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National Council of Clinical Directors, National Council of Chief Executive Officers, National Council of Chief Medical Officers, National Oral Health Council, National Council of Chief Consultants, National Council of Nurse Consultants

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"Meeting the Need – Partnerships and Prevention"
by

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Good Morning. I am honored to have this opportunity to speak to you all today and to offer you my thanks and sincere appreciation for all that you do for the individuals and communities we serve. We are entrusted with a tremendous responsibility for providing primary care and public health services throughout Indian country. Each of you plays an important role in meeting this challenge, and you have all made significant contributions in one way or another. Some of you contribute clinical skill and compassion in caring for patients, some of you have innovative ideas for providing better care, and still others are highly skilled at streamlining work and making things happen more efficiently and effectively. All of you have demonstrated your dedication and commitment to raising the health status of our people. Daily I think of each of you in my prayers. We touch the lives of people every day. I am thankful for the work that each one does and again would like to extend my sincere appreciation for a job well done. To all the National Councils represented here today: Clinical Directors, Chief Executive Officers, Nurse Consultants, Chief Medical Officers, Chief Consultants, and members of the National Oral Health Council, to our tribal and urban Indian health providers, and to all our employees who support us in the work that we do – thank you for the more than 10 million patient services you provide every year.

You are the most important factor in making this agency the outstanding health organization that it is today, and in making the Indian health system as effective as it can be. And we all know that there are challenges that we have overcome, challenges that we face today, and challenges that lie ahead. But we also know that challenges have never overshadowed our accomplishments. By any measure, you are outstanding.

We are in the business of health and we are a multi-billion dollar corporation. Our stockholders are the American Indian and Alaska Native people we serve, their tribal governments, Indian organizations that represent them, elected federal and government officials, and the taxpayers they represent. And our stockholders are also our families – because some receive the services we provide and others enjoy a quality of life made possible by being a part of this great agency.

The text is the basis of Dr. Grim's oral remarks at the annual National Councils of the Indian Health Service combined conference in San Diego, California, on Monday, February 23, 2004. It should be used with the understanding that some material may have been added or omitted during presentation.

To do our work requires resources. This month the President released his 2005 budget request for the Indian Health Service.

The budget request contains an $82 million increase for health services programs:

- to add up to 4 new epidemiology centers and increase support for the existing seven centers;
- to add 30 new community health aides/practitioners to provide service in Alaska Native communities, raising the number of aides and practitioners to 516;
- and funds to cover some of the mandatory federal pay costs and also provide tribally run health programs funds for comparable pay raises for their staffs.
- An additional $18 million was proposed for contract health services;
- and $2 million was requested to expand our Health Promotion and Disease Prevention Initiatives at the local community level.
- Across the board there were no reductions in health service programs.

The budget request for our facilities programs includes:

- an additional $23 million to add staffing for five outpatient facilities scheduled to open during FY 2005; 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 double the number of primary care provider visits that can be provided and bring new services to these sites.
- A request of $103 million for sanitation construction – an increase of $10 million, or 11%, over FY 2004, to provide safe water and waste disposal systems to Indian communities. Specifically, the President's budget request supports provision of safe water and waste disposal to an estimated 22,000 additional homes.
- A $42 million request 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, the 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 over 40-50 years ago. Having decent local housing will make it easier to recruit and retain health care professionals at these sites.

In addition to the increase requested for sanitation facilities, there was also an increase requested for facilities and environmental health support. Funding was maintained at the current level for maintenance and improvement and medical equipment. The budget request for facilities programs did not include funds for new facilities, which results in a $53 million decrease in the funding level for health care facilities construction.

In addition to providing funds for the provision of health care services to Indian people on or near reservations, the IHS 2005 budget request also provides $32 million to help support 34 urban Indian health organizations that provide service in cities with large numbers of Indian people.

The budget request for the Indian Health Service 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 1%.

In support of the President's key priorities, his proposal for the Department of Health and Human Services was for $580 billion or a 6% increase (of $32 billion) over fiscal year 2004 amounts. To give a little perspective to that amount, the HHS budget is the 6th largest budget in the world – only 5 countries have budgets higher than the HHS budget. The President also requested an increase in HHS discretionary budget authority of $819 million, or a 1.2% increase over fiscal year 2004.

The Indian Health Service overall budget request exceeded the average of 1.2% for HHS discretionary programs. The budget request is an increase of 1.6%, or $46 million over the fiscal year 2004 enacted budget level.

The total proposed budget authority for the IHS for FY 2005 is $3 billion. Adding in funds from health insurance collections estimated at $593 million, designated diabetes appropriations of $150 million, and $6 million for staff quarters rental collections, increases the proposed budget for the IHS to $3.7 billion in program level spending.

The increase will allow the continuation of quality health care services to Indian people by covering part of the increased costs caused by inflation and rising costs for

pharmaceutical and medical supplies and services. This increase reflects the impact of the Department's tribal budget consultations and a continuing Federal Government commitment to provide for the health of members of federally recognized tribes.

The President's budget request for the Indian Health Service must also be considered in the context of the national budget request and the proposed increases for the Department. Fortunately, we no longer exist in an era where the Indian Health Service is viewed by the Department as the sole source and agent for improving the health of Indian people – that responsibility has expanded to include all programs of the Department. Many of the increases in the budgets proposed for HHS programs also benefit Indian people. There are more than 320 programs within HHS with approximately 125 of them established for or directed toward Tribes and tribal organizations. And the Secretary reestablished the Intradepartmental Council for Native American Affairs as another way to build collaboration between all HHS programs so that American Indian, Alaska Native, and Native American health issues are addressed by the programs of the Department, and to expand the access and opportunities for Tribes to apply and receive program grants and contracts from the more than 320 programs of the Department.

An example of an increase or change elsewhere that will benefit Indian people, and also the Indian Health Service, is the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. The Secretary, the Administration, tribal leaders and IHS staff worked very hard to modernize Medicare so that more people, including American Indians and Alaska Natives, could benefit. The President's leadership, Secretary Thompson's support, and tribal advocacy ensured that the Act contained provisions that would benefit **all** Americans. It is particularly gratifying to note the specific references throughout the Act to the Indian Health Care Improvement Act and the numerous clarification statements referencing the IHS, tribal, and urban Indian health programs – a reflection of the importance of equity in proposed legislative language supported by the Department. 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.

Items in the Act that are particularly important to the Indian Health Service, tribal, and urban Indian health programs include:

- a provision that increases reimbursement rates for rural ambulance services, which will benefit numerous isolated tribal ambulance programs throughout Indian country;
- a provision authorizing reimbursement to IHS and tribal health facilities for emergency services provided to undocumented aliens. This is particularly important for IHS and tribal facilities in remote border locations of the U.S.;
- a provision that requires Medicare participating hospitals that provide inpatient hospital services to accept Medicare-like rates as payment in full when providing services to IHS beneficiaries referred for services;
- a 5-year authorization of reimbursement for increased Medicare Part B services provided by a hospital or ambulatory care clinic operated by the IHS or Tribe;
- changes in Critical Access Hospital reimbursement rates and other provisions made available to rural hospitals, which will assist tribal and IHS operated hospitals in responding to the escalating need for care by the increasing Indian elderly, youth, and infant population.
- And the payment rate to hospitals that furnish care to a disproportionate share of low-income and uninsured patients has been raised from 5.25 percent to 12 percent.

Provisions of the bill also support health promotion and disease prevention efforts. Beginning this year, all newly enrolled Medicare beneficiaries will be covered for an initial physical examination, electrocardiogram, and cardiovascular screen blood tests, and those at risk will be covered for a diabetes screening test. Before this Act, the IHS and Tribes were providing those services and now we can seek reimbursement for them – which will extend our health services dollars even further.

As you can see, meeting the health needs of our people goes beyond the IHS budget. There are opportunities for additional resources or maximizing the effectiveness of our resources through partnerships. Within the HHS, examples of effective partnerships include the Administration for Children and Families and their Head Start program, a partnership with the Administration for Native Americans so that the IHS could issue 20 grants for developing long-term care services for the elderly, and emergency preparedness training programs for Community Health Representatives. We also have ongoing partnerships with the National Institutes of Health to establish Native American Research Centers for Health, collaborations with the Centers for Disease Control and Prevention and the National Institutes of Health on diabetes research, treatment, and prevention, as well as partnerships with the Substance Abuse and Mental Health Administration in the area of alcohol and substance abuse prevention.

Another example of efforts to expand access to HHS programs and access to additional funds for Indian health programs was the intent of 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. On October 1st, Senators Campbell and Inouye introduced a bill based on the HHS feasibility study, to amend the Indian Self-Determination and Education Assistance Act to provide for a demonstration program – not to exceed 5 years to allow further self-governance by Indian Tribes. The Senate Committee on Indian Affairs intends to schedule a hearing on this bill; however, the congressional priorities for this election year are focused on developing and passing the spending bills for fiscal year 2005 and to adjourn to participate in campaign activities. Many other legislative efforts may be postponed until the next session of congress begins.

There are additional examples – but they all serve to underscore one theme; the Department wants to partner with Tribes 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. And I consider their leadership to be responsible for helping others in the Department, from senior officials to support staff, to also embrace that vision.

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 Boys & Girls Clubs of America to help them 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 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 to take a more 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. To learn more about the IHS and VA partnership, please attend the presentation tomorrow. This partnership is going to make a difference in the lives of so many people who truly deserve our care and our thanks.

Last year at this meeting I announced my intention to re-commit the energy of the Indian Health Service to Health Promotion and Disease Prevention. This initiative can have dramatic effects on quality of life for our patients, their families, and the communities we serve. It is another pathway toward eliminating the health disparities experienced by our people compared to the rest of America. In most cases, being healthy is a choice. Healthy behaviors can reduce the occurrence of serious illness or injury, and the need for health services. And, we need to have programs in place to help people who want to make healthy choices make them and stick with them.

Access to health care is not the greatest barrier to being healthy. That is only 10% of the problem. The greatest barrier, more than 50%, is a person's behavior. The IHS Office of Public Health will establish a number of initiatives to address this ever-increasing area of need, particularly in the areas of suicide prevention, SIDS, chronic depression, alcohol and substance abuse, and nutrition. This initiative has already established three goals for 2004:

- The IHS will host a national Indian Wellness Summit this September to coincide with the grand opening of the Smithsonian's Museum of the American Indian on the mall in Washington, D.C. The focus of the conference, uniting our efforts with those of our public and private partners, is to bring together information regarding successful prevention activities at the local, Area, regional, and national levels.
- The IHS will implement a Healthy Native Communities Fellowship Program. This will be a 4-week training program for approximately 50 people. The goal is to develop the capacity to provide consultation and partnership with local tribal communities to develop health promotion programs.
- This year we want to provide the resources and encouragement for a *Just Move It* national

campaign. This campaign is to support visible local physical activity events, programs, and activities.

Another area of concern relates to the serious problem of obesity in Indian country. This past weekend I met with a multidisciplinary group of IHS and tribal professionals to explore options for beginning to address nutritional issues in our patients. It was sobering to learn that only 15 percent of our patients have access to professional nutrition care, and only one in three Indian patients with diabetes sees a registered dietician. As a result of these discussions I will be creating an I/T/U Obesity Coordinating Committee who will report to the HP/DP Health Policy Advisory Committee. I am also considering an IHS-wide "Stop the Pop" campaign, similar to our prior successful initiative that removed cigarette vending machines from our facilities.

Another of our partnerships with the CJ Foundation, a national SIDS prevention organization, resulted in $200 thousand in grants going to two Tribes in the Aberdeen Area for SIDS prevention activities. The result was two tribally produced information videos and various information handouts. The CJ Foundation and the IHS are collaborating now on making these training and information material available throughout Indian Country.

Another partnership we have recently 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 is that NIKE is conducting a 3-day training course for tribal members to certify them as physical fitness coordinators. The trainers are then expected to return to their communities and implement fitness and exercise programs for their communities. NIKE and the IHS hope to conduct similar training programs for additional regions of the country.

Part of health promotion and disease prevention is improving the health literacy of our communities. Health literacy is another integral part of the factors influencing health status – literacy impacts health knowledge, health status, and access to health services – it even has an influence on compliance with health treatment. Health literacy is the ability of individuals to obtain, interpret, and understand basic health information and services and to use such information and services in ways that enhance health. Studies show that people of all ages, races, incomes, and education levels are challenged by low health literacy. Research also indicates a link between poverty and low health literacy rates. And approximately 32 percent of all Indian people fall below the poverty level.

The IHS reemphasized health literacy in 1995 with the development of the Patient Education Project. The Project continues to provide education and training to service units of the IHS on the importance of literacy, communication, and education to our health providers at all levels. And the results? The number of documented educational encounters increased from 452,000 in 2001 to over 1.6 million by August of 2003. In addition, by developing health factors on the Patient Care Component of the agencies' Resource and Patient Management System, we are now able to track behavior changes that result from education, and we are able to demonstrate learning preferences, barriers to learning, and readiness to learn at each and every patient visit. This is a tool that can make our efforts in improving health education and literacy more effective and increase the success of our health promotion and disease prevention initiative. I encourage you to use the information available through RPMS to develop local strategies for achieving the President's goal to eliminate health disparities.

Improvements in health delivery, patient safety, and reduction in medical errors are also being enhanced through investments in computer technology and information systems. One of the major initiatives and top Information Technology priorities of 2004 is the deployment of the IHS Electronic Health Record. This and other IT initiatives will improve our telemedicine capacity and 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 Electronic Health Record builds on the IHS's 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 based on the Veterans Health Administration's computerized medical record, and was pioneered in IHS by the Billings Area at the Crow and Wind River Service Units. 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. Our Electronic Health Record will help us address a number of critical issues:

- improved patient safety through direct provider order entry
- risk reduction through improved and more legible documentation

- protection of private health information through electronic security
- improved quality of care through clinical decision support, and
- improved cost recovery through better documentation of services provided.

The Electronic Health Record is being tested now at Tuba City, with further testing planned at five additional facilities. By the end of this year there will be 20 sites using it, and by 2008 all of our health facilities will use the Electronic Health Record. Planning for your own implementation should start now – and that can begin by attending one of the EHR presentations scheduled during this conference.

Not to diminish the importance of resources, partnerships, and improvements in technology to help us achieve our mission, but if we do not have the health professional and support staff to deliver services or use the technology, every other factor becomes academic. There continues to be a growing national shortage of health professionals. Within Indian health, the need is growing as current staff members retire, as new facilities are constructed with their larger staffing needs, and as our patient population increases through better health status. Some current health professional vacancy rates stand at:

- Physicians 10%
- Dental 24%
- Nursing 11%
- Pharmacy 11%

The Secretary and the Deputy Secretary and their staffs have frequently visited Indian Country and they know of our challenges and shortages. To aid the agency, the Secretary designated last July that at least 275 of the 1000 new Commissioned Corps members recruited as part of the President's and Secretary's goal to expand the size of the Commissioned Corps officers would be assigned to the Indian Health Service before the end of September of this year. The cost of additional staff can be covered by the reduction of contracted staff services and future budget requests. And as a larger Commissioned Corps force is developed, the length of deployments will be shortened as well as the frequency. And for extended deployments, those absences can also 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 2,154 work days of coverage for the Indian Health Service – you have proven that the system of Inactive Reserve filling temporary absences or priorities works.

I encourage all of you to become part of the recruitment process to fill our almost 800 health professional vacancies – 425 in the nursing field alone. In addition to supporting the goal of expanding the Commissioned Corps, we expect that the more qualified recruits we have some will select the Commission Corps and others will select the Civil Service or Direct Hire personnel system, with the result that there will be growth in all categories. Helping our recruitment and retention efforts is a new Supplemental Loan Repayment Program. We have a $17 million appropriation, with a $27 million spending authority, to guarantee the supplemental loan repayment to attract applicants. If the money is not used by September 15th, it will be returned so you can obligate it again. My expectation is that the entire appropriated amount and other funds will be used – our vacancy rates are too critical not to exhaust our resources to meet the need. And we have an increase of $24 thousand and $30 thousand for Incentive Specialty Pay for some hardship locations. And we can now offer a $30 thousand accession bonus and specialty pay for new pharmacists.

You all have consistently done a magnificent job under challenging circumstances, and we need to get you some help!

This is so important that I have my staff here, among them Admiral Bob Harry, and he has recruiters staffing a booth in the exhibit hall during the conference – not necessarily to recruit but to answer your questions about how you can help this recruitment process. The more you can explain the options for working with the Indian Health Service to your friends, colleagues, and those you mentor, or meet at conferences and conventions, the fewer vacancies we will have.

There have been some changes in the leadership in our Areas, and there will be some changes this year, that are important for you to know. Recently Don Lee assumed the leadership of the Aberdeen Area. This month Richie Grinnell assumed the Acting Director role for the Nashville Area following the retirement of Mike Tiger. The consultation process has begun with the Nashville Area Tribes and we anticipate the announcement for that vacancy will be released next month. Dale Keel continues as the Acting Director of the Oklahoma City Area, while the search and selection process for permanently filling the position continues.

This year there will also be changes that will begin at Headquarters. These changes are intended to improve our support of those in the field, our responses to the Department and Congress, and achieve the management and performance goals of the President and the Secretary. The changes are ambitious and are in their final stages before they are announced. However, the changes will not disrupt our support of the field or introduce any new reporting or operational procedures – except possibly a change in title or organizational responsibility for the same services and assistance Headquarters has provided in the past. A new management team and structure will be established in the Office of the Director and the functions of the Office of Public Health and the Office of

Management Support will be restructured into seven major offices. There will be senior level positions added to manage this broader organization. The new structure will reflect current and emerging priorities of the Agency but will not have any more organizational components than currently exist. All employees will be retained and there will be some slight growth in staff in support of agency priorities and renewed emphasis.

Where do we go from here? Providing quality, safe, effective, and acceptable comprehensive health care for American Indians and Alaska Natives remains a management priority. In January 2003, the IHS Strategic Plan was released. It was developed to serve as a critical road map to follow over the next decade. Our mission of raising the health status of American Indian and Alaska Native people is supported by the four goals of the strategic plan: building healthy communities; achieving parity in access to essential health care services by 2010; providing compassionate, quality health care; and Embracing Innovation. Everything we do must support one of the goals – or you need to ask why it is being done. If we are not working toward achieving one of the outcomes specified for the goal, then we are not advancing the mission of the agency. Our resources need to be applied to meet the needs of the people we serve.

There are so many opportunities for making a difference and creating additional opportunities. We must never be satisfied with past successes but build upon them. That, to me, is why it is so exciting working for Indian health – working with tribal and urban programs to maximize our resources, working with great leaders, and working with the employees of the Indian Health Service and our tribal and urban Indian partners as we do our very best to help our people.

As we face the challenges and opportunities ahead, I am confident that we can forge a better, brighter, and healthier future for American Indian and Alaska Native people.

Thank you.

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