8

INTERNAL RESTRUCTURING REFORMS

The June 2002 Interim RIW report addressed proposals to consolidate portions of the Indian health care system into HHS and how IHS reforms relate to the President's Management Agenda. Since June, the RIW has explored long range options for what the Indian health care system should look in 5-7 years.

Section 7 concludes with recommendations to guide the Indian health care system toward a new balance of treatment and rehabilitation services, disease prevention and wellness measures, and public health programs. Section 8 identifies internal reforms preparing the Indian health system to fit the new balance of health programs. The RIW considered four types of internal reforms:

8A: Administrative Support Reforms
8B: Facilities and Engineering Reforms
8C: System Infrastructure Investment
8D: Investment to Access Resources

8A: ADMINISTRATIVE SUPPORT REFORMS

IHS Administrative Workforce was Downsized

The IHS began serious internal reorganization in the mid-1990s that shifted resources and staff out of administrative roles and into front line health care roles. The workforce in IHS frontline service units has increased by 1,354 FTE (see charts in Section 4) since 1995. While specific FTE counts for the tribal service units are unavailable, reports indicate the tribal workforce also increased.

During this same period, the IHS administrative workforce was reduced by more than 2,000 FTE. The 2002 IHS administrative workforce is less than half of that of 1994. Reductions in the IHS administrative workforce were in response to several factors:

- Restructuring initiated by the 1995 Indian Health Design Team,
- transfer of IHS programs and resources to Tribes,
- administrative budget cuts directed by the Congress, and
- un-funded inflation and cost increases.

While restructuring, budget cuts, and inflation have prompted workforce reductions in all 12 Area Offices and headquarters, the extent of transfers to Tribes is not uniform among Areas. Downsizing to transfer resources to Tribes has been extensive in some Areas and less extensive in other Areas in which Tribes elected to retain the IHS to operate the health care system.

Request for Assessment and Restructuring Options

Following release of the Interim RIW report in June 2002, the RIW formally requested that IHS assess the strengths and weaknesses of administrative support for front line health programs. The RIW asked the IHS to recommend reforms to improve performance and prepare for changes expected during the next 5 years. The IHS assessed and prepared options to restructure the following administrative support categories:

- Human Resources and Personnel Support Functions
- Financial Management, Accounting, Budgeting Functions
- Contracting, Procurement, Acquisition Support Functions
- Records Management Functions
- Supply Management Functions
- Property Management Functions

The combined federal workforce in these administrative functions is approximately 650 FTE with annual costs estimated at approximately $40 million. Data on the workforce and costs of these administrative categories for tribal health contracts and compacts are not available. Details of the RIW request are posted on the RIW website and may be downloaded at www.ihs.gov/NonMedicalPrograms/IHDT2/.

Performance and Support is Inconsistent

The IHS administrative workforce is less than half of pre-1995 levels. However, neither the administrative organizational structure nor its operational work practices have fully adapted to the reality of significantly less resources. Moreover, the administrative support system still must prepare for new and different support needs in the front line health programs. Consequently, a number of performance issues were cited for the RIW:

- Quality and level of support services to front line programs is inconsistent
- Delays in obtaining critical support services, .e.g., personnel actions, vacancy announcements, recruiting of needed health care professionals
- There are wide variations in staffing patterns among Areas which lead to inconsistent servicing ratios and uneven levels of support
- A single vacancy or absent employee can create bottlenecks and breakdowns in support services on which front line programs depend
- Collateral duties can dilute service quality
- Due to previous downsizing, fewer specialists with extensive experience are available
- Erosion of experience has forced reliance on junior personnel with limited experience
- Inconsistent standards and uneven application of national IHS policies, e.g., items approved in some Areas are denied in others
- Replicating management staffing patterns across multiple Areas is less cost-efficient
- Downsizing has made compliance with some Federal regulations more difficult
- Coordination among similar staff across Areas is insufficient or missing

Administrative Realignment Options

The RIW considered four ways of realigning IHS administrative functions to address declining resources, inconsistent performance stemming from fragmented operations, and evolving needs of frontline health care programs:

- Central Shared Services
- Regional Shared Services
- Share Services With Another Agency
- Purchase Services Contractually

Feasibility, estimated efficiencies, advantages, disadvantages and transition issues for each realignment option were examined. Most significantly, the RIW wanted to see if the realignment would produce any savings that could be redirected to expand health care services to Indian people. Specifically, the RIW set the following objective:

> "*An objective of the restructuring options is to reduce by 10-20% the total resources devoted to the administrative functions at headquarters, Areas, and Service Units, with all savings being redirected to health care delivery.*"

Complete details and realignment options are posted on the RIW website and may be downloaded from www.ihs.gov/NonMedicalPrograms/IHDT2/.

Regional Support Model Offers the Most Benefits

After weighing the advantages and disadvantages of the realignment options, a consensus gradually emerged for the following conclusions and recommendations:

8.1 Realignment will improve consistency, quality, and timeliness of administrative support to front line health programs.

Timeliness and quality of administrative support services will erode further unless IHS's organizational structure and operational work processes are transformed to address declining resources and changing needs. The changes are not necessary because of the President's Management Agenda or the "One-HHS" restructuring. The changes are needed to improve performance and to adapt to changes anticipated during the next 5 years.

8.2 A regional configuration offers the best combination of potential savings, improved support service, and lower transition costs.

A regional approach will increase efficiency, lower costs in the long run, attract higher skilled staff and expand expertise, provide greater depth, backup, and coverage in a smaller workforce, and provide more consistent application of standards and policy.

8.3 No IHS Area Office will close.

Area offices will continue providing technical assistance to front line health care programs. Tribes value Area Offices for access to IHS leaders, for familiar working relationships, and for expertise on local health issues. While the mix of components at each Area office may vary overtime, all front line health care programs will have access to the full array of administrative support services from the combination of Area Office and regional center.

8.4 It is not feasible or appropriate to regionalize all administrative functions.

Realigning administrative functions which require specialized local expertise and are based on close working relationships with customers would be counter productive. For instance, specialized working relationships needed to administer tribal self-determination contracts and compacts, employee relations, and budgeting are examples of functions to retain at Area Offices in most cases. Commonplace administrative functions (e.g., commercial type functions) which are best carried out in an efficient standardized fashion are good candidates for regionalization. Examples of functions to regionalize include processing of personnel actions and paperwork, human resources record keeping and retrieval, reporting and statistics, travel, payroll, claims processing, commercial acquisition functions, auditing, and accounting.

8.5 Combined savings of approximately 100-150 FTE and approximately $5 million – $7.5 million can be realized by realigning some administrative functions into regional teams.

The regional approach offers a balance of potential savings, consistency and quality of services while also limiting the number staff that must be relocated. Estimates of savings are being independently examined by the technical staff from the IHS Business Plan Workgroup.

8.6 Direct all savings from regionalization (estimated at 100-150 FTE and $5-$7.5 million) into health care services for Indian people.

One way to visualize the savings is to imagine that 150 administrative staff will be transformed into 150 nurses. While organizational change is universally acknowledged as difficult, the IHS and Indian country must determine whether this trade-off is beneficial and worthwhile.

8.7 Preserve and track every Tribe's "shares" of realigned FTE and resources.

The IHS must track tribal shares regardless of the form the organizational structure takes. In practical terms, this means a tribe's shares will remain preserved and unchanged whether an administrative function is supplied by an Area Office or from a regional center. The resources are linked with each tribe and available for transfer to the tribe when it elects to contract or compact with the IHS.

8.8 Honor existing commitments that obligate Area Offices or headquarters to provide support services in a fashion specified in a binding agreement.

Any agreements that bind IHS to prior arrangements for providing administrative support will remain in effect through the duration of the agreement unless renegotiated.

Phased Transition Contingent on Results

All transitions are difficult. Transition of IHS administrative support functions to a regional model will involve technical difficulties and cost several million dollars which will delay realization of savings for several years. The RIW proposes a transition plan to avoid abrupt and disruptive conversions. The plan will minimize transition costs by lessening immediate need to relocate IHS staff and may realize earlier savings to enhance patient care services.

8.9 Regionalize appropriate administrative functions in a phased incremental fashion designed to avoid disruptions, develop and test new operational methods, and minimize conversion costs and employee relocations.

Organizational transitions are easier if voluntary. The odds of a successful transition are enhanced if consideration is given to testing solutions that work in real world conditions.

8.10 Phase-One: In-Place Regionalization: Begin regionalizing administrative organizational structures, span of support, and operational practices to create regional support teams "In-Place."

The first phase involves consolidation of delegations of authority, supervisory channels, and work processes into regional teams spanning 2-4 Areas. Area Office staff would not be relocated immediately. Some workforce reductions thru reassignments, retirement, early outs may be appropriate. Work would be reengineered with communication linkages, data bases, email, electronic file management, and internet customer support portals. With the right tools and training, it will not matter to the customer in a front line program whether help is located across the hall or across the U.S. This approach avoids abrupt disruptions, minimizes transition costs, tests regional support tools, and provides built-in incentive for IHS staff to make the transition successful to avoid geographic relocation. Realignment to in-place regional support teams could achieve performance and savings goals without requiring most staff to geographically relocate. However, if improvements are not realized, move to Phase-Two.

8.11 Phase-Two: Regionalization With Geographic Co-Location of Staff: After a period to develop and implement new regional support teams, and if initial results from phase-one are unsatisfactory, relocate appropriate administrative staff into 3 regional support centers.

The RIW suggests 3 regional centers as a working goal. Selection of appropriate locations for regional support centers will depend on balancing a number of criteria such as costs, transportation and travel linkages, proximity to a large and skilled American Indian and Alaska Native workforce, proximity to educational institutions, and balancing regional access and customer workload. An analysis of these factors is premature at this time, but must be undertaken before advancing to Phase-Two regionalization.

The following graphical depictions may assist visualizing RIW ideas for transitioning the existing fragmented administrative configuration into regional support teams.

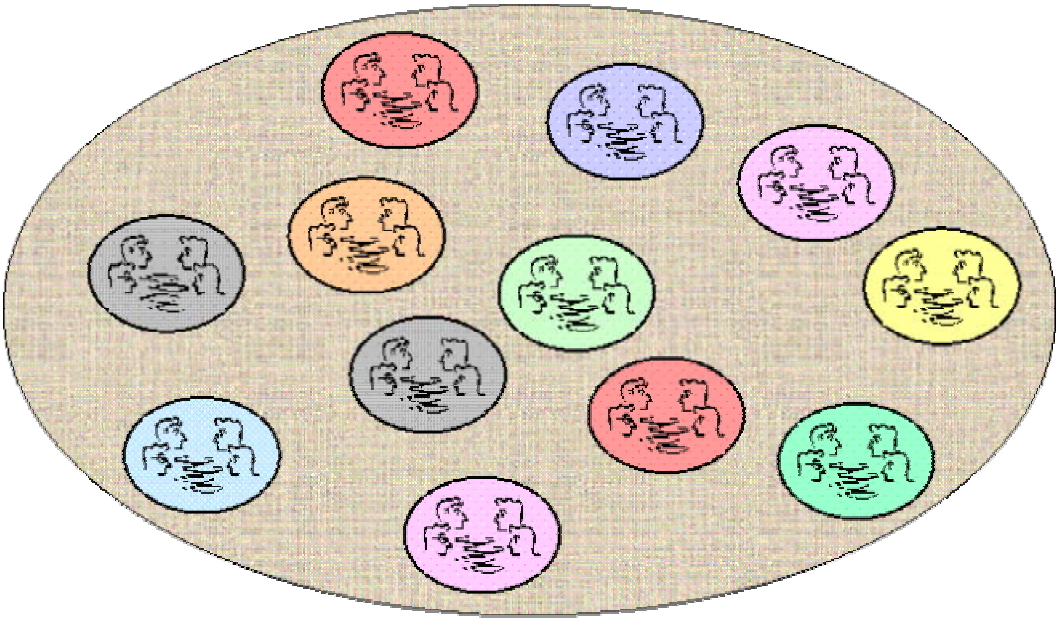

Figure 8.1, **Existing Configuration**
Area Offices are separate and unlinked with little sharing and backup capacity.

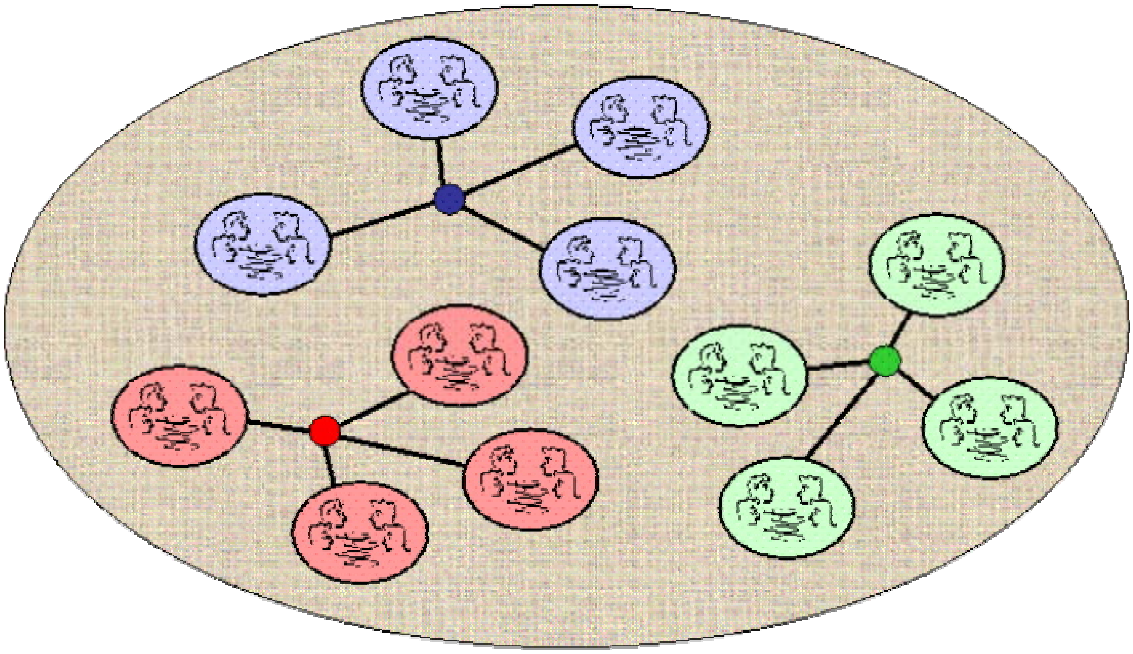

Figure 8.2, **Phase 1: "In-Place" Regional Support Teams**
Regional teams are configured "in-place" without significant staff relocation. Team responsibilities are extended to support I/T/Us in 3-4 Areas. Linkage, coordination, and backup capacity are provided.

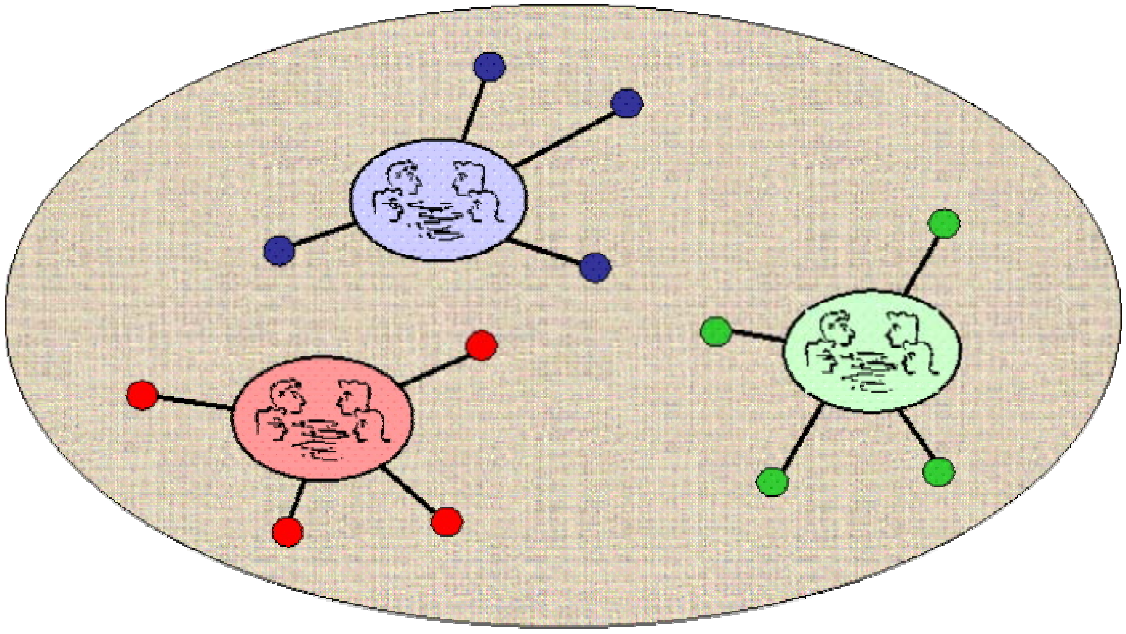

Figure 8.3, **Phase 2: Full Regionalization**
In this model, regional teams are relocated together in 3 locations. Teams support I/T/Us in 3-4 Areas. Coordination, cross-training, and efficiencies are easier to obtain than with in-place teams.

8B: FACILITIES AND ENGINEERING REFORMS

Tribal leaders are concerned with both the long period to become eligible for a new health care facility and with the lengthy period for planning, design, and construction phases, once approved for a facility. The RIW formally requested that IHS assess the strengths and weaknesses of IHS facilities and engineering programs, recommend reforms to improve performance, and prepare for changes expected during the next 5 years. The IHS prepared options for the following categories:

- Patient load benchmarks for planning facilities and programs
- Facility Construction Priority System Methodology
- Potential consolidation of engineering services sites
- Reforms to streamline facility planning, design, and construction

Patient Load Benchmarks

The IHS uses two sophisticated methodologies to plan for health care delivery programs. In the first step, the Resource Requirements Methodology (RRM) forecasts patient workloads and identifies appropriate services and staffing patterns. In the second step, the Health Systems Planning (HSP) methodology determines the appropriate facility space and design specifications. Both systems consider professional standards of care and industry standard thresholds and benchmarks to ensure safe high quality services and cost effectiveness. A detailed assessment of the planning benchmarks can be downloaded from the RIW webpage at www.ihs.gov/NonMedicalPrograms/IHDT2/.

8.12 The RIW endorses IHS patient workload benchmarks for determining the size and type of facility based on patient workload and population.

The IHS planning methodologies appear to be based on a sound rational basis and data. For instance, an older hospital is considered for replacement only if the forecast average daily patient load (ADPL) exceeds 15 except in cases of extreme isolation and distance to alternative hospitals. In-patient loads of less than 15 ADPL are neither cost effective nor sound for assuring high quality patient care and safety.

8.13 When applying patient workload benchmarks to plan new or replacement facilities, consider community input as an additional factor and maintain some planning flexibility consistent with assuring a safe and cost effective facility.

RIW members point out that no single standard is sufficient to address the wide array of circumstances found in Indian country. Some flexibility is necessary for unique circumstances.

Facility Construction Priority System

The IHS facility construction priority system ranks health care facility construction projects based on age, capacity, condition, and isolation. The ranking system was created in response to Congressional wishes to assure that federal funding for IHS health care facilities addressed the greatest needs in Indian Country. Congress's intent was to avoid a political "pork-barrel" process that arbitrarily favored jurisdictions served by powerful members of Congress.

There are currently 24 projects on the priority system list that was created in 1992. There are many more potential projects not on the list. IHS estimates that construction projects now on the list will require $900 million to complete. If annual facility construction funding averages $90 million, it will take 10 years to clear the list. Given the age and poor condition of many health care facilities in Indian Country, the long delays to obtain funding are extremely frustrating to tribal leaders. Moreover, because projects added to the list in 1992 have not cleared, a decade of cumulative growth in population, workload, and continuing facility deterioration is not reflected in the existing priority list. At the current pace of funding, another decade of cumulative growth in demand and deterioration of capacity will be ignored before the priorities are revised.

8.14 The RIW endorses the Facilities Appropriation Advisory Board (FAAB—a joint IHS/Tribal facilities construction workgroup) process for modifying the IHS facility construction priority system including necessary tribal consultation before adopting revisions to the priority system.

The FAAB workgroup has considered a range of issues, including provisions for small populations and proposes these modifications to the facilities priority system criteria:

40% -- Facility deficiency (capacity, age, condition)
15% -- Isolation and documented barriers
20% -- Health Indicators
10% -- Innovation
15% -- Type of Facility (station, ambulatory center, hospital, medical center)

8.15 The most significant obstacle in addressing facility deficiencies is the lack of resources for construction.

Revising the priority system itself will not provide Tribes with significant additional resources for facility construction, but may better reflect cumulative change in conditions since 1992.

Potential Realignment of Engineering Services

The RIW considered four ways of realigning IHS engineering services functions:

- Consolidate engineering services offices now in Dallas and Seattle
- Disperse Dallas and Seattle functions to Area Offices and headquarters
- Purchase engineering services commercially
- Assume leadership responsibilities for some HHS facilities functions

Complete details of assessments and realignment options are posted on the RIW website and may be downloaded from www.ihs.gov/NonMedicalPrograms/IHDT2/.

8.16 The RIW does not recommend further consolidation or dispersal at this time of engineering functions now located in Dallas and Seattle.

Members of the RIW request further study of this issue in view of the HHS proposal to consolidate HHS facilities programs in FY 2004. See Section 5 for concerns about consolidating IHS facilities and engineering programs within HHS. Furthermore, structural change may be unnecessary if measures to streamline work are successful.

8.17 The RIW recommends further study of whether Indian Country will benefit if the IHS assumes a "leadership" role for some HHS facility and engineering functions.

This concept has possible benefits from supporting the Secretary's "One-HHS" initiative, taking advantage of IHS facilities and engineering program strengths, and possible synergies and resources from working with other agencies. However, support for this concept is contingent on:

-- verifying that a new HHS role and linkage will not degrade IHS facility and engineering services, and
-- that other HHS agencies reimburse the IHS for the costs of services and support.

Streamline Planning, Design, and Construction

Construction of a new or replacement health care facility begins with identification of need (workload and population forecasts) and culminates with the completion of a new building. The process in between these two points is long, involved, and includes numerous players from the service unit, Tribes, Area Office, several Headquarters offices, and engineering services offices. This process involves a lot of people. It is good to involve all stakeholders, but this takes a lot of time. IHS identified four major items that slow down the planning and design process:

- Involvement of numerous stakeholders in planning and design
- Extensive waits for Congress to appropriate construction funding
- Insufficient planning expertise in the Area Offices (facility planning is infrequently undertaken in Areas and getting staff up to speed takes time)
- Local IHS staff and Tribes often have unrealistic expectations for the types of services that can be provided cost effectively and safely.

8.18 The RIW endorses no-cost measures to streamline planning, design, and construction as proposed by the IHS.

Complete details and proposals to streamline planning and design work are posted on the RIW website and may be downloaded at www.ihs.gov/nonmedicalprograms/IHDT2. While initiatives that increase costs require further study and justification, examples of no-cost streamlining measures the RIW endorses are:

- Centralize planning and for consistency and responsiveness
- Complete planning documents prior to appropriations
- Minimize phased funding except on very large projects
- Timely review of design schematics
- Minimize re-bid delays by combining bid solicitation with preference to Indian bids
- Increase review thresholds to $5 million and random sample contracts for review
- Centralize and contract for equipment purchasing and installation
- Base warrants on qualifications, not numerical limits by office
- Float engineering and contracting resources to field locations based on workload

8C: SYSTEM INFRASTRUCTURE INVESTMENT

A New IHS Business Plan

The Business Plan Workgroup is examining a variety of emerging business practices to improve performance, economize on costs, maximize collections and render support services to front-line health providers. The Business Plan Workgroup, 25 individuals who are Tribal Leaders, IHS officials, and

representatives of urban Indian health programs and national Indian health organizations, is charged to recommend a business plan for enhancing the level of patient care for American Indian and Alaska Native people over the next 5 years. The Business Plan Workgroup is updating and refining the IHS Business Plan and will submit the draft plan to American Indians and Alaska Natives to seek their input in the plan. In updating and refining the IHS Business Plan, the Business Plan Workgroup will explore how the Indian health care system can improve its business practices to address current and emerging issues over the next five years.

8.19 Adopt and implement a new IHS business Plan when delivered by the Business Plan Workgroup.

Enhanced Bio-terrorism Surveillance and Response

The Indian health care system must detect emerging health problems earlier so that resources and programs can be targeted effectively. Like all Americans, American Indians and Alaska Natives have new concerns about the potentially devastating effects of bio-terrorism and accelerating concerns about communicable diseases that could re-emerge with increasing resistance to antibiotics. American Indian and Alaska Native history includes devastation of whole Tribal populations by communicable diseases. Indian Country is understandably concerned about bio-terrorism and the re-emergence of communicable diseases. The RIW supports a coordinated approach to epidemiological surveillance and response for Indian Country in the following areas:

- opportunities to participate in bio-terrorism programs and resources;
- participation in the Health Alert Network newly established as part of homeland security measures;
- ways to coordinate with organizations such as VA, CDC and State health departments;
- concentrated tracking and attention on health issues and diseases of the American Indian and Alaska Native populations; and
- disease surveillance and response tailored to the unique environmental and cultural factors of Tribal communities.

8.20 Develop a coordinated approach to bio-terrorism that participates with and shares bio-terrorism preparedness resources from other Federal and State agencies.

Investment in information technology

The RIW reviewed a five-year plan to invest in information technology (IT) and to connect all local IHS, Tribal, and urban Indian health sites through an Indian Health Network. More importantly, the RIW envisions communications technology linking all Indian hospitals and health centers throughout the United States. A modernized nationwide network offers a way to integrate operations, and to access support services and assistance, and share capacities from any site in the United States. Such capacity is essential to full implementation of the regional support team model presented earlier. The historic constraints on progress resulting from geographic remoteness and the inefficiencies of dispersed small-scale operations would diminish as sites work together to increase buying power and lower costs. The emerging telemedicine and distance learning technologies are ideal for health care sites located in remote areas that often experience harsh weather conditions. The possibility of leveraging marketplace clout through the collaboration of hundreds of sites while maintaining local flexibility and independence is worth further exploration.

The RIW reviewed and supports the Information Technology Vision and Actions for 2007 and considers it a companion document to this report.

8.21 Triple investment in information and communications technology over the next five years.
8.22 Create an interconnected Indian Health Network for hundreds of widely dispersed health care sites to more effectively collaborate and pool information, expertise, and resources.
8.23 Standardize data systems and protocols to assure all locations work together using common standards for communication and interoperability.
8.24 Specify hardware and software standards to assure all sites maintain compatibility while preserving flexibility to select differing hardware.
8.25 Utilize compatible information systems developed in the larger, better funded federal health care systems such as Department of Defense and Department of Veterans Affairs.
8.26 Develop a national data warehouse where consolidated data is retrievable from all sites throughout the Indian Health Network.

Environmental Safeguards Technical Assistance

The RIW has identified a need for additional technical support from IHS, the Environmental Protection Agency (EPA) and others for environmental health, particularly with respect to safeguarding Indian communities against nuclear and hazardous waste, assuring water quality, and related functions.

The IHS environmental health programs works with partners to provide training, monitor environmental conditions, investigate problems, develop sound public health policies, implement prevention measures, and promote safe and healthy environments for all Indian people. But environmental health issues are sometimes confused with environmental protection issues. The IHS has proposed a modest expansion of technical assistance capacity to address environmental hazards while maintaining its "advocacy" posture and leaving environmental regulation and verification roles to EPA and other agencies created for that purpose. Complete details of assessments and proposals for providing additional technical assistance are posted on the RIW website and may be downloaded from www.ihs.gov/NonMedicalPrograms/IHDT2/.

8.27 Expand technical assistance capability within the IHS environmental health program by creating Environmental Safeguards Technical Assistance Teams.

This modest expansion creates mobile teams formed for short-term assignments and composed of staff from existing IHS and tribal programs. The teams would assemble the necessary expertise to provide TA on air, water, soil contamination and remediation. Additional costs are limited to per diem, travel, and backup support where necessary.

User Definition

Because of limited capacity and varying availability of services, Indian people often visit multiple IHS, Tribal, and Urban Indian facilities to obtain needed health care. This pattern of use creates a financial burden at every facility visited by the patient. However, for funding purposes, the IHS currently assigns each person to the health care facility nearest their place of residence. This way of defining a user does not account for costs in other facilities visited by the patient. Although the most fundamental problem is severe under funding for the Indian health system as a whole, the RIW has concluded that this issue further worsens financial burdens in some IHS and tribal facilities.

8.28 Reconsider the user count definition employed in IHS resource allocation formulas to account for costs in all facilities used by the patient.

RIW members remained concerned about financial consequences of the IHS user definition. IHS should appoint a joint IHS/tribal workgroup to fully explore legal, financial, and technical ramifications of revising the user count definition for resource allocation formula.

8D: INVESTMENT TO ACCESS ADDITIONAL RESOURCES

Resources for Indian health care likely will be insufficient during the next 5 years. Additional resources are needed to cope with growing Indian health care needs, assure access to health care services on a par with other Americans, and eliminate Indian health problems.

Given the magnitude of resource needs, it is frustrating to Tribal leaders that other Federal agencies often see Indian health issues solely as an "IHS responsibility." Moreover, when resources from other agencies are available to Tribes and Urban Indian programs, resources are often not accessed because of poor information or breakdowns in the application process. For instance, a recent study identified 45 grants and assistance programs within HHS for which Tribes are eligible but are not accessing.

The RIW has identified a 2-part strategy for improving access to resources from other federal agencies. The first part focuses on expanding cross-agency linkages, removing eligibility barriers, and gaining commitments from other HHS agencies for additional resources for Indian health.

8.29 The IHS executive leadership will work to persuade the Secretary to make Indian Country a very high priority for the Presidential priority of eliminating health disparities.
8.30 The IHS will work with sister HHS agencies to identify their role and responsibilities to eliminate health disparities of Indian people and seek concrete commitments to fund programs for eliminating those disparities.
8.31 Charge the Interdepartmental Council for Native American Affairs with identifying former IHS and tribal employees in DHHS regional offices to be included in tribal issues workgroups and to advocate for Indian issues.
8.32 Charge the Interdepartmental Council for Native American Affairs with drafting and recommending to the Secretary an element to include in all HHS agency director's annual performance contracts, specifying target resource amounts to be dedicated for use in Indian country.
8.33 Assign senior IHS employees to other HHS agencies to pursue policy support and funding for Indian needs.
8.34 Pursue legislation to remove barriers (Title XIX) that prevent Tribes from contracting directly.

These ideas have few costs, except for 8.32 which will include salaries and benefits for up to 5 IHS FTE assigned to other agencies.

The second part of the strategy focuses on investing in technical assistance capacity so Tribes, IHS, and Urban Indian health programs can realize all resources for which they are eligible. Untimely information about available resources and insufficient capacity to successfully apply is limiting funds that would otherwise flow to Indian Country. The RIW heard from several tribal programs and urban projects about programs built on successfully accessing multiple funding sources. Their message: "invest in expertise to write proposals and apply successfully."

8.35 Establish a Center for Tribal Access to Resources chartered to assist Tribes to realize all resources for which they are eligible.

The Center for Tribal Access to Resources would be funded by $1.5 million seed money from IHS. Establish the center through a tribal organization or Indian organization rather than as part of the IHS. As the Center develops its network and capacities, it can obtain additional funding through foundations and grants from organizations that support Native American issues. The center would assist Tribes, IHS, and Urban Indian Programs access and realize resources in three ways:

Information Clearing House Role

- Provide an internet portal for "one-stop shopping" of public funding available to Tribes
- Maintain an up-to-date, on-line data base of solicitations (RFP/RFP/PA) geared to tribal access
- Distribute information about new funding opportunities to Indian Country through newsletters, email, fax, and the internet
- Assemble from differing agencies all materials, forms, applications for accessibility in one place
- Provide tip sheets, kits, model applications, and success stories from which Tribes can further develop local expertise in applying for resources
- Identify useful "collaborators/partners" (Indian organizations, universities, etc.) with which Tribes can partner for technical expertise often required in solicitations

Technical Assistance Role

- Maintain a "Help Desk" that Tribes may call
- Provide technical assistance on applications and in preparing proposals
- Offer elective "quality assurance" review of tribal applications and provide feedback and pointers for improvements
- Provide workshops and seminars on all facets of identifying, accessing, and getting funding

Outreach / Partnership Role

- Match Tribes with new resource opportunities based on their unique characteristics and needs
- Actively outreach to Tribes, Indian Organizations, Urban Projects to promote ways to take advantage of emerging resource opportunities
- Actively outreach to federal agencies and other sources to advocate for tribal eligibility and inclusion in funding distributions
- Offer "Best Practices" workshops designed to bring together successful programs, "network", and share experiences and best practices
- Identify successful tribal program "mentors" that can assist other Tribes

RIW Report Conclusion

The RIW provides this report to the IHS with an understanding that its recommendations will be made available for consultation with Indian Country. The next big step is for the IHS to consult with tribes, Indian health organizations, and Indian people and consider all views and suggestions before adopting any recommendations that affect the Indian health care system.

The RIW considered complex issues and difficult challenges. We have worked hard to fulfill our charge to "recommend design changes to IHS that will advance the health of all Indian people by considering representative views from throughout Indian Country." Given the time available to us, we believe we have come up with a realistic guide for change. Even though our part is nearly done, the process is far from over. Consultation undoubtedly will produce even more ideas for consideration and much work to develop detailed transition plans remains.