



# Priorities

Intentionally Blank



## Overview

Resources for capital and operational expenditures are consistently limited. Clear priorities are necessary for the development of a reasonable, supportable and attainable master plan. Clear priorities are arrived at through the consistent application of mutually agreed upon criteria reflecting the concerns and support of all interested parties whom the master plan will impact. For the Portland Area, these priorities will have to be developed based on the Health Services Master Plan Work Group's developed objective criteria.

## First Meetings – (Round One: February 2003, Round Two: October 2004)

In order to put the project in its present context, the Work Group was asked to identify the strengths and weaknesses of the Portland Area as it exists today. The following items were identified.

### Strengths

#### Round One Responses

- Good Working Relationship between IHS and Tribe
- Tribes Communicate and try to collaborate
- Tribal Support
- Existing Staff
- Supportive Leadership
- Dedicated Health Care Providers
- Health Facilities Program/Staff
- Progress for Improvement
- Willingness to be progressive – try new approaches to old problems, new issues
- RPMS system – moving towards electronic patient chart – ability to retrieve data
- CHS Options
- Opportunity exists to share resources between service units and tribes
- Ability to adapt and provide services based on community needs
- A modern facility / well maintained facility
- Good method of data collection
- Diabetes program
- CHRs & transport to distant care
- Excellent CQI Process
- Strong infrastructure
- Access to 24 hour health care / 1 Hour PC access
- Provider Dedication in Rural area
- Ability to provide health care to remote sites by direct care or CHS
- Community and Wellness Based prevention
- Outreach
- Nearby Specialty Medical Care
- Central Location/Able to Expand

- IHS/Tribal Tenure
- Service not \$ focused

#### Round Two Responses

- Third party billing
- Third party billing
- Third party billing (70-75% billed)
- Superior billing practices and results
- Generating excellent third party billing dollars to bolster CHS program and pay for Wellness Center
- Location
- Aesthetic location
- Collaborative efforts with small tribes for services
- Facility
- New Wellness Center (one stop shop) to open within next 2 months
- Staff
- Dedicated staff
- Technologically proficient staff
- Tribes support each other
- Tribe wants accredited clinic
- Contracting for Patient CDP/MHP
- Commitment of Kalispel Tribal leadership to meet basic needs of tribal community
- We have good grant writers to cover monies the government keeps cutting when they continually break their treaty agreements
- Admin/HB strong
- "Medicare like rates" to go into effect for NA/AN by year end input and output
- Providing services for all residents of our very rural community



- Full compliment of providers (PCPs) under 5 year contracts

### **Weaknesses**

#### **Round One Responses**

- Lack of dental services
- Service delivery gaps within Service Area
- Dental services
- Family Practitioner FTE
- Local leadership
- Leadership
- Area support
- Short on support staff at area level
- Outdated policies and practices
- Communication
- Tribal support
- Facility deficiencies at Cusick
- Have to purchase hospital services from local monopoly hospital
- Lack of start-up for new tribes
- Cost of pharmaceuticals
- Pharmacy services
- Native CDP/MHP not enough
- County (CHSDA) wide access to Behavioral
- Health Services problematic RSN and reimbursement issues
- Need to improve Mental Health/Behavioral Health program
- Lack of A/CD services (inpatient) (3 Adult, 2 Youth Programs, 1 Youth transitional)
- Had to fund Wellness Center Tribally without IHS dollars
- Priority 1 CHS
- Appropriation
- Funding
- Funding levels inadequate
- Demand for care exceeds ability to provide care / backlog of services
- Lack of Space
- Resource allocation based on inaccurate patient population data
- Inadequate programs/limiting services
- Remote Isolated areas / Access to Care (Hospital 2 hours away)
- Infrastructure (water/sewer)
- Coordination of IHS service providers and tribal programs
- Recruitment & Retention of professional staff
- Aging facilities/equipment
- Reliable Data from all sites
- Assessing community based need
- Integrate internal & external environment
- Lack of common vision / equity
- Specialty Care coordination
- Fragmented conflicting I/T/U priorities
- Little pooling of assets for larger good.
- Different rules for health care \$ for populations depending on where they live
- Clinic hours unresponsive to patient needs
- Continuing Education
- Time management in acquisition process
- Not innovative or proactive
- Inability to negotiate rates with local non IHS providers
- Distribution of funds: should be divided as to area served not % across the board
- Unfamiliar with areas being served
- Too many \$ spent on Contract Care
- Insufficient equipment
- Ambulatory care facility underrepresented in national priority system

#### **Round Two Responses**

- Focus Health Care Money on fixing health problems, not on prevention of problems that would save \$s and 10-20 years down the road
- Urbans lack access to over worked tribe Service Units
- Not enough doctors and RNs for Community Progress
- EMS
- Clinic Dysfunction
- Imbalance in access to care
- Lack of comprehensive approach to optimizing returns from Direct PC and CHS resources for specialty and hospital care
- Too long wait for access to PC
- Lack of money (and \$ for ref to SC)
- Need better, comprehensive planning
- Lack of Staff



In addition to collecting the Work Group response at the Kickoff Meeting, each Service Area was asked to identify the strengths and weaknesses of their own Service Area. The following responses were collected directly from the questionnaires. Round One PSA are highlighted in yellow while Round Two's are highlighted with blue.

**2. What are your strengths in terms of serving your community (service area)?**

<p><b>Fort Hall</b></p>	<ul style="list-style-type: none"> <li>• Proximity to Pocatello &amp; Idaho Falls, good location</li> <li>• Stable, experienced staff with low turnover</li> <li>• Well maintained, clean facility</li> <li>• Accreditation with JCAHO and AAACH since 1985</li> <li>• Working jointly with IHS and THHS to provide services</li> <li>• Success in recruiting local staff</li> </ul> <p>Dedicated IHS and THHS professional and allied healthcare staff. Dedicated IHS and THHS administrative staff.</p> <ul style="list-style-type: none"> <li>• Qualified health professionals, Dedicated staff, State of the art equipment, Ability to provide services in spite of pending limitations, Development of programs i.e. diabetes audits, Low burnout rate of I.H.S. staff, Joint accreditation of I.H.S. and THHS, Modern I.H.S. facility for health care delivery, Community support, Equitable use of health resources SBHB CHAIRMAN</li> <li>• A strong working relationship with the I.H.S. Benefits Coordinator. The ability of this person to secure alternative resources for the payment of patient care. CHS MANAGER</li> <li>• CHR at full staff, have own building to house staff, have staff who speak Indian languages i.e. Shoshone &amp; Navajo, staff knows community well, and know resources (do refer whenever possible). CHR MANAGER</li> <li>• An excellent staff of five community health nurses, fitness coordinator, health educator, nutritionist, two nurse practitioners, and certified nurses aides. CHN MANAGER</li> <li>• Employ many community people, the department has close ties to community so therefore understands it well, staff truly cares about community and specialties outreach and services to match community. COMPUTER SYSTEMS ANALYST</li> <li>• Many staff are from the community and have remained with the program for many years. We have speakers of the native language. We are close to neighboring towns with additional services to clients. We are beginning to coordinate more closely with other Idaho Tribes to advocate with the state for the needs of our services population.-CFS MANAGER</li> </ul>
<p><b>Inchelium</b></p>	<ul style="list-style-type: none"> <li>• Beautiful area to live in if you're wired that way.</li> <li>• People who are brought in are very dedicated.</li> </ul>
<p><b>Neah Bay</b></p>	<ul style="list-style-type: none"> <li>• Quality personnel and programs</li> <li>• Located very near to most recipients of care</li> <li>• Many local (Makah) staff</li> <li>• Dedicated employees and volunteers</li> </ul>



	<ul style="list-style-type: none"> <li>• Pharmacy on site</li> <li>• Attempting to focus on local problems</li> <li>• Newly gained continuity of care</li> <li>• Good quality Primary Care</li> <li>• Short wait times to get an appointment – good access</li> <li>• Flexibility to allow walk-ins</li> <li>• 24 hour service, 7 days a week for urgent and emergent care – we have a contract with a phone triage program, Careline, out of Harborview Medical Center in Seattle for after hours care. Our providers are on call every night and on weekends if the RN feels the patient needs to be seen.</li> <li>• The staff knows patients in the community; many are family, friends and neighbors.</li> </ul>
<p><b>Nespelem</b></p>	<ul style="list-style-type: none"> <li>• Excellent care; good staff</li> </ul>
<p><b>Omak</b></p>	<ul style="list-style-type: none"> <li>• They have applied for a facility on a Joint Venture funding before and it was turned down (but more the form in which it was written, not for the lack of need. The need has been understood and documented)</li> </ul>
<p><b>Salem – Chemawa</b></p>	<ul style="list-style-type: none"> <li>• Central location</li> <li>• Proximity to Chemawa Indian School</li> <li>• Referral services near by.</li> <li>• Orthodontics program</li> <li>• CHSDA</li> <li>• Urban program</li> </ul>
<p><b>Toppenish</b></p>	<ul style="list-style-type: none"> <li>• The Service Unit has an ability to draw top talent because of our proximity to advanced hospital and clinic care; good public school systems; an outstanding community college; a four-year college offering degrees through Master’s levels; outdoor recreation. The facility was opened in 1990 and has been maintained with a high degree of care. The Yakama Nation’s leadership is very committed to patient care and supports the clinic directly in several health programs including physical therapy and diabetes. The Tribe manages several adjunct health programs through 638 contracting that augment clinic services.</li> <li>• The Service Unit has a strong, active Governing Board chaired by the Service Unit Director in which the Yakama Nation’s Health Director and Health, Employment, Welfare (HEW) committee actively participates.</li> <li>• The Clinic is large enough to offer comprehensive out-patient medical and dental services.</li> <li>• The Yakama Nation manages a number of health and health related programs under the tribe’s Department of Human Services. Through the relationship developed with Indian Health Services over many years, the tribe has assumed fiscal responsibility to contract for the P.L. 93-368, Indian Self-Determination programs; such as Contract Health Services, Alcoholism, Youth Treatment, Home Health, Nutrition, Diabetes, Maternal Child Health, Women Infant Children, and the White Swan Ambulance and White Swan Health Clinic. In addition to the P.L. 93-638 programs, the tribe has been successful in obtaining additional support with other health programs; such as, Catholic Family Counseling, Tobacco Prevention, Breast Cancer and Health Professional Recruitment funding.</li> <li>• In the tribe’s strategic plan, the strategic directions addressed by the health staff and leadership promoted the following: community education and</li> </ul>



	<p>empowerment, enhance program service, enhance recruitment into health professions, implement long term planning, enhance program networking, pursue and secure new funding services, focus on staff enhancement, propose strategies to protect cultural values, enhance health service, coordinating cultural community empowerment and creating new strategies in future planning.</p> <ul style="list-style-type: none"> <li>• The various health programs provide essential technical and professional support to the overall health of the Yakama Nation and its' service area. Qualified managers with staff who are primarily Yakama tribal members administer these programs. The health programs function under the oversight of the Yakama Tribal Council Health, Employment and Welfare Committee.</li> </ul>
<p><b>Warm Springs</b></p>	<ul style="list-style-type: none"> <li>• Highly professional, caring, and well trained staff.</li> <li>• Team concept of providing health care by Tribes/IHS employees.</li> <li>• Proactive staff in pursuing the latest and best techniques and technologies to better perform their jobs.</li> </ul>
<p><b>White Swan</b></p>	<ul style="list-style-type: none"> <li>• White Swan Health Clinic has a long-standing commitment to the community of White Swan. For 24 years the White Swan Health Clinic has been the only source of local health care for the people living and working in this isolated area. The White Swan Health Clinic staff has established a high level of trust with the community due to the low staff turn-over rate, and that the medical provider has cared for families in the area through multiple generations. The White Swan Health clinic is able to provide emergency health care with the help of the Ambulance staff that is located within the facility.</li> <li>• The White Swan and Toppenish Ambulance Service are available 24 hours a day seven days a week and are staffed with local community members who have worked for several years and have gained the trust of the community members. The Ambulance has been an active participant in local events such as community functions and school activities. The Ambulance Service is available to provide Emergency Services to all areas of the Reservation including the remote wilderness areas closed to the public. The Ambulance Service works closely with local state, federal, and private agencies during emergencies and natural disasters.</li> </ul>
<p><b>Puyallup</b></p>	<ul style="list-style-type: none"> <li>• Comprehensive community-based services accessible to outside agencies.</li> <li>• Available public transportation.</li> <li>• Great location for recruitment.</li> <li>• Desirable location</li> <li>• Strive for culturally appropriate services.</li> <li>• Traditional medicine. Both men and women healers. They bring in healers in from across the country, while 2 are local. Tribe covers expenses.</li> <li>• Regular staff training and education.</li> <li>• Low staff turnover.</li> <li>• Competitive wages and benefits package.</li> </ul>
<p><b>Lummi</b></p>	<ul style="list-style-type: none"> <li>• Provide comprehensive care</li> <li>• Specialty support</li> <li>• Good access (perhaps too much)</li> <li>• Full compliment of staff on site</li> <li>• Great fitness center</li> <li>• Great people – staff dedication/professionalism</li> <li>• Facility has been around and is known</li> </ul>



<b>Spokane (Wyncoop)</b>	<ul style="list-style-type: none"> <li>• Number of services we offer (our staff and specialty clinics)</li> <li>• Good staff – longevity/dedication</li> <li>• Primary Care Facility is newer and well laid out</li> </ul>
<b>Quileute</b>	<ul style="list-style-type: none"> <li>• Established</li> <li>• Gained respect of community</li> <li>• Good track record</li> <li>• Facility in pretty good condition</li> </ul>
<b>Siletz</b>	<ul style="list-style-type: none"> <li>• Clinic location in Siletz is central to many tribal members and services</li> <li>• Community works closely with the Clinic and A&amp;D in health and prevention endeavors</li> <li>• Area offices provide good coverage of our 11 counties</li> <li>• Blessed with excellent health department staff and tribal staff</li> <li>• Tribal government promotes continuing education for staff and tribal members</li> <li>• Diabetic program has close ties with medical, dental, optometry, and health education programs</li> <li>• Dental in same physical plant as medical offices</li> <li>• Dental prevention program outreach with Headstart</li> <li>• Information systems (computers) is state of art (except for A&amp;D)</li> <li>• Tribe has good reputation for services and follow through</li> <li>• Pharmacy provides good service to all natives – people travel long distances to come here. Pharmacist providing counseling, and working with Tobacco Cessation program.</li> <li>• Accredited AAAHC since 1999/A&amp;D state licensed</li> <li>• Nationally recognized Tobacco prevention program</li> <li>• A&amp;D is part of the health department (rather than Social Services) and prevention services are part. Close cooperation with Mental Health, A&amp;D and Medical. Able to coordinate on Hep C treatment.</li> <li>• Quick turn around RPMS, data entry, and electronic billing</li> <li>• Centralized medical records for all programs</li> <li>• Encourage student interns – ties with OHSU – research possibilities</li> </ul>
<b>Cow Creek</b>	<ul style="list-style-type: none"> <li>• Easy access to health care within CCH &amp; WC (no waiting)</li> <li>• Adequately staffed</li> </ul>
<b>Upper Skagit</b>	
<b>Cowlitz</b>	<ul style="list-style-type: none"> <li>• New</li> <li>• Lots of support from Health Board and Tribal members</li> <li>• Only Tribe in SW Washington             <ul style="list-style-type: none"> <li>◦ Centrally located in area with large numbers of Indians without service</li> </ul> </li> </ul>
<b>Burns</b>	<p>The Burns Paiute Tribe is the smallest tribe in Oregon with 324 tribal members. This allows tribal staff to get to know community members on a 1-1 basis. Health referrals are done quickly. Patients have quick access to health concerns.</p>
<b>Hoh</b>	



<p><b>Kalispel</b></p>	<ul style="list-style-type: none"> <li>• The Kalispel Tribe currently provides limited services in the areas of mental health and substance abuse. The Kalispel Tribe has been fortunate in being able to hire American Indians for its counseling roles. Its real strength has been the provision of culturally appropriate services.</li> <li>• The Kalispel Tribe has long had a vision for the development of a Medicine Wheel, or wellness model, for the provision of health and wellness services. There is unanimity within the Business Council on pursuing this model as the Tribe goes forward to develop a health and wellness center.</li> </ul>
<p><b>NW Shoshone</b></p>	<ul style="list-style-type: none"> <li>• Contract Health Service area is small and the Providers are near us</li> <li>• We have an excellent medical community that is very supportive of the tribe.</li> </ul>
<p><b>Snoqualmie</b></p>	
<p><b>Stillaguamish</b></p>	<ul style="list-style-type: none"> <li>• Facilities</li> <li>• Location of services</li> <li>• Committed staff</li> <li>• Tribal support for Social &amp; Health Service delivery</li> </ul>

Portland Area PSAs cited many positive aspects to their healthcare delivery systems. Among these are comprehensive care, quality of care, committed and quality staff, respect of community for services and staff, as well as support from health boards and tribal members. All participating PSAs cited strengths and are proud of many aspects of their service, facilities and staff.



**3. What are your weaknesses in terms of serving your community (service area)?**

<p><b>Fort Hall</b></p>	<ul style="list-style-type: none"> <li>• Facility too small to provide all services as desired. Most every department needs more space.</li> <li>• Funding and collections limited, inadequate. Affects training, personnel, services, travel &amp; equipment.</li> <li>• Limited funding for expensive, higher level services like prosthetics, crown/bridge. Limited time for such service due to lack of personnel and high need for emergency service by patients. (Dental)</li> <li>• Budget uncertainties</li> <li>• Accelerating health care costs</li> <li>• Staffing needs (especially a full time diabetes educator). *Currently an RN who spends part of her time. 15 positions are funded out of 3rd party billing. Concerned about that dropping. Most of these are Health Information Management, but it affects others as well.</li> <li>• Limited access to outlying districts, Funding limitations, Lack of tele-medicine (Broadband) health services, Limited funds for training, Limited federal assistance from I.H.S., Inadequate health professionals, Excess time spent waiting to see doctor. SBHB CHAIRMAN</li> <li>• Patient education. Facilities are not available for large meetings, events. CHS MANAGER</li> <li>• Need budget to meet appropriate rate of pay for current CHR's. Currently, CHR Generalists are paid at the lowest hourly rate for the amount patients served. The base budget is not enough to meet needs for CHR program.</li> <li>• Don't have the proper facility to promote healthy lifestyles for the community to come to nor do we have the staff needed to reach the large community. Need more specialists, more help in Diabetes education, prevention and services.</li> <li>• There are very limited mental health services in Idaho and we offer more than the local cities. Sometimes we identify needs and there are no services to help meet those legitimate needs. People still associate a lot of stigma with requesting mental health services and are reluctant to utilize the services. We are primarily based in the office. We have seldom remained "full staffed" for significant periods of time. In all our collaborative work we struggle to offer one stop shopping to clients we aren't there yet. -CFS MANAGER</li> </ul>
<p><b>Inchelium</b></p>	<ul style="list-style-type: none"> <li>• The tribal understanding of the administration of the health care system.</li> <li>• The entitlement process/mindset may be supporting significant no-show rate (around 30%)</li> <li>• A close knit community creates challenges for staff that are expected to live here and function professionally under communal expectations that often are difficult to unrealistic.</li> </ul>
<p><b>Neah Bay</b></p>	<ul style="list-style-type: none"> <li>• Quantity of personnel</li> <li>• Provider turnover, we cannot hire and retain physicians who are interested in local problems (turnover of 2 to 3 years) – lack of continuity of care</li> <li>• Lack of follow-up care</li> <li>• Limited CHS funds for Priority II care (i.e., Optometry, Dental, Physical Therapy)</li> <li>• No hospice care</li> <li>• No elder care</li> </ul>



	<ul style="list-style-type: none"> <li>• Many CHS providers will not accept Medicaid/Medicare and IHS patients</li> <li>• Too many resources devoted to after hour care (emergency services are provided, but Providers are emergency care providers)</li> <li>• Tribal programs are fragile and not coordinated</li> <li>• Not enough space</li> <li>• Budget constraints</li> <li>• Referral network – lack of rate quotes, distance to services</li> <li>• Lack of local follow-up services with referral patients</li> <li>• Inconsistent feedback and information from referral providers</li> <li>• Need to improve communication and networking with tribe and tribal health programs</li> <li>• No PHN to serve the community</li> <li>• Limited mental health options</li> <li>• Limited funding to add new services</li> <li>• No radio contact – for disasters, emergencies</li> <li>• Cell phone reception is often sporadic</li> <li>• Perception in community that health care is based on life and death need rather than preventative because of CHS funds</li> <li>• <i>Enrolling eligible members in Medicaid, Medicare, etc.</i></li> </ul>
<p><b>Nespelem</b></p>	<ul style="list-style-type: none"> <li>• Training needed for support staff (scheduling course coming up in March)</li> </ul>
<p><b>Omak</b></p>	<ul style="list-style-type: none"> <li>• The 25 mile rule means Colville is losing Contract Health Dollars – Omak's residents are going to other care. 48% of patients have 3rd party insurance that's not being taken advantage of.</li> </ul>
<p><b>Salem – Chemawa</b></p>	<ul style="list-style-type: none"> <li>• Inefficient, undersized facility</li> <li>• No CHS, except for Chemawa students</li> <li>• Shortage of providers</li> </ul>
<p><b>Toppenish</b></p>	<ul style="list-style-type: none"> <li>• We are seriously under funded. The clinic's budget was decided in the late 1980's and was based on a maximum population to be served of approximately 10,000 persons. Currently, the clinic has an enrollment of 22,538 patients. Patient visits last year exceeded 94,000.</li> <li>• The calculation formulas used by IHS for base budgets result in under funding for most of the IHS facilities. The Yakama Service Unit is seriously affected by this formula because it does not factor in the actual use of this facility. We need a minimum of 16 more exam rooms to accommodate patient needs; a minimum of 4 additional doctors; additional Clinic and Public Health nurses; at least three (3) more Mental Health counselors (Psychiatrically trained) plus a Psychiatrist; two (2) more Physical therapists; five (5) more custodial/maintenance staff; three (3) more Medical Records clerks; one (1) more medical technologist, and more space in addition to the exam rooms to accommodate the additional staff.</li> <li>• The Service Unit Dental Program is forced into inadequate space. The Dental Program as is, does not have the capacity to provide basic dental care to the present service population. In order to provide basic dental care to the present service population not considering growth, the Dental Program should be relocated to an independent structure that provides for twice the current resources.</li> <li>• The Service Units in general need a more responsive Acquisitions program. It is not uncommon to wait 4 to 6 months to acquire essential medical equipment,</li> </ul>



	<p>supplies. A recently implemented Acquisition policy prohibits Service Units from paying bills exceeding \$2500 or from acquiring equipment exceeding \$2500. The result is considerable additional work for the Service Units to get bills paid and to acquire essential equipment.</p> <ul style="list-style-type: none"> <li>• Headquarters or Department policies frequently do not consider the direct health care delivery system. Example: the Department (Department of Health and Human Services) decided several months ago that no cell phones or palm corders could be acquired and an immediate freeze was imposed. Our Service Unit has Public Health Nurses who travel in quite remote locations who need these commonly used electronic devices. Consequently, both our Doctors and PHN's were forced to use their own cell phones with out reimbursement.</li> <li>• Lack of adequate funding directly contributes to the inability to pay competitive, private sector salaries for medical and dental specialties. Example: Yakama Service Unit has a Pediatric dental officer because we were able to locate and train a general dentist who entered the Service Unit as a first year pediatric dentist. A nationwide shortage exists of Pharmacists and dentists so the private sector can prevail on salaries and or benefits.</li> <li>• As a result of the Yakama Nation Strategic Plan, a goal is to provide one-stop shop services. However, the various tribal health programs are located within several building located on or near the Yakama Nation Headquarters: the Indian Health Service facility, the health annex and in other locations apart from the primary health providers. Toward the goal of one-stop shop, the Yakama Nation has a need for a facility that houses all of the Department of Human Services programs to support this goal.</li> <li>• Through the strategic plan, health articulated a three-fold vision with the key elements as follows:             <ul style="list-style-type: none"> <li>○ Community Empowerment and Wellness through community outreach program, community health education, Assisted Living Options, Wellness Activities Facility.</li> <li>○ Culturally Strong and Healthy Yakama Nation through retaining cultural traditional values, financial enhancement for health.</li> <li>○ Improved Expanded Patient Care and Treatment Care through improved patient accommodations, expended involvement in health programs, develop safety and health codes, and specialized health care centers.</li> </ul> </li> <li>• The service area population continues to increase; however, the funding level of the current programs has not kept pace with the population.</li> </ul>
<p><b>Warm Springs</b></p>	<ul style="list-style-type: none"> <li>• Space constraints and space utilization for examining and treating patients.</li> <li>• Efficiency issues regarding use of Professionals to maximize their clinical expertise and performance of duties.</li> <li>• Performance Improvement Plan in progress, working on Clinic re-design (Open Access) and operational audit.</li> </ul>
<p><b>White Swan</b></p>	<ul style="list-style-type: none"> <li>• The White Swan Health Clinic building is outdated and in need of numerous upgrades and structural remodeling. The building is too small to accommodate additional services and staff that are needed for this area.</li> <li>• The White Swan Ambulance has two locations. One station is located in White Swan; the other is located in Toppenish, Washington. During times of power outages the White Swan Ambulance garage has to be opened manually by a large pulley system. This creates a delay in response time. The Toppenish station is located in a one-room office that does not have adequate facilities for the staff. The White Swan Ambulance has an Intermediate Life Support Certification status.</li> </ul>



<p><b>Puyallup</b></p>	<ul style="list-style-type: none"> <li>• Service population exceeds available space, staff, and time. CHSDA is Pierce &amp; King County, but Pierce is patient base. Must be resident of Pierce County or have Tribal connections.</li> <li>• Long waiting time for services and appointments.</li> <li>• Unpredictable funding and revenue.</li> <li>• Hours of operation limits accessibility.</li> <li>• Limited time and personnel to do prevention services.</li> <li>• Limited by fee-for-services mode. Ask Lois McKee about this for clarification.</li> </ul>
<p><b>Lummi</b></p>	<ul style="list-style-type: none"> <li>• Info technology is needed (equipment, training, space)</li> <li>• Education for patients (payor education); personal responsibility</li> <li>• Communication problems</li> <li>• Coordinated Elder care</li> <li>• Staff recruitment and retention (again, benefits package is a big issue)</li> <li>• Funding</li> <li>• Space – more for services that need exposure (i.e. Women’s clinic, dental, meeting &amp; ed space)             <ul style="list-style-type: none"> <li>○ Some space may need to be re-oriented</li> <li>○ Need storage</li> </ul> </li> <li>• Equipment (better and newer)</li> <li>• 60% walk-in traffic (only about a 2 week waiting period, so it is a tribal issue folks just prefer walk-in access)</li> </ul>
<p><b>Spokane (Wynecoop)</b></p>	<ul style="list-style-type: none"> <li>• Recruiting can be a problem (unable to pay)</li> <li>• Patient Care tends to be complex – very few common colds or sore throats</li> <li>• Lack of CHS funds (Priority 1 limitations are strangling us –This is a year long restriction)</li> <li>• Not able to offer Optometry Services (funding services to pay staffing)</li> <li>• “Same day appointment system” is overloaded. Options include triage slots (Nurse will decide if case is required). This has driven “no-show” rate to very low. They were directed to do this by Area Director/</li> </ul>
<p><b>Quileute</b></p>	<ul style="list-style-type: none"> <li>• Transportation – referral care help (only 1 CHR)</li> <li>• Lack of space</li> <li>• Communication in general (accessing a doctor for consultation)</li> <li>• Lab process</li> <li>• Lack of pharmacy Services (many CHS \$ used)</li> <li>• Main Health issues: 1) Diabetes, 2) Alcohol and Meth use, and 3) Pregnancy (young)</li> </ul>
<p><b>Siletz</b></p>	<ul style="list-style-type: none"> <li>• Rural community: Few close referrals and many transportation issues</li> <li>• Large population area to serve – 11 counties – barrier of distance. Casino employees are 40 miles away and would prefer their own Clinic. CHS requires patients to come to Siletz if they live within 40 miles.</li> <li>• Lack of health care dollars (OHP, CHS) for high risk population (many patients with generational trauma, alcohol, at-risk behaviors). A&amp;D has no after hours care.</li> <li>• Clinic has limited capabilities in diagnostic imaging</li> <li>• Medical Records short on storage space and off site storage delay retrieval</li> <li>• Need space for food prep and exercise program (we share with other programs)</li> <li>• No space for indoor exercise program</li> <li>• Prevention programs are all from grants funded – no stable ongoing funding</li> </ul>



	<p>(Tobacco, Diabetes, Youth Mental Health)</p> <ul style="list-style-type: none"> <li>• Lack of elders long term care – need small group homes</li> <li>• Lack of coordination between health and other tribal social service programs for elders and youth</li> <li>• Difficulty to recruit and keep professionals due to inadequate family insurance, poor County schools and rural location that discourages the young and single</li> <li>• Underserved youth-at-risk – not Tribal health presence at Toledo high school located 10 miles from Siletz. There is stigma for you going to separate A&amp;D center for services. (State of Oregon is in bad shape financially. DHHS will take a big hit, which will affect Mental Health.</li> </ul>
<b>Cow Creek</b>	<ul style="list-style-type: none"> <li>• No coverage at hospital (Mercy Medical Center Hospital)</li> <li>• Service Unit large – few tribal members use clinic (60/40 tribal to non-tribal employee ratio).</li> <li>• Few OHP (Oregon Health Plan) Providers (dental)</li> </ul>
<b>Upper Skagit</b>	
<b>Cowlitz</b>	<ul style="list-style-type: none"> <li>• New</li> <li>• Large geography</li> <li>• No reservation</li> <li>• Lack of Services (dental)</li> <li>• Lack of direct service dollars from IHS</li> </ul>
<b>Burns</b>	<p>We are very isolated and have to travel long distances for specialty care (260 miles round trip) or 600 miles round trip to attend trainings with Indian Health Services in Portland. We do not have an on-site provider. Most of our care is through contract services. Medical care is expensive in this area. We have a lack of space for providing services.</p>
<b>Hoh</b>	
<b>Kalispel</b>	<ul style="list-style-type: none"> <li>• At this time, the Tribe offers only mental health and substance abuse services. Approximately 50% of the tribe is uninsured and must travel to Wellpinit for services or rely on CHS. However, the Wellpinit Service Unit is near continuously on Priority I and as such, the uninsured within the Tribe are often denied access to services.</li> <li>• The Tribe has suffered connectivity issues that are being addressed. As such, data has not been entered into RPMS on a regular basis. In addition, quality improvement initiatives are relatively undeveloped, HIPAA standards are not being enforced. There is a high degree of awareness of these challenges. As the new Health and Wellness Center opens, it is the intention to begin with the RPMS EHR and to utilize the QI system of the Indian Health Services to immediately implement a quality improvement system for the Tribe.</li> </ul>
<b>NW Shoshone</b>	



<b>Snoqualmie</b>	
<b>Stillaguamish</b>	<ul style="list-style-type: none"><li>• Limitations in funding</li><li>• Limitations in access to Medicaid funding for non-natives</li><li>• Inability of insurance companies to recognize Tribal programs for payment of services</li></ul>

The Portland Area participating PSAs identified many common weaknesses. These include space limitations, accelerating health care costs, education of tribal members on health care system, lack of elder and hospice care, referral network complications (distance and poor discounting), long wait times, transportation, and recruiting issues. All participating PSAs cited weaknesses but are pressing forward to deliver their best efforts in spite of these weaknesses.



In order to understand the concerns of the group and to understand what the group thought was important, the group was asked to respond to the following question relating to priorities or priority services:

Round One participants were posed the following question: *What should be prioritized at the end of this exercise?*

Round Two participants were posed the same question with “services” specified (the intent is the same): *What services should be prioritized at the end of this exercise?*

Responses are found below by group. The left hand column represents their responses and the right hand column indicates the relative importance of each characteristic based on the group’s voting. This voting occurred after discussion of each item. Round Two did not participate in a voting exercise.

Services	Score
<b><u>Round One Responses</u></b>	
• Comprehensive Preventive Health Plan	6
• Population User Numbers that are agreeable to all	5
• Provide Adequate Services to meet needs appropriate to Population	4
• One health system – all services located under one building for patients for health care	4
• Identification of site(s) that will have greatest health services needs	4
• Facility upgrade or expansion to meet population growth.	
• Facilities have to get better to accommodate changes in way to do business	2
• New health (clinic) facility for Omak (IHS/Tribal)	
• Where are facility improvements needed	
• Physical Plant	
• Alcohol Care	2
• Geriatric Care	1
• Increase sharing or designed sharing of clinical separation	1
• Shared health care facility along Columbia River	
• More Funding	1
• Funding beyond our needs – not so we almost reach finalization of service, but to reach it and maintain	
• Chronic health needs versus resources	1
• Funding and staff for Tribal and Urban patients in High Population growth areas (“dark green areas”)	1
• Identify both need and opportunity to balance resources among all populations served	0
• Resource allocation (\$, staff, facilities) based on equitable assessment of need	0
• Prioritize plan. Agree and implement in timely manner.	0
• Work on weakness identified	0
• Quality Care – Meeting/exceeding standards of patient care at each service unit.	0
• Staff/facility balanced to meet regional health delivery system needs	0
• Greatest Resource Shortage: what health needs will grow greater than others so model for deliver can be updated to meet changing needs in 2012+	0
• Staffing of health care personnel for demand based on community/pop needs and trends.	0
• Vision of health care system in Portland area and the beginning steps to achieve it.	0
• System Design and facility designs should be driven by morbidity, mortality & disease burden data.	0
• Hospital based care	0
• I/T/U Primary, Specialty, hospital based, alcohol and geriatric care service delivery. Primary Care, Specialty Care,	0
• The direction should be (whatever is prioritized) that improves the health care of the	0



- tribal members (Bang for the Buck)
- The major needs for improvement for each program 0
- True/Actual Needs 0
- Strengthen the weaknesses, maintain and improve the strengths 0
- Basic Benefits package / available core services 0
- What is the future of the healthcare system in Neah Bay / IHS and tribal collaboration and direction 0
- Use the statistical data to develop the appropriate programs to fit the need 0
- What services (direct) are to be provided at each location 0

**Round Two Responses**

- H.P.D.P.
- Preventive
- Move to prevention model of care
- Health education
- Health education
- Diabetes
- Optical
- OB/GYN – General Woman’s Health
- Pediatric Services
- Dental services
- Dental
- Dental care
- Mental health CD
- Alcohol/general CD issues
- Contract health
- Access to a PCP
- Family/General Practice



In order to gain consensus on what is important, and to pursue that goal united, master plan task force members were asked to work together in defining how priorities should be established. They were asked to develop such priorities with an “area wide leadership hat” on, so the needs/concerns of all would be represented. In order to understand the concerns of the group and to understand what the group thought was important, the groups were asked to respond to the following questions.

Round One was asked: *What characteristics of a service area should dictate their level of priority relative to future capital expenditures?*

The left hand column each round’s responses and the right hand column indicates the relative importance of each characteristic based on the group’s voting. This voting occurred after discussion of each item.

<b>Characteristics</b>	<b>Score</b>
• Areas with inadequate care & potentially high user population	21
• Limited Access to Basic (Core) services	7
• Distance to Care / Remoteness	6
• Target those with low level funding	5
• Socio economic needs	2
• Area that has least square meters to meet their future population growth	2
• Prioritize by number of users	2
• Age and condition of health care facilities – worst case relative need	1
• Areas with least resources to take care of own population (no ability to reclaim costs, billing, or collections)	1
• Morbidity / Mortality Rates	1
• Mental Health – Alcohol / Drug	1
• Area with the highest growth anticipated (fastest rising demand)	0
• Health needs based on medical priority I, II, III, IV	0
• # of Diabetic Patients	0
• Length of time to next available appointment	0
• Level of Health Care Service (Mort, Morb, Fac Size, Wait times, Incidence of cancer, diabetes...)	0
• Prevention Programs	0
• Service Area with trends indicating a growing younger population	0



Round Two was asked: *What characteristics of a Service Area / Facility / Patient Population should give that Service Area priority in future planning and investment?*

After the development of responses, the responses were categorized to determine common themes. The following list reflects the discussion and categorization by the work group:

Health Status

- Health Status
- Status of healthcare situation in that community
- Need – caveat: how do we assess this?

Vote

Impact (benefit) per use of limited dollar

Lack of Access

- Poor access
- Availability of services in that respective area

Greatest need based on dollars per member (CHS) and acuity rating (i.e. diabetes rates, CVD rates, cancer rates, etc)

Population Growth

- New Tribes
- Population increase

Low resources – inequity means high priority

**Blended Results (from Group 1 & 2)**

The intent of the questions was the same. The blending of both priority exercises, despite the fact that Round Two did not vote on criteria as Round One did, results in the following priority criteria that require the February 2005 workgroup to evolve into measurable factors that can guide the priority process. Typically four criteria are developed into measurable factors. A fifth is cited here should the workgroup feel it important or desire to replace one of the other four.

**Areas with inadequate care & potentially high user population**

- Ratio of User Pop to Existing Providers
- Ratio of User Pop to Existing Space
- Unmet Need
- Deferred Services
- Lowest Healthcare Services to Population Ratio
- Population Age/need based
- Number of People to Serve
- Enrolled Members

- Availability of Services in a respective area

**Distance to Care / Remoteness**

- Remote Areas (by User Pop)
- Least Access to Care
- Remote Locations
- Remoteness

**Areas with Low Level Funding**

- (No sub-points available)

**(If needed) Health Status**

- *Health Status*
- *Status of Healthcare situation in that community*
- *Need*
- *Morbidity / Mortality Rates*

**Limited Access to Basic (Core) services**

- Basic Services
- Access to Basic Benefits Package (Direct, CHS, Other)
- Poor Access



## **Project Status Summary**

Development and application of Priority Criteria for the Portland Area Health Services Master Plan was ended after the project demonstrated a repeated inability to secure broad tribal representation at area workgroup meetings. Diverse and representative involvement in the forming of these critical factors is essential for successful application. At some future date the Portland Area may desire to reconsider forwarding this effort should the tribes desire. Existing development to date can be of use for the Portland Area office as it seeks to help individual PSAs pursue their own priorities.