHEF or due to the inability of a small CHS program to meet the threshold requirement to access the CHEF

- Determine if the CHEF program should establish different thresholds for each IHS Area to ensure that smaller CHS programs can better access the program
- Identify ways that the IHS can assists smaller clinics and CHS programs with limited staffing to increase access to the CHEF program
- Provide estimates of how lowering the CHEF threshold to $19,000 (as previously recommended) would affect the amount of funds needed to adequately fund the CHEF program

Secretary Sebelius understands the workgroup's concerns. She reiterated that consultation with the governor is the key for tribes to get their issues across with the state. Mr. Dixon has been reaching out to other consortiums, such as CRIHB, to encourage this. He tried to go to their meeting, but his Board denied his request because he hurt his ankle.

Mr. Dixon's term is up next year, in 2013. Elaine Finke is the alternate representative, and her term is up as well. The election occurred a couple of weeks ago, but there are still some issues with some of the positions. The next STAC meeting is on December 6-7. He will provide an update from that meeting at the next CATAC meeting. Mr. Dixon encouraged all members to e-mail him with any information that should be brought up with the STAC. His email address is SIRTRIBALCHAIR@CITLINK.NET. Travis will send out STAC report to all CATAC members.

ACTION ITEM:

Travis will send STAC report to all CATAC members.

Emerging Issues:

Mr. Masten expressed his appreciation for the thorough notes from Rachel Pulverman and Travis Coleman, especially the Executive Summary from the last meeting.

Mr. Devers asked for an update on finances, since the election. Ms. Kerrigan said there have been no proposed cuts to the IHS budget. Congress passed a law that said on January 4, they could sequester up to 8.2% from every federal agency across the county. The only exceptions are the DOD and VA (they will only be cut about 2.5%). This will be discussed during the budget formulation on November 15. If there are cuts, IHS/CAO needs to know where tribal leaders want them made, as 8.2% is a large cut. Ms. Kerrigan does not see how an 8.2% cut would not affect the tribes. This would be the first time there will not be enough funds for contracts/compacts. During the last sequestration, IHS was exempted (with DOD and VA), but IHS is a discretionary part of the budget now as opposed to an entitlement program.

Mr. Masten introduced an ambulance program in Hoopa, for which he hopes to persuade IHS to provide funding. Pamphlets will be provided describing this at the budget

formulation meeting on November 15. The ambulance program is costly to operate since they cover a large area. Ambulance personnel have delivered over 20 babies and are the most well-trained in the service area. This program is necessary to save lives, and the pamphlets show the tragedies that have occurred throughout the area. The ambulance program currently serves the Yurok Reservation in the north, the Karuk tribe in the northeast, a fairly large community in the South, and the 299 corridor from Redding to Eureka in addition to Hoopa. He has already talked to Dr. Roubideaux about this at the NCII meeting, and she mentioned she will be in the California Area later this year and agreed to meet with them then. One possibility is to make this a pilot project. He asked Mr. Dixon to bring it up at his next STAC meeting and encouraged all CATAC members to show their support.

Ms. Kerrigan mentioned her work with the Veteran's Affairs (VA) Office of Tribal Government Relations. They are planning a VA Veterans Conference for April 2013. The VA will provide all of the speakers to present on veteran's' benefits and eligibility. The hope is the conference is attended by benefits coordinators, CHS clerks, patient registration clerks, and other staff that interact with veterans from tribal healthcare programs so they are aware of the services for which the veterans are eligible. Usually, the VA asks a tribe to co-sponsor the event. This approach was successful in Washington and Oregon. The IHS/CAO approached United Auburn Indian Community (Thunder Valley Casino) to see if they would have the availability and also donate the space. If a southern California tribe will partner with the VA, they are willing to hold a separate workshop in southern California. Ms. Kerrigan asked Mr. Devers and Mr. Hernandez to ask one of the larger casino/hotels to co-sponsoring the event. The event requires guest rooms for 100-150 attendees at the government rate and the conference would last 2 days. The VA provides presentations and handouts. The event will also training tribal veteran representatives (TVRs). All of the big tribes have TVRs, but IHS/CAO does not know about the smaller California tribes. Mr. Devers said they do not have a TVR, but others would want to attend. Ms. Kerrigan confirmed that they would all be invited. Ms. Sanchez agreed to check with Morongo. If Thunder Valley Casino does not agree to host the event within the next four weeks, a southern site will be necessary to maintain the April date. The VA has a lot of money, but they cannot spend it on conferences.

ACTION ITEM:

Representatives from the southern region will contact local casino/hotels regarding hosting a VA conference in April or later in 2013.

The meeting adjourned at 3:20.

Additional Tribal and program leaders, Indian Health Service staff, and guests in attendance during the November 14, 2012 CATAC meeting:

Name	
Mary Benedict	Primary Contract Support Costs Workgroup representative
Dominica Valencia	Alternate Tribal Leaders Diabetes Committee representative
Jackie Wise Spirit	Riverside/San Bernardino Health Board member
Carolina Manzano	Southern Indian Health Council, Executive Director
Patty Muse	Southern Indian Health Council, Executive Assistant
Daniel Pratt	K'ima:w Medical Center Board member
Leona Ibanitoru	Susanville Indian Rancheria, Executive Director
Maria Hunzeker	Feather River Tribal Health, Executive Director
Molin Malicay	Sonoma County Indian Health, Chief Executive Officer
Ernesto Padilla	Lake County Tribal Health, Executive Director
Jess Montoya	Riverside/San Bernardino, Chief Executive Officer
Lessie Aubrey	Karuk Tribal Health, Executive Director
Fredrick Rundlet	Consolidated Tribal Health, Executive Director
Daniel Aguaro	Central Valley Indian Health,
Leora Treppa-Diego	Lake County Tribal Health,
Jackie Kaslow	California Rural Indian Health Board,
Vickey Macias	Cloverdale Rancheria
Zahid Sheikh	Tule River Tribal Health, Executive Director
Scott Black	American Indian Health Services, Executive Director
Mark LeBeau	California Rural Indian Health Board,
Inder Wadhwa	Northern Valley Indian Health, Executive Director
Arvada Nelson	Quartz Valley, Executive Director
Frank Kearns	Tuolumne Me-Wuk Tribal Health, Executive Director
Lisa Davies	Chapa-De Tribal Health, Executive Director
Rosario Arreola-Pro	California Rural Indian Health Board,

IHS/CAO staff and Consultants	
Gary Ball	Staff Architect
Rachel Pulverman	Student Trainee (Public Health Analyst)
Steven Zerebecki	YRTC Planner
Dr. David Sprenger	Medical/Psychiatric Consultant

INDIAN HEALTH SERVICE
CALIFORNIA AREA TRIBAL ADVISORY COMMITTEE MEETING
Holiday Inn Capitol Plaza
300 J Street
Sacramento, CA 95814
November 14, 2012

Location: California Room (8 AM-12 PM) Hermosa Room (1:30 PM-4 PM)

8:00 AM	**Welcome and Introductions**	**Ms. M. Kerrigan**
8:15 AM	**Feasibility of Constructing regional medical centers and specialty care/ambulatory surgical centers in California**	
12 Noon	**Lunch**	
1:30 PM	**Review Executive Summary – June 21, 2012**	
1:45 PM	**Youth Regional Treatment Centers North and South updates**	
2:15 PM	**California Representatives to National IHS and HHS Workgroup List and Reports**	

CMS	**TTAG**
Contract Support Costs	**CSC**
Behavioral Health	**BHWG**
Budget Formulation	**BFWG**
Contract Health Services	**CHS**
Diabetes Committee	**TLDC**
Workgroup on Tribal Consultation	**TCW**
Self-Governance	**TSGAC**
Facilities Appropriation	**FAAB**
HHS Secretary's Tribal Advisory Committee	**STAC**

3:30 PM	**Emerging Issues**	
4:00 PM	**Adjourn**	