Midwest Alliance of Sovereign Tribes Meeting

"Indian Health Service Update"

by

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March 12, 2007

Good Morning!
I appreciate the opportunity to be here today to speak with you about the new and promising health priorities of H H S and the Indian Health Service. Under the leadership of Secretary Leavitt, these priorities are being implemented by HHS to help provide access to high-quality health care and prevention services for all American people. The IHS, together with other HHS agencies, will be working in partnership with Tribal Nations and tribal organizations to implement these priorities for American Indian and Alaska Native individuals and communities.

These are the nine HHS Priorities for America's Health Care, presented along with indicators of how the IHS is supporting each one. The nine areas are:

Health Transparency,
Health Information Technology,
Medicare Rx (Prescription),
Medicaid Modernization,
New Orleans Health System,
Emergency Response & Commissioned Corps Renewal,
Prevention,
Pandemic Preparedness, and
Personalized Health Care

The text is the basis of Dr. Grim's oral remarks at the meeting of the Midwest Alliance of Sovereign Tribes on March 12, 2007. It should be used with the understanding that some material may have been added or omitted during presentation.

Time is obviously of the essence to make these healthcare priorities work for the benefit of all Americans. As of March 12 . . . there are only 679 days left in this administration.

Let me start with Health Transparency. The Secretary's vision for this priority is that "the growth of health care costs is restrained because consumers know the comparative costs and quality of their health care . . . Consumers gain control of their health care and have the knowledge to make informed health care decisions."

Health Transparency means harnessing the power of major purchasers of healthcare, including the federal government, to drive change in the healthcare marketplace. It is a long-term strategy to empower consumers by providing them with more information about the price and quality of healthcare they receive. The power of a health system-wide electronic medical records system will be used to fuel the change.

This is an important initiative for the IHS, and we are committed to ensuring that our health care programs provide transparent information regarding health care quality and price. Since 2001, the IHS has been able to retrieve clinical quality information at local facilities through the use of our HIT system. This data is shared with facility staff, as well as local communities and consumers. The IHS is also developing mechanisms to provide internal health care price data.

The President signed an Executive Order in April 2004 announcing a commitment to the promotion of Health Information Technology, or HIT. He called for widespread adoption of electronic health records within 10 years so that health information will follow patients throughout their care in a seamless and secure manner.

The goals of this priority include improving population health by connecting health care so that different health information systems can quickly and securely communicate and exchange data. Some of the numerous benefits of HIT initiatives will include a reduction in medical errors, avoidance of costly duplicate testing, and elimination of unnecessary hospitalizations. The President has set a goal for most Americans to have electronic health records by the year 2014.

The IHS already has an advanced integrated HIT system in place, and has had an electronic health records system in place for over 25 years. Our Resource and Patient Management System, or RPMS, consists of more than 60 software applications and is used at approximately 400 IHS, tribal, and urban locations. The IHS maintains a centralized database of patient encounter and administrative data for statistical purposes, performance measurement, and public health and epidemiological studies.

The IHS electronic health records initiative enhances computer-based physician order entry, encounter documentation, access to medical literature, and other essential capabilities. The IHS is also working with Tribes to further enhance information systems to allow better clinical practice management and administrative reporting systems at all sites, even in the most rural and isolated locations.

New models of care delivery through telemedicine are also now a reality. Care delivery through telemedicine continues to expand. Many different types of telemedicine help IHS and tribal health care teams provide quality, cost-efficient care in a timely fashion. Examples of

telemedicine innovation include the Joslin Vision Network, care coordination outreach for patients with heart failure and other chronic diseases, increased behavioral health services, and tele-nutrition counseling. Growing telemedicine collaborations with Tribes and other federal agencies − such as our partnerships with the Alaska Native Tribal Health Consortium and with the Veterans Administration − also help extend critical infrastructure and service delivery capabilities for many IHS and tribal facilities.

The next priority is a continuation of the largest expansion of Medicare in 40 years. It includes continuing quality improvement to make Medicare Part D even better, with streamlined and better choices for beneficiaries.

Enrollment in the Medicare Prescription Drug Benefit continues to grow in Indian Country. The IHS has signed Medicare Part D agreements with the 15 plans and patient benefit companies. We are now working on agreements with three more plans to meet specific regional needs. The IHS also continues to work with Part D plans to encourage them to develop tribal and urban program agreements with terms and conditions similar to those negotiated by the IHS.

Medicare Part-D premiums continue to be an area of concern for the IHS and Tribes. While the IHS does not have statutory authority to pay premiums for Medicare Part D, there is no prohibition against a Tribe using tribal funds to pay for such costs. During the National Indian Health Board meeting in 2006, Phil Norrgard, Human Service Director for the Fond du Lac Tribe, spoke about how the Fond du Lac Tribe was able to increase collections by paying Medicare Part D premiums for tribal members. A copy of Mr. Norrgard's NIHB presentation is available on the IHS website at www.pharmacyissues.ihs.gov under the "Medicare and Medicaid" section.

Linked to the Medicare Rx priority is the Medicaid Modernization priority**.** This priority seeks to:

- Help provide coverage to millions of people who are not covered now.
- Help people in differing economic situations through flexible benefits and incentives tailored to meet their needs.
- Help people with disabilities have access to care in their homes and communities.

To facilitate Medicare/Medicaid innovation for the benefit of Indian people, IHS and Centers for Medicare and Medicaid Services (CMS) staff meet regularly to ensure close coordination of policies, foster increased state/tribal innovation, and develop ways to improve access to care for Indian people. This interaction between IHS and CMS is crucial as we work on a variety of Medicare and Medicaid issues important to Indian Country, such as the requirement that Medicaid beneficiaries provide citizenship documentation and the reduction in Medicaid reimbursement for pharmaceuticals.

CMS is committed to improved tribal input on various CMS payment and program policies and regulations that impact on Indian people. The CMS Tribal Technical Advisory Group has worked with CMS on a variety of Medicare and Medicaid issues this past year. And Valerie Davidson, the Chair of the Advisory Group, served as a member of the Medicaid Commission, which was tasked with recommending ways to modernize the Medicaid program to provide the

most cost-effective quality health care to its beneficiaries. The Commission submitted its report to Secretary Leavitt on December 29, 2006.

The IHS has also provided assistance to CMS in its efforts to improve communications with tribal and state governments in the implementation of Medicaid, Medicare, and the State Children's Health Insurance Program. One area that IHS is working closely with CMS on is getting Medicare-like rates approved and in place. We have been working with CMS, HHS, and the Office of Management and Budget to review all comments and recommendations, and to approve regulation language. This is a time-consuming process, and the IHS has been working diligently to get the rates implemented as soon as possible.

The second part of the Medicaid Modernization initiative focuses on long-term care, an important issue in Indian Country. The Secretary's vision for Long-Term Care Reform is that:

- States can give people access to health insurance without waivers.
- Self-direction is available in long-term and acute care settings and access to community-based long-term care is increased, and
- The integrity of Medicaid is assured while guarding against financial abuse.

The IHS Vision for Long-Term Care complements the Secretary's vision, with a focus on supporting Indian elders and their families with medical, personal, and social services delivered in a variety of settings, ranging from a person's own home to institutional settings.

Elders play a vital role in providing a sense of structure and cultural identity that helps keep our families and communities emotionally and mentally healthy. It is therefore essential that we develop services to support Elders so they can remain as much as possible with their families and within their communities. The IHS as an agency supports tribal development of long-term care services with technical support, with grant funding to help develop services, with advocacy within the federal system, and with support for the integration of health services into the long-term care system.

The next priority focuses on helping New Orleans recover from the devastating effects of Hurricane Katrina. The goal of this priority is to leverage the power, resources, and authority of HHS and other federal agencies to accomplish the redesign efforts of the Louisiana Healthcare Redesign Collaborative established last July.

I am proud to say that the IHS is playing a key role in meeting this goal. The IHS Phoenix Area Chief Medical Officer Vincent Berkley is devoting half of his schedule to serve as the HHS Senior Health Official in Louisiana. IHS Commissioned Corps officers are also serving as key members of assessment teams that are evaluating the region's hospitals, nursing homes, and other health systems. This effort, of course, benefits the state's Tribes as well as the general population. I know you share our pride in this IHS effort, which reflects the Indian tradition of doing more than our share for the welfare of our nation.

The next HHS priority is a continuation and extension of the preparedness tasks from the Katrina Lessons Learned report. The objective is to ensure that America is prepared to prevent and address the health effects of a disaster, natural or manmade. I am proud to say that the IHS

former Chief Medical Officer, RADM Craig Vanderwagen, has been chosen by the President to spearhead this effort as the HHS Assistant Secretary for Preparedness and Response. Dr. Vanderwagen has stated that he will use many of the lessons learned from his work in Indian Country to tackle the huge task of improving emergency preparedness services for 300 million Americans.

Part of this initiative includes a transformation of the Commissioned Corps to establish it as a national resource that is ready to respond rapidly to urgent public health challenges and emergencies. Strategies will be developed to increase the size of the corps and improve its ability to respond quickly to urgent public health needs. This includes:

- Increasing the number of officers by 10 percent, from approximately 5,925 officers to 6,600 officers by December 2008.
  - Approximately 2,250 officers are currently assigned to IHS. It is anticipated that this increase will occur primarily in clinical positions.
  - Since the IHS is the primary user of these clinical positions, we may be the primary recipient of these new officers.
  - This should aid in the IHS goal to reduce the number of funded vacancies.
- Changing the recruitment process so that it includes stronger personal incentive programs and a better approach for assigning officers.

The Secretary's Prevention priority is one that is closely aligned with the main health care initiatives of the IHS. The Secretary's Vision for Prevention mirrors our goal for chronic care management, with a focus on reducing the risk factors of many health conditions through preventative actions. Also, there is an emphasis on taking personal responsibility for one's health by making healthy lifestyle choices, taking advantage of medical screenings, and avoiding risky behaviors.

The Prevention priority has an overarching agenda organized around the President's "Healthier U.S." initiative with four broad organizing principles:

Eat a nutritious diet
Be physically active
Get your medical screenings
Make healthy choices

These are principles that I would like for every American Indian and Alaska Native and their communities to understand and embrace. I am pleased to report that the IHS and Tribes have many wellness programs already in place that support these goals.

Wellness programs throughout Indian Country are focusing on increasing physical activity to improve health. Exercise is a cornerstone in the treatment and prevention of many chronic conditions, especially type 2 diabetes, which has reached epidemic proportions in the Indian population. Regular exercise and physical fitness promote weight loss, improve insulin sensitivity, increase muscle strength, reduce stress, enhance self-esteem, and improve the overall quality of life.

Another important aspect of prevention, as the Prevention priority states, is nutrition. The availability of community nutrition services throughout Indian Country has increased. Blending traditional and local nutrition and fitness activities can help families and communities make the lifestyle changes needed to lose weight.

Screening programs are an important part of IHS prevention programs. For instance, screening to identify people who have diabetes or who are at risk for developing diabetes is an important step in preventing and treating diabetes. Screening for pre-diabetes provides an opportunity for primary prevention by encouraging individuals to make lifestyle changes that can prevent or delay the onset of diabetes. Since over one-third of people with diabetes do not know that they have it, screening also provides an opportunity for secondary prevention by diagnosing diabetes as early as possible to prevent or delay complications.

Prevention is also a key issue in the behavioral health field. Suicide Prevention is an area of great concern to the IHS and Tribes.

- Suicide rates are from 1.5 to 3 times higher for American Indians and Alaska Natives.
- Suicide is the second leading cause of death for 15-24 American Indian and Alaska Native youth.

To help address this alarming problem, the IHS is supporting the HHS National Strategy for Suicide Prevention. We are working to:

- Promote awareness that suicide is a public health problem that is preventable.
- Implement training to aid in recognizing at-risk behavior.
- Develop and implement community based suicide prevention programs.
- Improve and expand surveillance systems.

In recent years, IHS has also addressed this issue through:

- A joint conference with Canada to share information and promising programs.
- The National Suicide Prevention Project, which supports:
  - Programming and service contracts for suicide cluster response and suicide prevention, and
  - The development of a website with information on community mobilization.

Alcohol and Substance Abuse continue to be severe problems in Indian Country. A recent study by the Substance Abuse and Mental Health Services Administration (SAMHSA) indicated that American Indians and Alaska Natives were about 1.5 times more likely than other ethnic groups to have a past year alcohol use disorder (10.7% vs. 7.6%) and to use illicit drugs (5.0% vs. 2.9%).

This is not a problem we will solve by ourselves. Collaboration with other federal agencies is the key. IHS is actively collaborating with SAMHSA, the Bureau of Indian Affairs, the Department of Housing and Urban Development, and the Department of Justice, and others in order to bring together convergent interests and resources to address this problem.

One other crucial area of behavioral health prevention that I, and many other Indian health care leaders, are very concerned about, is addressing the alarming increase in the use of methamphetamine in Indian Country.

- Beginning in 2000, marked increases were noted in patients presenting at IHS and tribal clinical sites for amphetamine related problems, and that trend continues through today.
- The number of patient services related to amphetamine abuse went from about 3,000 contacts in 2000 to over 7,000 contacts in 2005, an increase of almost 250% over 5 years.

I have heard firsthand from Indian people about the deadly impact of this drug, and the devastating effects on our young people and their families, and on the entire community.
I believe more extensive information is needed on this problem, and that is why we are working on collecting reliable data to measure the extent and severity of Meth abuse in Indian Country.

There is some good news: The HHS recently awarded $1.2 million to the American Association of Indian Physicians to address methamphetamine abuse in Indian Country. Indian organizations and Tribes will share in the award to combat Meth abuse. And the IHS and the BIA have joined forces to address this epidemic from both a public health and a law enforcement prospective.

Addressing all the diverse elements that contribute to overall good health demands, among many other things, adopting a strong Chronic Care Management Model to help guide our health care efforts. Chronic care issues are currently the focus of many health care efforts, both in Indian Country and across the nation.

The IHS is adapting the MacColl Institute Chronic Care Model for use in the Indian health care system. This model addresses the underlying causes of poor physical and mental health, rather than just treating the symptoms. This means addressing all the elements that contribute to good health, including the cultural, medical, behavioral, social, and sanitation needs of the population we serve.

This model of chronic care highlights the importance of an informed, interactive patient in the health care process. The chronic care model is based on the premise that improved outcomes result from productive interactions between a proactive health care team and an informed patient.

During 2006, the Chronic Care Management Workgroup developed an innovative program using the Chronic Care Model at pilot sites to test foundational changes in the delivery of care for chronic conditions. The purpose of these pilot sites is to demonstrate that changing the way we deliver care can improve patient outcomes for a variety of chronic illnesses in a cost-effective manner. The pilot program will also support other innovative efforts within the Indian health system to address chronic conditions, especially those that integrate behavioral health and health promotion principles. Each Area will have at least one pilot site.

So far, eight federal pilot sites have been selected at:

- Gallup Indian Medical Center –Albuquerque Area
- Albuquerque Service Unit – Albuquerque Area
- Warm Springs Service Unit – Portland Area

- Chinle Comprehensive Health Care Center – Phoenix Area
- Wind River Service Unit - Billings Area
- Sells Service Unit – Tucson Area
- White River Service Unit - Phoenix Area
- Rapid City Service Unit – Aberdeen Area

Also, five tribal sites were recently added:

- White River Service Unit - Phoenix Area
- Indian Health Council, Inc. - California Area
- Cherokee Nation Health Services - Oklahoma Area
- The Choctaw Health Center – Nashville Area
- Eastern Aleutian Tribe - Alaska Area
- Forest County Potawatomi Health and Wellness Center - Bemidji Area

We also have one urban program site: the Gerald L. Ignace Indian Health Center - Bemidji Area

The underlying principle of prevention in the IHS is that the best health promotion programs are those that are developed in consultation with our key stakeholders, the American Indian and Alaska Native people. We know that listening to those of you who are most affected by the outcomes helps us to best target the specific needs of each community.

And we know that building on the existing strengths and assets of Indian people, families, and communities ensures the most effective use of resources and yields the best possible results, whether we are dealing with ongoing chronic conditions or emerging infectious diseases.

As I mentioned before, in order to effectively combat chronic conditions, we must address a host of factors. This requires active partnerships with tribal, federal, state, and private organizations. This is why the IHS has established many partnerships with private and public entities, including the ones you see here.

One important collaboration I would like to highlight is the IHS/Veterans Health Administration (VHA) partnership, which has resulted in several initiatives of value to Indian veterans. One outcome of this partnership has been the IHS/VHA website collaboration. This website contains important information specifically for Indian veterans, including key points of contact for IHS/VHA services, updated information on various programs that are offered, and answers to questions frequently asked by Indian veterans.

Other examples of IHS/VHA partnership initiatives include areas such as patient safety, health information technology, diabetes prevention, and behavioral health. There is also an important program called "Seamless Transition" that is currently underway to address issues for all veterans, including Indian veterans, who are returning from recent and current conflicts abroad.

Another important collaboration I would like to mention is a recent signing of an MOU between the IHS and the Mayo Clinic. The purpose of this MOU is to establish a formal collaborative relationship in support of efforts to reduce health burdens in American Indian and Alaska Native communities.

The IHS has also recently begun an important chronic care management collaboration with the prestigious Institute for Healthcare Improvement, or IHI. The IHI is a not-for-profit health care organization that provides a source of expertise and knowledge to improve health care worldwide. The IHI has a strategic partnership network that includes other organizations such as large hospitals and HMOs. Their mission is to improve healthcare by working with different hospital and health-based groups using evidence-based care.

They are specifically working with us on all the elements of implementing and evaluating the Chronic Care Management Initiative, which will help address some of the most pressing health care needs in Indian Country.

The IHS is also well into addressing another HHS priority, Pandemic Preparedness. HHS has developed a Pandemic Influenza Implementation Plan based on the actions outlined in the *White House Homeland Security Council's Implementation Plan for the National Strategy for Pandemic Influenza.*

In order to be as prepared as possible to deal with such a disaster, the IHS has developed an agency pandemic influenza plan. It supports the HHS Pandemic Influenza Plan, which, in turn, supports the National Strategy for Pandemic Influenza. It is included in the high-level HHS operational plan, which includes plans for all the HHS agencies.

To assist local pandemic influenza plans, the IHS planning efforts include a "workbook" that is designed specifically for use at the local levels to gather specific details. The detailed plan may also serve as a template for Tribes to use in developing tribal-specific plans.

The IHS Areas and Tribes are obviously committed to emergency planning and response. Each of the Areas has included pandemic influenza planning into their general emergency preparedness plans.

In fact, on November 9, 2006, the Navajo Area, in coordination with numerous Navajo Nation Agencies, held a highly successful mass flu vaccination exercise at 16 sites throughout Arizona and New Mexico. They vaccinated more than 23,600 community members in **one day**. Deputy Secretary Alex Azar participated in a live video teleconference with the Navajo Area Office at the start of the Exercise.

And the Nashville Area Office has developed the first Area Emergency Coordination Center that will not only serve as an area command center in emergencies, but also as a back-up operations center for the Agency. Developed under the guidance of the IHS Headquarters Emergency Services Program, the center will have multiple paths of redundant communication and information gathering capabilities. It will serve as a coordination point for emergencies in the Area and throughout IHS.

The Emergency Coordination Center also includes a fleet of five response trailers that are equipped with generators, satellite phones, and other equipment for rapid response to emergencies. These trailers are being deployed throughout the Area in strategic locations for

rapid response. They can be equipped with cots, blankets, medical supplies, generators for special needs patients and other equipment as needed.

The Albuquerque Area will eventually have a similar coordination and mobilization center as the IHS continues to expand its National Emergency Management Program for the benefit of Indian people.

The last HHS priority I want to mention briefly is Personalized Medicine. Personalized Medicine is the approach to managing a disease by using genomic or molecular analysis to achieve the optimal medical outcomes for that individual.

Recent advances in basic science have positioned us to harness new and increasingly affordable potential in medical and scientific technology. With clinical tools that are increasingly targeted to the individual, our health care system can give patients and providers the means to make more informed, personalized, and effective choices.

The goals of this initiative include:

- Accelerating the development of targeted therapeutics and prevention methods,
- Improving regulatory/oversight processes,
- Enhancing safety and effectiveness of health care,
- Translating expanded information for clinical and personal use, and
- Increasing value in health care through personalized approaches.

The Secretary's priorities for health obviously complement and support our goal of eliminating health disparities among American Indian and Alaska Native people. Together with the support of our sister agencies in HHS, the IHS is working in concert with Tribes and tribal organizations to further our mutual mission of raising the health status of Indian people to the highest level possible.

Now for a topic that is always on our minds . . . the IHS budget. The proposed budget authority for the IHS for fiscal year (FY) 2008 is $3.3 billion. Adding in funds from health insurance collections estimated at $700 million, designated diabetes appropriations of $150 million, and $6 million for staff quarters rental collections, increases the proposed budget for the IHS to $4.1 billion in program level spending.

The FY 2008 proposed budget includes new funds to help provide for the additional 30,000 people who are expected to seek services in FY 2008, cover increased pay costs for the federal and tribal employees who provide these services, and meet the rising cost of providing these services. Funds will go primarily to Clinical Services, but also to other IHS programs that are providing additional services and support functions.

A total of $13 million is included for the continuation of the construction of the Barrow Hospital, located in Barrow, Alaska. An additional $19 million is included to staff and operate one joint venture project at Muskogee, Oklahoma, and a Youth Regional Treatment Center located at Pyramid Lake, Nevada.

The request includes $227 million for mental health and substance abuse budgets – an increase of $25 million, or 12.3 percent, over the FY 2007 Continuing Resolution level. These funds will assist in addressing behavioral health issues in Indian communities. The suicide death rate for the American Indian and Alaska Native population is currently 60 percent greater than the national average, and data on methamphetamine use reveals a 30 percent increase between FY 2004 and FY 2005 alone in IHS patients seen for this growing problem.
In FY 2008, Tribes will control an estimated $1.8 billion, or approximately 54 percent, of the total IHS budget request under P.L. 93-638 compacts and contracts. To enable Tribes to develop the administrative infrastructure necessary to successfully manage these programs, the proposed budget includes a total of $272 million for **contract support costs**, an increase of $7 million over FY 2007 CR level.

The budget request includes:

- An additional $49 million, or about a 9% increase, for contract health service costs
- An additional $18 million, or approximately a 15% increase, to provide much needed dental health care services to the Indian population. Studies have shown that almost 32 percent of adult Indians have advanced periodontal disease, compared to only 12 percent of adults in the general U.S. population, and that over two-thirds of Indian adolescents have untreated tooth decay, compared to 24 percent of similar aged children in the general U.S. population.
- $150 million for diabetes prevention and treatment grants. Through the Special Diabetes Program for Indians, the IHS has awarded $850 million in grants over the past 6 years to over 300 Tribes and Indian organizations to support diabetes prevention and disease management at the local level.

The proposed budget does not request funding for the Urban Indian Health Program. The reasoning behind the budget cut for the program is that, unlike Indian people living in isolated rural areas, urban Indians can receive health care through a wide variety of federal, state, and local providers.

The Secretary's priorities for health obviously complement and support our goal of eliminating health disparities among American Indian and Alaska Native people. Together with the support of our sister agencies in HHS, the IHS is working in concert with Tribes and tribal organizations to further our mutual mission of raising the health status of Indian people to the highest level possible.

Another important part of achieving our goals for Indian health is the reauthorization of the Indian Health Care Improvement Act, the cornerstone of legal authority for the provision of health care to American Indians and Alaska Natives. I'm optimistic that the remaining issues concerning the Act can be resolved and that reauthorization could occur in the 110th Congress. There has been much progress over the past 6 years and I applaud your hard work and patience. We just celebrated the 30th anniversary of the Act and recognize its significance in elevating the health status of Indian people.

I thank each of you for your support of the IHS and HHS over the years as we addressed and overcame many health challenges, and for your continued support as we address future challenges on behalf of the health and welfare of American Indian and Alaska Native people.
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