Intro – Good morning, Mr. Chairman, thank you for giving me the opportunity to address the Subcommittee on the very timely and important issue of health care delivery and quality. As you know, this issue has been of great concern in the health care delivery system provided to the Northern Cheyenne Tribe by the Indian Health Service. As we continue to witness the dramatic changes in the structure and delivery of care and steady decline in our quality of patient care. Today, I would like to provide you with my perspective on the impacts of the budget shortfalls, access to care, and the quality of care administered to our Northern Cheyenne Tribal members.

The impact of the budget shortfalls are evident year to year. The only variation and question to this situation is the money and services ending in June or May of each year. The amount that is allowed in the budget does not allot enough money to provide care for the entire year. The impact of this budget shortfall places a limitation to our services to healthcare with the inability meet the minimal need of survival for our people. The limitation of services during this time period has increased the morbidity and mortality of our Northern Cheyenne Tribal members. They do not get the services provided to the general population in regards to minor surgery and emergent situations such as gall bladder attacks, kidney stone blockage, broken bones, and head injury get minimized to prevent getting an outside opinion.

The mismanagement of the Indian Health Service to properly supervise the position of the Contract Health Representative at the local level has placed Northern Cheyenne Tribal members being reported to the collections department because of the inability to pay the bills in a timely manner. These are bills that have been pre-authorized by the Indian Health Service and have not been made accordingly. The Indian Health Service has not made any comments in regards to this issue. At an estimate this costs exceeds more than 2 million dollars. This is a direct violation of the trust responsibility and the inability to perform these functions required by this office has left another impact to our community members. The outside providers that are waiting for payment now have lost the trust and respect of these providers. Not only did this impact our population but also with the limited socio economic status of our community members they have now gotten their credit ruined and the ability for enrolled tribal members to have opportunities such as purchasing reliable transportation and affordable appliances and improvement loans.

The continued mismanagement of the Indian Health Service in regards to the Contract care process has had them deny payment for services that were referred out by the Emergency Room Physician. This process needs further clarification to not only our community members but also to the Northern Cheyenne Tribal Administration, in regards to the status of a referral by the Attending Physician and not addressing this prior to the transfer for care outside of the local facility. The denial of services goes back three to four years and only states that the denial is based on the inability to apply for Medicaid. These individuals will not be able to go back three to four years to complete these processes, therefore, setting them up again for failure and bankruptcy at the cost of a service that was thought to be provided and referred by the Indian Health Service.

Additional impacts of the budget shortfall is a direct result to our community members ability to get specialized services, These services include the rehabilitation of Coronary bypass surgery, cancer treatment and transportation, heart disease, and liver failure.

These shortfalls also dictate the ability for community members to get care that is not provided at the local service unit. The priority levels follow the budget shortfalls with further limitations to the user

population. During the second half of the year, community members are only sent out when they are in a life or death situation. This has compromised our community in other areas and we have lost individuals who did not meet the screening criteria waiting to get care during this time. The budget does not account for our geographic area, lack of reliable transportation, and the limited socio-economic status of our population in regards to transportation. The Service Unit is not able to provide the entire service of transportation to our community members. They have made an internal decision to provide only to the dialysis patients which are transported six days out of the week. As this department had been retroceded to the Indian Health Service from the Northern Cheyenne Tribe we have had no input into the priority of transports. In addition to the budget shortfalls we will now start to address the issues of accessibility of care for our community members.

The access to care for our community members is limited and based on timing. The inability of the local service unit to have any specialty services available onsite decreases the access and ability of our community members to get patient education and guidance for newly diagnosed chronic disease's such as Heart Disease and failure, Diabetes, Cancer, amputation, Renal failure, stroke, and liver failure. Currently the Indian Health Service only allows for one follow up visit after a major surgeries such as Heart Bypass, intensive care hospitalizations, amputations, and stroke awareness. The lack of screening for preventable diseases which increases our risks for Cancer, Heart Disease, and Strokes. The inability to provide a continuum of care for our population decreases and inhibits the community the opportunity the chance for full recovery and preventing any further complications when they come back home. The community members have frequent re-admission to either the emergency room or hospital because of the fragmentation of care. The delay of treatment options provided for the community have increased the morbidity and mortality with such disease process as Heart Disease and Cancer. The response to patient and family needs has been dramatic and the inability to have created a structure that can accommodate the growth of our community in response to the need for more complex patient care services. Healthcare isn't just improvement and measurement. It is about our core values, our culture, and ultimately our vision for the future. With this, I would like to address the quality and patient care issues.

Quality at its most basic is doing the right thing, in the right way, for the right person. The challenge is knowing as a community member and administrator what the right thing is. The Indian Health Service has made several mistakes in regards to the misdiagnosis of conditions within our population. These mistakes have caused the community members to lose limbs, shorten the life span, and in some cases death. They are now faced with living with a chronic condition that they thought was non-emergent and only a virus by the local provider. The shock and anger associated with this affects the trust with the providers at the local service unit. As a licensed professional they are required to advocate for the patient rights and conditions knowing when the time is right and what treatment options are available and needed. The approach with medication is generic across the board with the entire population. Medication is stocked and ordered to a limited availability. If a patient was to come out of the hospital with a new medication and the local service unit did not have this medication, the patient would have it changed or go without. The gap between what is known and what is delivered is evidenced by this continued practice at the mercy of the community member.

Quality is measured thru three dimensions: structure, process, and outcome. Structure and the foundation represents the basic characteristics of physicians and the ability to communicate with other hospitals, other professionals and other facilities such as skilled nursing homes. The Northern Cheyenne

Tribal administration is unaware of the communication between facilities. The current structure and framework is limited and based on the availability of the budget.

If we truly wanted to be a model or a candidate for this nation's health care organizations, we need to be offered a systematic process to evaluate and address the patient care issues and concerns in a confidential manner. The inability to have a complaint management process in place limits the ability to identify and measure the goals and objectives of the current healthcare system. Have a strategic planning session that will bring forth priorities that the administration feels is important and needs to be addressed. This allows the opportunity to deliver a better care to our patients, and having a greater and more positive impact on the lives of all of our community members with a criteria and a commitment to quality, satisfaction, and continuous improvement.

In closing, for years we have voiced our concerns at the Tribal Consultation meetings with the Indian Health Service when doing the budget formulation and prioritized Contract Health Services each year and each year we continue to run out of funding. We have lost tribal members, disabled many, and harmed the welfare of others due to the inability of being provided quality and consistent health care to our people. I am asking you at this time to ensure the survival and welfare of the Northern Cheyenne Tribe we are requesting that you hear us and guarantee that the Indian Health Service fulfill the general trust responsibility.

Sincerely,

Llevando Fisher

Llevando Fisher, President
Northern Cheyenne Tribe