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"An Update on National Issues"

by

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It is an honor to be here with you today on behalf of the Indian Health Service. I am pleased to have this opportunity to provide you with an update on key national issues that affect Indian health programs and American Indian and Alaska Native people.

I will start with a foundational policy issue – Tribal consultation. On November 14, 2003, in his Proclamation for American Indian Heritage Month, President Bush reaffirmed the government-to-government relationship that exists between the United States and American Indian and Alaska Native Tribes: by stating "The United States has a strong relationship with American Indian and Alaska Native entities. By continuing to work on a government-to-government basis with these Tribal governments, we are fostering greater understanding and promoting Tribal self-determination and self-governance." The Secretary and the Deputy Secretary are committed to visiting and consulting with Tribes for the purpose of expanding access to HHS programs. Deputy Secretary Claude Allen recently said "There is no substitute for meeting with people in their communities and to learn directly from them of their ways and the issues that they face, and how this Department and our programs impact them in their daily lives. It is why the Secretary and I travel regularly into Indian country and I urge each of the Health and Human Services Senior leaders to continue to do the same."

Regina Schofield, Director of the Office of Inter-Governmental Affairs is committed to the continued success of the Tribal/Federal partnership that has been established through annual Tribal consultation sessions with HHS.

The commitment of the Secretary to "One Department" when it comes to Tribal issues has resulted in many significant gains. Some of the more significant accomplishments of the past year include:

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Improved Tribal access to HHS Resources: Between FY 2001 and FY 2003 HHS resources that were provided to Tribes or expended for the benefit of Tribes increased $3.9 billion in 2001 to $4.4 billion in 2003. These gains came in both appropriated funding as well as increased Tribal access to non-earmarked funds and increases in discretionary set asides. This reflects an 11% increase in access to HHS funding for Tribes over a 2-year period.

Medicare Reform Act: The Secretary, the Administration, Tribal leaders, and IHS staff worked very hard to modernize Medicare so that American Indians and Alaska Natives would benefit. The President's leadership, Secretary Thompson's support, and Tribal advocacy ensured that the Act contained provisions that would benefit all Americans. An intent of this bipartisan agreement was clearly to ensure that Indian health programs are included in future regulations, policies, and programs that will be developed from this legislation.

Federal reimbursement of emergency health services furnished to undocumented aliens, the Temporary Drug Discount Card provision, and the Permanent Medicare Part D Drug Benefit beginning January 2006, are all responsive to Tribal legislative priorities identified for Centers for Medicare and Medicaid Services.

CMS Tribal Technical Advisory Group (TTAG): In response to Tribal leader comments at the regional Tribal consultation session supporting a CMS-TTAG, HHS established the TTAG requested by Tribal leaders. The first formal meeting was held on February 10, 2004 in Washington, D.C.

HHS Tribal/ State Relations Collaboration Project: HHS, the National Congress of American Indians and the American Public Human Services Association have entered into a collaborative project to work together on health and human services provided to Indian Tribes and Native organizations. This is in response to Tribal leader's comments at the regional Tribal consultation sessions requesting HHS to help bridge Tribal/state relations for HHS programs administered through states. HHS is forming a workgroup to focus on key areas of priorities identified by Tribes such as TANF, Child Welfare, and Information Systems.

First National Administration for Children and Families National Tribal Consultation Session On December 2, HHS held a first-ever Administration for Children and Families national Tribal consultation session in Phoenix Arizona. HHS has committed to maintaining an open dialogue on the issues raised and to work collaboratively with Tribes to address those issues.

HHS Restructuring: During regional consultation sessions, Tribes requested that IHS be exempted from the FTE reductions and the Human Resources consolidation associated with the HHS restructuring and consolidation efforts. In keeping with these recommendations IHS FTE targets for FY 2004 and 2005 have been revised to preclude reductions and the IHS HR function is not included in the HHS HR consolidation initiative.

All Inclusive Rate: During the regional consultation sessions, Tribes requested issuance of the 2003 all-inclusive rates. The rates were released on September 17, 2003 and were made retroactive to January 1, 2003.

Head Start Program: During the regional consultation sessions, Tribal leaders urged that the Head Start program not be moved to the Department of Education. In keeping with this recommendation the Head Start Program will remain in HHS.

HHS Revising Tribal Consultation Policy: In response to Tribal leader comments at the regional Tribal consultation sessions to improve Tribal consultation and inter-governmental relations, the Secretary is revising the existing HHS Tribal consultation policy and is involving Tribal leaders in this process. A workgroup is being formed to assist HHS in completing the revisions. Indian Health Service is working with Tribal leaders to revise our own Tribal consultation policy. This is an important Tribal initiative and I am committed to facilitating and completing this process over the next few months.

An example of efforts to expand access to HHS programs and access to additional funds for Indian health programs was the Secretary's action last March in sending to the Congress the HHS Title VI Self-Governance Feasibility Study. In that report the Secretary recommended that Self-Governance be expanded within HHS beyond the IHS to 11 other HHS programs within three other Agencies: the Substance Abuse and Mental Health Services Administration, the Administration on Aging, and the

Administration for Children and Families. The report also recommended that the Secretary retain the discretion to expand the Demonstration project to six other programs.

One important issue on which I have sought input from Tribes is the restructuring of the IHS Headquarters. Last month I presented my reorganization plan to the Secretary and gained his approval to move forward with implementation. The new structure will reflect current and emerging priorities of the Agency. The new structure will have three offices inside the Office of the Director and seven offices outside the Office of the Director. The three "interior" offices include the Office of Tribal Self-Governance, the Office of Tribal Programs and the Office of Urban Indian Health. I have responded to requests from Self-Governance Tribes to leave the Office of Tribal Self-Governance separate from the Office of Tribal Programs. I have also agreed to add 3 additional staff to the Office of Tribal Self-Governance to provide needed support to this function. Implementation of the restructuring has begun and should be complete by the end of the fiscal year.

Tribal consultation can have a very positive impact on the IHS budget. In February the President released his 2005 budget request for the Indian Health Service. The IHS budget request continues to reflect the commitment of the President and the Secretary to meeting the health needs of Indian people within the scope of national priorities. The President's request provides substantial increases to improve our Nation's security and win the War on Terror. It also increases funding for key priorities such as economic growth and job creation, education, and affordable health care – which are key factors that influence the health status of our people. At the same time, the national budget request restrains overall increases in spending in other areas of government, and in discretionary programs, to less than 1percent. Because of the programs and responsibilities of the Department that link to the President's priorities, the overall increase in discretionary spending for the Department was 1.2 percent. And because of the priorities of the President and the Secretary to eliminate health disparities and to improve the health status of American Indians and Alaska Natives – the overall proposed budget increase for the Indian Health Service (a discretionary program of the Department) for FY 2005 is 1.6 percent.

Some highlights of this increase are that the budget request contains an overall program increase of $98 million. If enacted, the 2005 budget request will enable the IHS to add up to 4 new epidemiology centers and increase support for the existing seven centers; add 30 new community health aides/practitioners to provide service in Alaska Native communities, raising the number of aides and practitioners to over 500; include funds to cover some of the mandatory federal pay costs and also provide Tribally run health programs comparable funds; provide an additional $18 million in contract health services; and to request $2 million to expand our Health Promotion and Disease Prevention Initiatives at the local community level.

Our request for FY 2005 will enable us to complete all construction projects currently underway. Within the overall program increase is $23 million for the staffing and operational costs expected to be incurred during the year for five outpatient facilities scheduled to open in FY 2005 at the Pinon and Westside health centers in Arizona, the Dulce health center in New Mexico, the Idabel facility in Oklahoma, and the Annette Island health center in Alaska. When fully operational, these facilities will have the capacity to double the number of primary care provider visits and expand services to these sites.

Also within the overall program increase is $103 million for sanitation facilities construction – an increase of $10 million, or 11percent over FY 2004, to provide safe water and waste disposal systems to an estimated 22,000 additional Indian homes.

The FY 05 budget request reflects an amount of $42 million available for the completion of construction of two outpatient facilities—at Red Mesa, AZ, and Sisseton, SD—and to provide necessary staff housing for the health facilities at Zuni, NM, and Wagner, SD.

When completed, these outpatient facilities will provide an additional 36,000 primary care provider visits, replace the 68-year-old Sisseton hospital, and bring 24-hour emergency care services to the Red Mesa area for the first time. The IHS will also be able to add 13 units of staff quarters and replace 16 house trailers built between 40-50 years ago. Improved availability of local housing will make it easier to recruit and retain health care professionals at these sites.

The President's 2005 budget request also provides $32 million for 34 urban Indian health organizations.

The total proposed budget authority for the IHS for FY 2005 is $3 billion. Adding in funds from health insurance collections estimated at nearly $600 million, designated diabetes appropriations of $150 million, and $6 million for staff quarters rental collections, this increases the proposed budget for the IHS to $3.7 billion in program spending.

The reauthorization of the Indian Health Care Improvement Act continues to be a legislative priority for the Tribes, the IHS, and the Department. Key features of the Act include the following:

- Local Priority-Setting - To better focus resources where they are most needed throughout Indian Country. The proposal provides Areas, service units and Tribes authority to set priorities in various parts of the legislation. This theme is highlighted throughout Title I of the proposal related to the recruitment and training of health professionals to meet the staffing needs of local Indian programs.
- Targeting of Specific Diseases - The proposal seeks to target for prevention and treatment certain diseases and health conditions in the American Indian/Alaska Native population such as tuberculosis, diabetes, cancer, heart diseases, and substance abuse.
- Health Facilities - The proposal authorizes innovative approaches to address deficiencies in health care facilities, as well as the availability of appropriate health care facilities.
- Modernizes and updates a number of Medicare/Medicaid/Social Security Act provisions to enhance opportunities for increased collections and expand access for Indian people to additional types of culturally appropriate health care.
- Integrates substance abuse, mental health and social services programs into a new title devoted to behavioral health in order to more effectively address prevention and treatment efforts.
- Enhances the role of Tribes in the development of health care policies and priorities to improve health status of their members.
- Provides new opportunities for program development for urban Indian health programs to meet the health care needs of Indian people living in urban areas of the country.

Both the House and the Senate have reauthorization bills that were recommended by Tribal and urban Indian leaders after consultation meetings with the IHS, during 1999, and which have since been refined by the National Steering Committee, working with staff members of various House and Senate committees. There have been multiple hearings, with the most recent occurring last October. The Senate Committee on Indian Affairs and the House Committee on Resources are the primary committees with jurisdiction over the reauthorization legislation. The Department has received a request for our views on this legislation from Congressman Richard Pombo, Chairman of the House Resources Committee, and we are in the process of preparing our response.

There are opportunities for additional resources or maximizing the effectiveness of our resources through partnerships. Within the HHS, examples of effective partnerships include Administration for Children and Families and their Head Start program; National Institutes of Health to establish Native American Research Centers for Health, and support for the Tribal Epidemiology Centers; Centers for Disease Control and Prevention and the National Institutes of Health on diabetes research, treatment, and prevention; and Substance Abuse and Mental Health Services Administration in the area of alcohol and substance abuse prevention. Also the Administration for Native Americans where IHS issued 20 grants for developing long-term care services for the elderly, and emergency preparedness training programs for Community Health Representatives.

All of these examples serve to underscore one theme; the Department wants to partner with Tribal Nations and Urban Indian health programs to eliminate health disparities among all Americans.
I consider their commitment to meet the health needs of Indian people to be unprecedented. I also consider their leadership to be responsible for helping others in the Department, from senior officials to support staff, to also embrace that vision.

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Partnerships between government and private industry are another way to meet the health needs of our people. For example, Indian youth suffer rates of illness and death in nearly all age groups that are significantly higher than the rates for US-all races. We can treat the illness and we can also explore ways to prevent the onset of illness. The IHS is partnering with *The National Congress of American Indians and the National Boys & Girls Clubs of America* to help reach their goal of increasing to 200 the number of Boys and Girls Clubs on Indian reservations by 2005. There are now approximately 170 Boys and Girls Clubs on Indian reservations. This partnership focuses on healthy lifestyles and helping keep youth in school. We also continue to support the *United National Indian Tribal Youth (UNITY)* organization that focuses on helping develop leadership qualities in our American Indian and Alaska Native youth and young adults. And we also support the *American Indian section of the Society for the Advancement of Chicanos and Native Americans into Science (SACNAS) program*. The SACNAS program provides more opportunities for our youth to enter college and post graduate science related vocations.

Another of our partnerships with the *CJ Foundation*, a national SIDS prevention organization, resulted in $200 thousand in grants going to two Tribal organizations in the Aberdeen and Bemidji Areas for SIDS prevention activities - $100,000 from the CJ Foundation and $100,000 from the Office of Minority Health in the Office of the Secretary/Office of Public Health Science. The result was Tribally produced information videos and various information handouts. The CJ Foundation and the IHS have collaborated to make this training and information material available throughout Indian Country.

Another partnership we have entered into is with the *NIKE Corporation*. We are collaborating on the promotion of healthy lifestyles and healthy choices for all American Indians and Alaska Natives. The MOU is a voluntary collaboration between business and government that aims to dramatically increase the amount of health information available in American Indian and Alaska Native communities. The goal of the MOU is to help those communities gain a better understanding of the importance of exercise at any age, particularly for those individuals with diabetes. One of the outcomes was that NIKE conducted a 3-day training course for Tribal members to certify them as physical fitness coordinators. The trainers are now expected to implement fitness and exercise programs for their communities. NIKE and the IHS hope to conduct similar training programs for additional regions of the country.

Another beneficial partnership is one that focuses on the health needs of American Indian and Alaska Native veterans. The Department of Veterans Affairs and the Department of Health and Human Services established a Memorandum of Understanding to improve the access and quality of health care for our nation's American Indian and Alaska Native veterans. We have long had partnerships with the VA in the regions where we operate together, but this MOU is intended to take a national approach to helping out both the veteran community and the Indian community. By the end of this year, each Veterans Health Administration network and facility manager will have met with their IHS counterparts and local Tribal leaders to develop a comprehensive plan, describing how they intend to meet the needs of the American Indian and Alaska Native veterans living in that region. This partnership is going to make a difference in the lives of so many people who truly deserve our care and our thanks.

One of the major information technology priorities for 2005 is the deployment of the IHS Electronic Health Record. The Electronic Health Record of the Resource and Patient Management System builds on the IHS' 20-year record of maintaining a database of patient-centered clinical information in the interest of improved quality of care and public health. The IHS Electronic Health Record is the product of the partnership with the Veterans Health Administration and collaboration with them with their Computerized Patient Record System. Development is lead by the Billings Area at the Crow and Wind River Service Units. The Electronic Health Record is being tested now at Tuba City, with further testing planned at five additional facilities. Our Electronic Health Record will help us address a number of critical issues, such as improved patient safety through direct provider order entry; risk reduction through improved and more legible documentation; protection of private health information through electronic security; and improved quality of care through clinical decision support, and improved cost recovery through better documentation of services provided. By the end of this year there will be 30 sites using it, and by 2008 all of our health facilities will use the Electronic Health Record.

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In addition, we have partnered with the Chickasaw, Choctaw and Gila River Tribes in the development of the Patient Accounts Management System. When completed in 2005, this will revolutionize our third party collections efforts at the facility level, improving the resources and service capability.

Our telemedicine initiative will expand our access to expert medical consultation services, as well as virtually eliminate geographic and transportation issues during the diagnostic and possibly the treatment phase of providing care. Telemedicine, as well as internet access, also addresses, the issue of professional isolation for some of our staff at more remote health facilities.

The goal of these and other IT investments is to improve health delivery, patient safety, and reduction of medical errors. The RPMS system has received high marks from the Department for its value in supporting the mission of the IHS, and the Electronic Health Record makes the RPMS database more accessible and useful to providers, nurses, and other users, allowing them both to retrieve and enter clinical information at the point of care.

The most effective and efficient use of our critical resources, partnerships, and improvements in technology, requires that we also have the best possible health professional and support staff to deliver services. There continues to be an increasing national shortage of health professionals. Within the Indian Health delivery system the need is growing as more staff members retire, as new facilities are constructed with their larger staffing needs, and as our patient population increases.

Some current health professional vacancy rates stand at 11 percent for Physicians, 24 percent for Dental, 11 percent for Nursing, and 7 percent for Pharmacy.

The Secretary and the Deputy Secretary, and their staff, have frequently visited Indian Country and they know of our challenges and shortages. To aid the agency, last July the Secretary designated that at least 275 of the 1000 new Commissioned Corps officers recruited would be assigned to the Indian Health Service before the end of September 2004. The cost of additional staff will be offset in part by the reduction of contracted staff services. As a larger Commissioned Corps force is developed, the length of deployments will be shortened as well as their frequency. For extended deployments, those absences may be covered by the revitalization of the Inactive Reserve Corps, a part of Secretary Thompson's Commissioned Corps Transformation Initiative. Since the Secretary began the transformation initiative in August 2001 – the Inactive Reserve has provided over 2,000 work days of coverage for the Indian Health Service – demonstrating the effectiveness of the system.

In addition to supporting the goal of expanding the Commissioned Corps, we expect some of our qualified recruits to select the Civil Service or Direct Hire personnel system, with the result that there will be growth in all categories.

There have been some changes in the senior leadership in our Areas, and there will be additional changes this year, that are important for you to be aware of. Recently Don Lee assumed the leadership of the Aberdeen Area. In February, Richie Grinnell assumed the Acting Director role for the Nashville Area. Dale Keel continues as the Acting Director of the Oklahoma City Area, while the search and selection process for permanently filling the position in both of these Area Offices continues.

In closing, I want to thank Tribal Leaders for your commitment and the many hours of time that you dedicate to consultation with the Department and the Agency on critical legislative and policy issues. Your efforts do make a difference and your voices are being heard at all levels of government. The Secretary and I will continue to advocate for greater Tribal access to more programs within HHS and your contributions benefit many people beyond your own Tribes. Thank you for the opportunity to speak with you today and to share the IHS goal of raising the health status of American Indians and Alaska Native people to the highest possible level.

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