INDIAN HEALTH SERVICE/CALIFORNIA AREA OFFICE
TRIBAL ADVISORY COMMITTEE MEETING
February 27, 2013

EXECUTIVE SUMMARY

CATAC Members:		**Region Represented:**
Mr. John Green	Present	Northern
Mr. Stacy Dixon	Absent	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	Absent	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
Mr. Ed Fluette	Associate Director, Office of Environmental Health and Engineering
Ms. 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 9AM on February 27 in the CAO Conference Room at the John E. Moss Federal Building, 650 Capitol Mall, Suite 7-100, 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 welcomed all committee members and reviewed the meeting agenda. Chris Devers opened the meeting with a prayer.

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

Ms. Kerrigan began by noting that this is a long-term strategy. Although IHS has seen funding increases, they have not been significant. She introduced the Innova Group, who presented the slides they plan to speak on at the Annual Tribal Consultation in Pala on March 13.

Mr. Anthony Laird introduced the presentation as being much shorter and simpler than the one presented at the Program Directors meeting in November. He also introduced Mr. John Temple, who will provide commentary throughout the presentation. He introduced the Innova Group and the type of work they do. He noted that everyone wants the regional medical center near their healthcare program, but there are many considerations for the location(s). He discussed the many reasons to consider regional care and the definition of regional care. While discussing how regional care works, he discussed population grouping. The centers should be located where there are at least 30,000 users. Redding, Sacramento, Fresno, and Temecula met all requirements for a regional medical center.

Mr. Silver Galleto asked if the four regional centers would all be the same size. Mr. Laird said there may be two larger centers, if those areas serve a larger population.

Mr. Laird introduced six models for number and locations of regional centers.

Mr. Pete Masten Jr. asked if the Innova Group considered the number of eligible Indian populations within a radius to these health centers. Mr. Laird said they did do this to see how many users might come to the centers; however, there are certain remote populations that will never be within a 2-3 hour travel time.

Mr. Temple asked why the IPs are displayed as different colors in models 4-6. Mr. Laird said they will all be the same type of IP, and the colors are just to help view the table. He also noted that Sacramento is an Area medical center in all of the scenarios because Sacramento has the best opportunity to provide the greatest number of services. Mr. Galleto asked if the Sacramento center would provide the same number of services in all models. Anthony said no, they would not. He said he will describe how they are different later in the presentation.

Mr. Jess Montoya said recruitment of providers should be considered. Mr. Laird said provider recruitment was considered when choosing the four locations in these models. Mr. Temple added, however, that they did not weight recruitment among the four locations.

Mr. Masten said population is a critical factor. If there are only two centers, how would this correspond to the current CHS program? Also, how many CHS dollars is this going to save with the various scenarios? Mr. Laird said they will address this later in the presentation.

Mr. Hernandez asked about the unmet need accounted for with these scenarios. For example, if the federal government is currently providing funding of $1,000 per patient, but should be providing funding of $5,000 per patient, how much of this gap would be closed by these regional centers (especially since patients would be receiving better services)? Mr. Hernandez also noted that if there is a hospital nearby, sites receive less CHS funding. Mr. Temple said he doesn't think they have done this analysis, but it may be a possibility. He asked what the CHS adjustments would be if there was a hospital in the Area. Ms. Kerrigan does not think the CHS funding will be adjusted any time soon. Mr. Temple said he has not seen an adjustment either. Mr. Hernandez said there have been two increases for CHS. California received additional funding because there is no hospital in the Area. Mr. Hernandez reiterated that these regional centers need to be justified as to their benefits if they could possibly affect CHS funding. Ms. Kerrigan added that the IHS may not unilaterally reduce funding levels unless Congress fails to appropriate money. Therefore, it is unlikely that these facilities will result in reduced CHS funding. When she worked in Phoenix, they opened ten hospitals and never saw a decrease in CHS funds. In addition, Ft. Yuma opened a new facility but did not see a decrease in CHS funds. Even if the California Area pursues these facilities, there will still be an unmet need in California and there will still be tribes that will not benefit from these facilities. We need to compliment CHS funding. Plus, this will not happen tomorrow. The California Area is still working on establishing the YRTCs and that is the priority.

Mr. Galleto asked about billing at these facilities. Ms. Kerrigan said these facilities would not be able to serve non-eligibles. These facilities would be fully dedicated to California and its tribes and the unaffiliated. Mr. Galleto then asked how these facilities would generate more money. Ms. Kerrigan said all of the facilities will bill third party for everyone that they can. The facilities will use the income to expand and maintain services, and ensure that they are accredited. Mr. Montoya clarified that the ongoing cost will come from Congress, so income will go back into the facility.

Ms. Kerrigan explained the next steps if the Area proceeds with one of these scenarios. Once the tribes agree on the number of facilities, this will be put into the IHS Facility Construction Priority list. This will not be added to the list until there is agreement across the state. Those facilities that are already waiting for Congress would have first priorities. After the sequestration, there is a chance these facilities could be established in the California Area.

Ms. Kerrigan further explained that we can support two facilities under any circumstance, but the tribes may not want facilities in the Redding/Clovis area, for example, and those centers may not offer the range of services in Fresno and Temecula. Mr. Montoya said if this was a ten year plan, this might be more palatable. Mr. Hernandez and Mr. Malicay need leverage for California in the time being. Ms. Kerrigan said California's funding increases are based on historical amounts, and we do not get any lump sums. This is just one strategy to bring in more resources to California to save CHS dollars and offer a standard of care that everyone would like to invest in. Mr. Hernandez said Margo is

correct that we don't have a say on the funding. His fear is that other Areas will get the majority of the funds. Mr. Hernandez likes this long-term plan.

Ms. Nelson asked about the historical criteria for CHS funds. She added that this "rationed healthcare" results in deaths. This distribution may make the federal government feel better, but not Indians. Mr. Hernandez agreed and said the focus right now is on prevention. This takes money out of the pockets of people here, per patient.

Mr. Devers asked about scenario three, and the logic of not having both centers as inpatient and outpatient. That way, if someone is critically ill, they could be referred to a closer hospital that covers the cost. They have seen substantially high numbers of patients who are very ill, and have a four or five day stays in the hospital (which is a lot of money). Mr. Laird said population alone drives the rational for this.

Mr. Montoya noted that Fresno may not need pediatric care because they have a hospital that provides a lot of charity care. Mr. Laird said they have not been able to analyze the care provided in each location.

Dr. Magruder commented on the prevention perspective. He said the new perspective on prevention emanates from the white house. This comes from the Affordable Care Act. He thinks the most critical item of consideration should be how the Affordable Care Act impacts care in urban areas. All should consider that this type of facility in rural areas may better meet healthcare needs, since the ACA allows those in urban areas to more easily access facilities (such as the children's medical center in Fresno).

Ms. Nelson noted that if the centers were located in frontier areas, they would not attract specialty professionals. Frontier areas are not the places to have these centers because they cannot serve their people there now (they have to fly them to Reno or Redding, for example). Dr. Magruder said they should consider what type of healthcare providers could be recruited to those areas.

Mr. Temple said he has been working with Alaska, and they are concerned about the Affordable Care Act. More of their patients that have been loyal to them will go to other places. Now, they must do their own marketing and provide the best care. Furthermore, if these facilities are built, they should be the choice for patients.

Mr. Devers added that this should not detract or diminish trust responsibility the federal government has to Indian people. Regardless of what the Affordable Care Act mandates, all California Indians should be guaranteed coverage.

Mr. Masten asked about the impact these centers would have on income to local healthcare programs. These centers may impact follow-up, transportation, or revisits, for example. Currently, much follow-up is referred back to the healthcare program physicians. Mr. Temple said he wondered if California tribal healthcare program providers were comfortable with providing this type of care. Mr. Masten said Hoopa physicians often assisted with surgeries at hospitals and other facilities. Plus, Hoopa

hires specialists to come out to their healthcare program. Other programs do this also. Ms. Kerrigan said the Portland Area did this project first, and is going to proceed with seeking Congressional funding. We will see what kind of impact these facilities have on their healthcare programs. They are similar to California because they are 100% contracted/compacted.

Ms. Kerrigan said she spoke with Bob McSwain at HQ and he said these ambulatory/surgical centers are the way of the future. There will be fewer IHS acute hospitals built, as the ambulatory/surgical centers will save CHS funds. He was happy that the California Area is doing this study and encouraged Ms. Kerrigan to proceed with this strategy for as long as it takes for people to work through qualms. She added that she does not have another strategy to bring in additional funding. She cannot get more CHS funding or more appropriation for hospitals and clinics. Increases have only been given for population growth and inflation. The same amount was provided across all areas. In other words, CHS dollars are not determined out of the California Area Office. Separate from recording deferrals or denials, she has no other route to pursue regarding unmet need. More funding in the budget is all going into facilities construction. Congress authorizes those types of projects. None of this will happen today or tomorrow – this presentation is just to inform everyone of this strategy. The goal is to bring in more money into California. Eventually, the tribes must go to Congress for this to be funded. Tribal advocacy will make this project successful or unsuccessful.

Mr. Masten said he agrees with what Ms. Kerrigan said and respects Mr. McSwain and his opinions. He just wants to make sure this will not be detrimental and that many patients will utilize these centers.

Mr. Hernandez said California should not prioritize the “haves” and “have nots”. Some areas of the state will not have access to these centers. He hopes Ms. Kerrigan considers all of the tribes in California when planning for these centers. Every Native American person deserves medical services 100%. That is why he is afraid of this plan – because it is tilted towards the populated areas and travel time.

Mr. Marquez wants to ensure that these centers are culturally relevant, because he knows many patients won’t go to hospitals because they are not culturally appropriate. He asked how these will be designed and how they can compete with other centers. Mr. Laird said they have looked at this from a high level, but there are other ways to analyze this (such as with personal conversations with healthcare programs). Mr. Marquez added that Congress will look at what is already in existence in California. The process will be drawn out, so he wants to know what additional information they can give tribes to market this. Examples of this are how much funding we will truly need. Mr. Temple said they are not a lobbying firm or a marketing firm, but they can provide information on funding and resources needed. He said Innova has not analyzed any tertiary requirements (such as transplants). There will need to be quality recruitment and quality operations. Leadership will need to be brought in to make these centers succeed. The operational component is important, but Congress may not ask these issues.

Dr. Magruder thinks that Mr. Marquez's questions are important. The group should analyze how to be competitive and successful based on who will be looking at the proposal. He thinks the key is how this proposal improves overall access to care. These should not be located in competitive areas, such as near Stanford. He reiterated that the group may want to focus on those members of the population that have least access to care at this time. For these reasons, he wondered why Sacramento and Fresno are being considered.

Mr. Temple explained that they have been working on this with federal agencies for some time, so they know what makes a good case to Congress. He referenced Alaska, but the CATAC noted that Alaska is different because the tribes work together and have more funding. Mr. Marquez added that the only way to compete with the other Areas is if we have all of the information laid out.

Mr. Montoya said many program directors and legislative staff have been advocating for Medicare-like-rates for outpatient benefits. This might affect Innova's formula in the long-term. This is for CHS outpatient visits.

Mr. Devers said he envisions tribal leaders asking about the time the Innova Group has spent with facilities as they are today, discussing what is working, what is not working, and how to expand on those services with a vision such as this. The tribal leaders will think this is being planned without their input, and they will not support it because they do not want to be told what is best for them. They want to be asked for their input. Mr. Temple said their most recent experience was in northern California, but someone from their company visited every organization in the state to develop a master plan for the California Area. That was some time ago. Mr. Laird added that there were three site visits to every clinic in California. That information is dated, but still valuable. Mr. Devers said this is important to hear. Mr. Temple said maybe that should be one of the first slides, showing the history behind these concepts.

Mr. Thom likes the scenario with two centers the best. California deserves specialty care, and they will not get it with four centers. His tribe sends patients to Medford, Oregon and it takes two hours to get there. He would prefer to travel to Sacramento to keep money in California. Mr. Temple asked if they would come to Sacramento. Mr. Thom added that they cannot even get a provider to work at their site in Happy Camp. Mr. Laird said it is important to know where patients are currently travelling to access care. While it may sound like a lot of time to travel 2-4 hours, that may be the current solution.

Ms. Nelson said some of their patients currently are already travelling to Sacramento. She asked if we could use the fact that other Areas have hospitals as an argument. Plus, we have the largest urban population. Ms. Kerrigan said the one argument we have if this is something we want to pursue, is that the level of need funded (LNF) in California is 52%. Some tribes are funded over 100%. Although we've seen fundamental increases, costs have also gone up. Mr. Thom added that the medical center in Tucson gets more money than all of California.

Mr. Hernandez asked for how long the Innova Group plans to present at the Annual Tribal Consultation in Pala. The presentation took two hours during this CATAC meeting. Mr. Laird said the presentation should only last one hour.

Mr. Hernandez asked if they want to sell a concept or present a planning solution. Mr. Thom said he would like to see them sell the concept of two clinics because of the specialty care – more to offer to tribal members.

Mr. Hernandez said if Ms. Kerrigan is going to try to sell this to California tribes, there must be an emphasis on involving everyone. He thinks an hour is too long, especially for this dry presentation. He suggested having someone from Portland present on how this works. This should be presented as a friendly concept, presented broadly, just to get them thinking about this. You do not want to leave them with only facts and figures. Mr. Temple clarified that the group wanted them to present all six scenarios.

Mr. Masten agreed with Mr. Hernandez that there needs to be someone preceding this presentation, letting everyone know that this is a concept/vision and has not yet been discussed. We want to avoid the perception that we are pushing this on them.

Ms. Kerrigan said this was meant to be informational only, rather than a decision being made. This will show what our state would look like if we had these kind of facilities. Mr. Hernandez said he does not think it would be wise for the Director to present this. Someone should present this as a vision, to convince them that this could happen 5-10 years from now. Someone should be able to talk about other opportunities, such as CHS. Attendees should also be asked for their feedback after the presentation.

Mr. Fluette commented on the structure of the presentation. He asked for a list of the questions that were provided on the different slides. Once the Innova Group proceeded to the next question, he forgot about the other questions. He also noted that the list of services will not be seen on the small screen at the Annual Tribal Consultation, and that is an important slide to show.

Mr. Laird asked for additional input, which can be sent through Ms. Kerrigan or Mr. Fluette.

Ms. Kerrigan thanked the Innova Group for their presentation.

Review Agenda topics for the Annual Tribal Leaders' Consultation Conference:

Mr. Devers thinks the preliminary agenda looks good. He likes early registration.

Ms. Kerrigan noted that there are fewer presentations to allow more time for discussion. There will also be an open microphone for tribal officials.

Monday afternoon will be a CATAC meeting for the moderators only.

Mr. Devers clarified that it is Angelo Lovato, not Anthony Lovato.

Ms. Kerrigan noted a need to add introductions of elected tribal officials.

Ms. Kerrigan's presentation will provide a preview of the agenda.

Ms. Kerrigan noted that if there is a sequestration, it will impact everyone, and the CATAC may not be able to meet next fiscal year. Regardless, there will be time for regional tribal caucus elections to CATAC. Ms. Nelson asked how much the sequestration will cut, and Ms. Kerrigan said 8.2%. Mr. Hernandez said his national workgroup meetings are going to be virtual from now on, due to the budget. He said the group may even be disbanded, if they do not meet virtually. Ms. Nelson added that IHS is under constitutional provisions and should not be cut. Ms. Kerrigan said she wished we would be treated like the Veteran's Administration or the Department of Defense, which are exempt from cuts. Mr. Montoya said the program directors are planning a 16.8% cut because most of the programs were paid 48.7% of their funding. Should this occur, this cut will be taken from the remaining percentage. Ms. Kerrigan said tribes' requests need to be sent to their congressman. She said Mike Thompson is a huge supporter of Indian health and supported us with the northern YRTC property. Anyone in his district could lobby him. Others should lobby their senators as well.

Mr. Devers recalls that tribal leaders were able to create a resolution at a past Tribal Consultation for the YRTCs. He asked for time for the tribal leaders to do something at the Consultation if they need/want to. Mr. Fluette noted that the resolution Mr. Devers is referring to was sent to the D-Q board for the northern YRTC and they were strongly influenced by the 30+ letters they received as a result of this.

Mr. Devers said he and another Chairman sit on a committee that works on providing healthcare coverage for lower income individuals. He would like an opportunity for them to give a presentation and inform all Californians. He asked if anyone from IHS/CAO has been able to speak with them. They have another meeting in March and are currently working on how to get this information out. Ms. Kerrigan said this is already on the agenda, from 9:30am-12:00pm. Mr. Galleto asked if they will be discussing 10 month coverage of optional benefits. Ms. Kerrigan said no; they will be emphasizing the Affordable Care Act and the California Health Benefits Exchange.

Ms. Kerrigan said the final day of the Consultation will be a site visit to the southern YRTC. Ms. Sanchez asked if anything more has been done with the YRTC, and Ms. Kerrigan said they have been designing it. Mr. Fluette added that the mobile homes have been cleared off of the property so it will look different.

Mr. Devers and Ms. Nelson asked about Dr. Roubideaux's attendance for a question and answer period. Ms. Kerrigan said she will ask about this.

Moderators for the Annual Tribal Leaders' Consultation Conference:

Ms. Kerrigan asked for volunteers from the CATAC to be moderators at the Consultation, along with a federal employee. Ms. Sanchez volunteered for the afternoon on the first day. Mr. Marquez volunteered for the afternoon on the second day. Ms. Nelson volunteered for the morning on the second day.

Before lunch, Mr. Hernandez noted that he is no longer volunteering for the CATAC or CHS workgroup, but said it has been an honor to work with the CATAC group. He thinks the group has accomplished a lot, and is hopeful of the regional centers and the YRTCs.

The group was dismissed at 12:00 noon for lunch and reconvened at 1:30PM.

Youth Regional Treatment Centers update:

Ms. Kerrigan announced that IHS now owns acreage adjacent to D-Q University. IHS/CAO will schedule a dedication to the land in late June. We have to wait until the property dries out. Right now, the ground is too soft for people to walk on. Also, the Chair of the D-Q board passed away so the IHS/CAO is now working with a new group of people.

In the north, the IHS/CAO needs money for design and construction. For the south, the IHS/CAO is in the design phase. Ms. Kerrigan said we are seeking input on the design for the YRTC. We have developed soft models of the YRTC sites (displayed in the CAO conference room). These are "bubble diagrams". The plans preserve the land and surrounding creatures, such as butterflies. The county will assume the road and maintain it (and pave it). Ms. Nelson asked how long the road is, and Mr. Fluette said it is about half a mile long. When creating the bubble diagrams, the committee reviewed patient flow.

Ms. Kerrigan asked Mr. Devers and Mr. Hernandez to comment on the design. Mr. Hernandez said the group did not want the kids to see the delivery trucks, so delivery entrance is in the back. The building is also designed so all rooms have a view. There is also a cultural center and baseball field. He thinks it is designed well. Mr. Galleto asked Mr. Hernandez if the IHS/CAO is taking the suggestions of tribal leaders as he asked, and he said yes.

Ms. Nelson asked about the amount of beds at the YRTC and Ms. Kerrigan said there will be 32 co-ed beds.

Ms. Kerrigan said once there is money for the design, the IHS/CAO will conduct a similar activity in the north to request tribal input; However, for the most part, we will use these same designs. This will save money.

Mr. Galleto asked about Thursday, March 14 at the Annual Tribal Consultation. Ms. Kerrigan said those who have not seen the site can see it then. Those who have seen the site can get a better idea of how the buildings will look.

Mr. Galleto asked about the next steps, especially in reference to the $34 million needed. Ms. Kerrigan encouraged all to seek the full amount. She said we are in the 2013 budget for design and she does not know about the 2014 or 2015 budget. We must wait until the president issues the funding. Her advice is to have their tribal chairman write letters to the Senate Select Indian Committee and Health Committee. The YRTCs will be the next buildings to initiate construction in the IHS. IHS will only fund construction that is underway and we are in a continuing resolution until March 27. Hopefully, we will get funding this year for the YRTCs.

Ms. Kerrigan noted that the IHS just finished formulating the budget for 2014 and 2015 and the YRTCs were prioritized, but whether that budget gets passed by Congress is unknown. The sequestration will probably delay this process.

Mr. Montoya said he has been sending letters to tribal chairs advising them of these issues. He asked if the southern tribes offered any additional support for this project. Mr. Devers said the tribal chairs committed to sending the letters.

Mr. Fluette said that since the federal government owns the land in the north, we do not need to work with the county, but Ms. Kerrigan said we will want to work with the locals.

All were provided a worksheet that was used in the design discussion with southern California tribes. This shows the questions that were asked in the design phase. Another formal consultation will be done in the north. Mr. Galleto asked who was invited to complete this. Ms. Kerrigan said the Southern California Tribal Chairmen's Association invited her to discuss the design.

Mr. Galleto said that they brought up the YRTCs with Senators and Congressmen when they were in D.C.

Ms. Kerrigan said the Innova Group also helped with the design of these facilities.

Ms. Nelson asked if there has been any training for tribal leaders about the constitution and how to use that for lobby efforts. Ms. Kerrigan said she believes tribal officials in California are savvy. Mr. Hernandez suggested hiring lobbyists and focusing on the bigger tribes.

Mr. Fluette added that these YRTCs are relatively small projects (less than $20 million each) compared to what IHS is building ($100+ million). Requests for funding, therefore, should be for full funding.

Mr. Montoya said they wrote a letter asking why Dr. Roubideaux did not prioritize California's YRTCs. They have not yet heard back from IHS/HQ.

Mr. Galleto asked if staffing and operating costs should be included in the requests. Ms. Kerrigan said she suggests including everything in the request. We may have to request those additional costs in later years.

Discussion on Veteran's Administration Agreements:

Ms. Mary Benedict presented on her program's work establishing an agreement with the Veteran's Administration (VA). She said they had a call with the VA about setting up reimbursements. They also met with the VA Director. Hoopa has been waiting for the final IHS agreement, and it has now been posted to the VA's webpage. Hoopa is now working on site readiness. To learn more about this process, you can visit http://www.va.gov/tribalgovernment. There are some requirements in the agreement, including accreditation by JACHO or AAAHC and/or being able to bill for Medicare. Your site must also have volume estimates and your staff must take enrollment training. The agreement is not yet in place, but the first step is to view "Getting to Know the VA", which has a link to putting these agreements together. This will start this process. Each healthcare program will do an agreement with their local VISN.

Mr. Malicay added that everyone must start the process by logging onto that site. Although not all sites are accredited, all can bill for Medicare, so they should still be eligible. There is some detail that each site must work out before an agreement can be put in place. All sites must log on and meet with their VISN. He also noted that it is difficult for a veteran to be eligible. There are different benefits and requirements for each. Ms. Benedict added that benefits employees will need a lot of education.

Ms. Benedict said the Hoopa still needs to work on how their system communicates with the VA's system. IHS may need to be involved in this conversation.

Mr. Galleto asked if sites could bill retrospectively, such as for veterans seen in January, and Mr. Malicay said no.

Ms. Benecit also noted that the agreement is for Native Americans, but sites can negotiate serving non-native veterans as well. She also said the VA will charge about $7 for administrative fees for the first two years, but after that, everything will be electronic and the VA will no longer charge that fee.

Mr. Devers mentioned the VA Summit in Pala on April 8-9. He said, although these agreements are in place, all must remember that this is only for eligible veterans. Mary said there is a lot to learn, and a benefits person from each site should be sent to the summit.

Mr. Galleto asked what the agreement covers. Ms. Benedict said they must still learn what is billable and what is not billable. Also, if the veteran has not enrolled with the VA, they will not be eligible. Mr. Malicay added that hardly anyone gets reimbursed for dental.

Ms. Kerrigan said she will be sending out a flyer for the VA Summit. She suggested everyone send at least one health benefits coordinator from each tribal health program. Once you register, the VA will send more information. Mr. Malicay suggested noting how to register for the event in the email.

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

CMS TTAG: Representatives: Mr. James Crouch (absent) and Mr. James Russ (absent)

All CATAC members were provided a summary of the last TTAG meeting.

Contract Support Cost (CSC) Workgroup: Representatives: Ms. Michelle Hayward (absent) and Ms. Mary Benedict (absent)

All CATAC members were provided a letter from Dr. Roubideaux, dated January 14, 2013, about contract support costs.

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

Mr. Marquez said the workgroup will not be meeting as often as they have been meeting. The formula was the main point of discussion at the last meeting. No changes have been made to the formula. He provided a copy of the resolution to request a funding increase to all CATAC members. He also provided a table of the MSPI and DV allocations so far. The next meeting will occur next month. The workgroup will discuss who should get the funding. Right now, funding is based on performance. Mr. Marquez was not sure how IHS distributes this money. Ms. Kerrigan said they generally calculate new funding based on active users.

Mr. Marquez said the group also discussed that this was supposed to be a pilot program. The original programs need to be monitored to see what the results were. This will be analyzed during their reauthorizations. Last year, the group did not allow RFPs. This year, since funding is based on performance, they must re-think how they will allocate the funds. Mr. Malicay asked if these funds are reoccurring, and Mr. Marquez said they are - the group decides which regions to fund. He said there are only four funded programs in California right now. Ms. Nelson asked how they measure performance. Robert said they are deciding that now. Mr. Malicay asked if the workgroup assumes everyone has the same need, and Mr. Marquez said yes. Currently, the workgroup only looks at active users (not location, not current funding, etc.).

Dr. Magruder asked about the best way to measure performance and if there are successful interventions out there. Mr. Marquez believes success is based on opinion. Mr. Thom added that if you save one life, that is a success. Ms. Kerrigan mentioned that one tool programs are using is a behavioral health kiosk in waiting rooms. This has shown to be efficient and non-intimidating. Ms. Dominica Valencia said they have that at her clinic and patients were offended by the questions. Her clinic had to educate

patients, and they still do not know if the patients are being truthful with their responses. Ms. Kerrigan asked her if her clinic would still have the kiosk if they could do it over again. Ms. Valencia said yes, because it is important to ask these questions.

Mr. Galleto asked who the resolutions should come from. Ms. Kerrigan said the tribes carry more weight, but Mr. Marquez said the boards can complete them also. Mr. Marquez will email the resolution with additional documents.

IHS Budget Formulation Workgroup (BFWG): Representatives: Mr. Stacy Dixon (absent) and Mr. Dennis Heffington (absent)

All CATAC members were provided a letter, dated December 19, 2013, from Dr. Roubideaux. On February 12-15, Stacy Dixon, Dennis Huffington (alternate), and Beverly Miller went to Washington D.C. for budget formulation. They will provide an update at the next tribal leaders meeting.

IHS Contract Health Services Workgroup (CHS): Tribal Representatives: Mr. Johnny Hernandez and Mr. Chris Devers; Technical Representatives: Mr. Molin Malicay and Mr. Jim Crouch (absent)

Mr. Malicay said the workgroup is focusing on the funding formula and how to improve it to get more money. Those who benefit from the current formula do not want to change it and vice versa. The formula currently looks at active users, medical pricing (in different Areas), and proximity to hospital (yes or no question). The group, however, noted that not all hospitals have all services. They are leaning towards changing the last factor of the formula. They are also considering adding unmet need as the fourth element in the formula. They recommended that the group meet again and tweak the formula in this way. Mr. Masten asked how changing the formula in this way would affect California, and Mr. Malicay noted that California will benefit the most by not changing the formula. Adding unmet need as the fourth factor would benefit California.

The workgroup is also seeking training for CHS staff and tribal members. Currently, everyone interprets the manual differently. Plus, the manual has been revised and will be released later this year.

Mr. Malicay announced that there are three new CHSDAs (Arizona, North Dakota, and South Dakota). The workgroup recommended they redistribute their funding locally.

Mr. Malicay and Mr. Frederick Rundlet confronted Dr. Roubideaux to discuss Medicare-like-rates. She assigned someone to work with them. Ultimately, all the tribes passed this and the GAO approved of this. The workgroup also recommended Medicare-like-rates, and it looks like this will be approved.

Mr. Malicay said they may not meet again since funding is limited.

Ms. Kerrigan asked if the CHEF fund is underutilized by programs, and Mr. Malicay said yes, it is underutilized in California. He said they learned some tricks about how to best achieve CHS funds. Oklahoma uses their funds well, but the California Area does not know how to utilize the funds well. Since there are no hospitals in the California Area, most costs meet the $19,000 threshold. The only solution is more education. Ms. Kerrigan said Ms. Johnson will do a presentation on CHEF at the next Program Directors Meeting. Mr. Malicay noted that there is also much turnover among program directors, so that makes it difficult as well.

Tribal Leaders Diabetes Committee (TLDC): Representatives: Ms. Rosemary Nelson and Ms. Dominica Valencia

Ms. Nelson said the most important issue is reauthorization of the SDPI. It was granted a one-year extension. She provided information about how the funding is distributed. She also noted that some are urging spending $1 million dollars for gardens, with only one in California. She does not think this is the appropriate course of action. She would rather focus efforts on collecting statistics so that Congress knows the facts. A booklet of statistics was finally printed thanks to the Choctaw Nation of Oklahoma.

Based on recent meetings, Mr. Montoya believes the work has been done to reauthorize the SDPI and many people supported it. Ms. Nelson added that the National Indian Health Board has been working hard on this.

Ms. Nelson provided all CATAC members with the strategic plan the committee created to ensure they stay in existence. The group will not be disbanded, despite all of the budget cuts.

Dr. Magruder suggested speaking with Council and State Territorial Epidemiologist (CSTE) if Ms. Nelson is focused on collecting data. They should be able to help navigate that data to the CDC. Dr. Magruder will send contact information to Ms. Nelson.

Ms. Nelson mentioned the interaction between historical trauma and diabetes. Dr. Magruder asked how to treat this now that we understand the problem. She said she does not know. Ms. Helen Maldonado said that one step is to revert to traditional ways. Ms. Valencia added that patients need to be able to discuss how they feel, but elders are resistant to this. Mr. Montoya said his program is combatting this with bio feedback and counseling, and Ms. Maldonado said UIHS is doing this also.

IHS Director's Advisory Workgroup on Tribal Consultation (DAWTC):
Representatives: Mr. Charlie Wright (absent) and Ms. Hayley Hutt (absent)

No update provided.

Tribal Self-Governance Advisory Committee (TSGAC): Representatives: Mr. Leonard Masten (absent) and Mr. Robert Smith (absent)

All CATAC members were provide the meeting minutes from the last meeting in June.

IHS Facilities Appropriation Advisory Board (FAAB): Representatives: Mr. Pete Masten

This committee has not met for over 2 years.

HHS Secretary's Tribal Advisory Committee (STAC): Representatives: Mr. Stacy Dixon (absent) and Ms. Elaine Fink (absent)

No update provided.

Emerging Issues:

Mr. Galleto mentioned CRIHB's proposal for the remaining 8-10 months of optional benefits. Ms. Kerrigan said there is no decision to be made. Within the Department of Health Care Services in California, Ms. Sam Wilburn sent a proposal through the department to CMS requesting consideration of another project (such as the state of Arizona's 1115 waiver). This would make tribal healthcare programs eligible. The issue is with non-Indians that come to a facility. Since healthcare programs are obligated to provide the same services, they are asking where the money will come from to serve those patients. CMS is considering this right now. There is nothing we can do about this. Mr. Galleto noted that they have had tribal consultations, and they are running out of time. Ms. Kerrigan said the tribal healthcare programs have wanted to set up a demonstration project similar to Arizona's, but the state has been resistant. Ms. Wilburn has finally put this forward. Mr. Galleto said by the time it gets approved, there will only be three months left. Mr. Montoya thinks this will be extended to 2021 because they would not go through all of this effort otherwise.

Dr. Magruder met an individual offering to do free research for Native Americans. The group agreed to have him talk to a small audience and see what he has to say. Ms. Kerrigan will work with Dr. Magruder on this.

The meeting adjourned shortly after 4:00pm.

Additional Tribal and program leaders, Indian Health Service staff, and guests in attendance during the February 27, 2013 CATAC meeting:

Name	
Mary Benedict	Primary Contract Support Costs representative
Dominica Valencia	Alternate Tribal Leaders Diabetes Committee representative
IHS/CAO staff	
Susan Ducore	Nurse Consultant/Immunization Coordinator
Toni Johnson	IT Specialist/CHS Coordinator/Business Office Specialist
Helen Maldonado	Diabetes Coordinator
Rachel Pulverman	Student Trainee (Public Health Analyst)
Rick Wermers	Director, Health Facilities Engineering, Office of Environmental Health and Engineering