There are (at least) three primary tracks to staff and pursue in building needed infrastructure:

1. **EPIDEMIOLOGIC -**
   Detailed review of the utilization, incidence, outcomes and support services data for all the health programs and clinical facilities,... to confirm our suppositions about the planned reorganization and integration of health care services. Hard experiential facts, projections and trends should be the basis for restructuring. The system for data collection/analysis also needs to be designed and maintained to support management decisions.

2. **FINANCIAL -**
   We still need to do careful analysis and projections on the anticipated costs of what the proposed system calls for. This will provide the practical, rational component for decision making so that the "wishes" are examined in the light of real world costs. For this task, an objective cynic is more valuable than an optimistic dreamer, like me. It's really vital to have good information developed on this element.

3. **OPERATIONAL SERVICE NETWORKS -**
   This is the difficult task of not only working out the best referral patterns and internal controls, but of changing the attitudes and daily practices of the staff members at the various programs and facilities,... to make the personal commitment change and to actually do things differently. Unless both IHS and tribal staff understand and "buy into" the proposed healthcare system, it will never work the way it is intended.

We had some interesting and talented folks at the "roundtable critique" who might be both capable and willing to play a vital fulltime part in making this a reality. The tribe will need bright, seasoned professionals to set up this complex system and cannot afford to compromise by taking chances with anyone lacking a solid track record. You will want to talk to Jim, Pam, Joe Byrd, Barbara Mitchell, Patrice Whistler and perhaps others who were at the discussion, to get their impressions of some of the active participants, but here are my thoughts:

For the first (epidemiologic) track, **Dan Cameron**, who is apparently less than content in his IHS Area Office role, displayed some significant insights about the need for careful data analysis. I'm aware that he is being recruited for other positions (Alaska wants him for a major undertaking) but his familiarity with the IHS data base and positive comments from Terry Rice, who knows him well, lead me to think he might do an excellent job in this regard. He could also serve the role of setting-up and maintaining the tribally-centered data collection/analysis for ongoing management of the system.

For the second (financial) track, **Cliff Wiggins** would be magnificent, if we could lure him away from the IHS Director's office in Rockville. His background is in mathematics and finance, with an extraordinary experience and understanding of the appropriation and allocation processes being utilized by the IHS. In addition, his maturity, diplomacy and analytic insights would make him an impressive candidate to lead the implementation team and coordinate their efforts.

For the third track, establishing a properly integrated service network, I'm not sure that I've seen anyone except **Dick Mandsager** (Medical Director and SUD at Anchorage ANMC) that could do it alone and, unfortunately, he's not available, except to provide some short-term help with the transition to tribal management of the IHS hospitals when we get to that point. We probably need a combination of individuals for this important task. The best clinician to design referral patterns, internal service restructuring and quality assurance measures might be **Martin Kileen** (well-known to Jim Danielson and me), but he has another year of Preventive Medicine residency to complete and won't be available until '94. He also has genuine skills in electronic data systems (Marquette electronics engineering degree, in addition to his MD) and knows the IHS data system.