Indian Health Service

Northwest Portland Area Indian Health Board/ California Rural Indian Health Board Meeting

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"IHS Update"

by

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Good afternoon. It is a pleasure to be here today with all of you at this very nice luncheon, and to have the opportunity to update you on some of the health and administrative initiatives that are underway in the Indian Health Service (IHS).

I always enjoy the opportunity to meet with the Indian Health Boards, since you are one of our most important partners in ensuring that high quality, culturally appropriate health care services are available to all American Indian and Alaska Native people. I am sure I speak for all of us in Indian health when I say that I am very appreciative of the support and advocacy role that the California Rural Indian Health Board and the Northwest Portland Area Indian Health Board, and indeed all the Indian Health Boards, play in Indian health issues. The work you do, in partnership with the IHS and other Indian health organizations, is helping to make significant improvements in the quality of life and health for American Indian and Alaska Native people and their communities.

Let me begin by introducing some IHS management and health initiatives that I believe will have a significant impact on Indian health in the years to come.

The text is the basis of Dr. Grim's oral remarks at the meeting of the CRIHB/NPAIHB on July 19, 2005. It should be used with the understanding that some material may have been added or omitted during the presentation.

It has become obvious to all of us in Indian health care that the health disparities for American Indians and Alaska Natives cannot be addressed solely through the provision of health care services. The IHS public health functions that were effective in eliminating certain infectious diseases, improving maternal and child health, and increasing access to clean water and sanitation are not as effective in addressing health problems that are behavioral in nature, which are the primary factors in the current mortality rates.

The prevalence of diabetes, in particular, has reached epidemic proportions in Indian communities. It has become evident that changing behaviors and lifestyles and promoting good health and a healthy environment are critical in preventing disease and improving the health of American Indians and Alaska Natives.

That is why I have established these three main focus areas, or Director's initiatives, to address these issues:

Behavioral Health
Health Promotion and Disease Prevention, and
Chronic Disease Management

The IHS and Tribes are working closely together on these focus areas to help achieve significant improvements in health that are critical to the future of Indian communities.

These focus areas are being targeted at health outcomes that will have a beneficial impact, demonstrate measurable achievements, and attempt to change basic practices and procedures as well as unhealthy behaviors.

Behavioral Health may be the underlying thread through the above initiatives. It has become obvious to all of us in the Indian health system that addressing behavioral health and mental health issues in our communities is crucial. Often times in our programs in the field there is a separation between our behavioral health programs and the clinical staff, and we are looking at ways to meld the two. Our providers in the hospital and clinic settings need to be adequately prepared to deal with behavioral health, mental health, and substance abuse issues. How to better prepare our clinical staff is one of the keys to this initiative.

We also need to focus on screening and primary prevention in mental health. The recent shooting incident at Red Lake Reservation has been a tragic reminder to all of us in Indian country, as well as to the Nation as a whole, of the importance of increasing our efforts to effectively address mental health issues in our youth.

In particular, the high level of mental illness and suicide rates among American Indian and Alaska Native youth are of paramount concern to the Indian health system and Indian communities. Not only is suicide the third leading cause of death for Indian youth ages 15-19, but the tragic truth is that the rates of suicide among Indian youth are the highest of any racial group in the nation.

These are statistics that hit at the heart of the tragic effects of mental illness on the rates of disease and mortality in Indian communities. We know that mental health issues such as depression can make chronic disease management more difficult and less effective. In order to adequately address mental health issues, Tribes and the IHS are working in concert with federal, state, public, and private organizations to address all the contributing factors to mental illness, such as poverty, lack of educational opportunities, domestic violence, social isolation, and perhaps most devastating of all, low expectations and the hopelessness of our youth.

It is also vital that we continue to promote and develop community resources and involvement, in order to target health promotion efforts at the local level. Community health outreach will be at the heart of the Health Promotion/Disease Prevention (HP/DP) initiative.

The IHS and Tribes have taken a number of actions aimed at health promotion and disease prevention, which include:

- An Indian Health Summit held in D.C. last September;
- The establishment of a HP/DP Policy Advisory Committee;
- The appointment of Area HP/DP coordinators;
- The Healthy Native Communities Fellowship; and
- Various partnerships to promote healthy lifestyles, such as
    - Working with *the National Boys & Girls Clubs of America* to help reach their goal of increasing the number of Boys and Girls Clubs on Indian reservations to 200 by 2005. There are now approximately 185 Boys and Girls Clubs on Indian reservations;
    - Working with the *NIKE Corporation* to focus on the promotion of healthy lifestyles; and
    - Participation in the "Just Move It Campaign" with a goal of getting one million Native people *up and moving*.

In Indian country, and across the nation, we are struggling with chronic diseases and conditions, such as diabetes, obesity, cardiovascular disease, cancer, and injuries. We must address not only the primary prevention of these chronic diseases if we are to critically influence the future health of our communities, but we must look at better chronic disease management in our clinical care of our patients.

A multidisciplinary team headed by Dr. Kelly Acton has been tasked with looking at Chronic Disease models that would best meet our needs and could be adapted to our programs. With the adoption of a model for managing chronic diseases in a more effective and efficient manner, we believe we will see, over time, an improvement in our years of potential life lost due to chronic disease.

Within the IHS, our model of care for chronic disease will prioritize health promotion and disease prevention, behavioral health, and chronic disease management. This model is being developed based on the "chronic care model" of clinically supported patient self-management and empowerment. The Indian health system model will include new tools for prevention and treatment, tools that include improved applications of standards of care, community and organizational partnerships, and newer technologies and approaches to care, such as telehealth and case management.

One management issue that I will take a moment to update you on is the 2007 Office of Management and Budget (OMB) program assessment rating tool, or PART, which the IHS and OMB began working on in March. This year the OMB selected tribally-operated health programs as the subject of the PART assessment. Tribally operated health programs manage approximately $1.5 billion worth of appropriated resources that are awarded pursuant to the Indian Self-Determination and Education Assistance Act, Public Law 93-638 (P.L. 638), each year. This includes funding awarded under both Title I contracts and Title V compacts to over 330 Tribes and Tribal organizations. The PART evaluation focused more on the tribal management of these programs than on the IHS's management of P.L. 638.

The primary offices within the IHS that are involved in completing this year's PART assessment are the Office of Tribal Programs, the Office of Tribal Self-Governance, the Office of Clinical and Preventive Health, and the Division of Finance, as well as staff from the immediate Office of the Director. Several Tribal representatives also participated by providing invaluable feedback and guidance throughout the process. Among those representatives were Mr. James Crouch from the California Rural Indian Health Board and Mr. Jim Roberts from the Northwest Portland Area Indian Health Board.

The OMB PART assessment consists of four sections covering "Program Purpose and Design," "Strategic Planning," "Program Management," and "Program Results and Accountability." Specific questions related to these four categories must be responded to, and all answers must be supported with documentation and other evidence. Throughout April, May, and June, the PART team worked to gather data and other related evidence to respond to the questions posed under the PART assessment. Then the OMB provided feedback based on preliminary answers submitted to them. The challenge to our PART Team was to educate the OMB concerning the unique authorities under P.L. 638, and the intricacies of the Federal Government's government-to-government relationship with Tribes.

On June 30th our final responses to the PART assessment were provided to the OMB. The OMB will complete their initial evaluation and provide the IHS with their preliminary scoring of the program in early August. The IHS will then be given an opportunity to appeal the scoring on particular questions before OMB assigns a final score. This appeal will be due by August 12th. After evaluating the IHS appeal, the OMB Appeals Board will render its final decisions and scores in early September. The OMB assigns overall scores for the PART on a scale of 0 to 100; rating programs as effective, moderately effective, adequate, and ineffective.

However, the final score will not be released until February 2006, when it is distributed with the 2007 President's budget. The process, including communication related to specific questions, responses, and scoring, has now been embargoed under the OMB PART rules, so we will not be at liberty to discuss specifics concerning the PART assessment from here on out.

Of course, in order to implement initiatives and address health disparities, we must have adequate resources. The federal appropriation for the IHS is therefore of interest to all of us in Indian health.

The President's FY 2006 Budget request for the Indian Health Service is a clear indicator that your priorities as communicated through the consultation processes are being heard. The FY 2006 budget request focuses on current services needs, which have been your highest priority for the past several years.

During the 2005 Regional Tribal Consultation Sessions and the Department of Health and Human Services Budget Consultation Session, Tribes were very clear about the need for additional resources as well as their budget priorities. Those priorities included full pay cost increases, increases to address population growth, and contract health services. The Department responded and worked very closely with others in the Administration to include those priorities in the 2006 President's Budget Request. We all agree that additional needs remain to be addressed; however, in this extremely difficult budget environment, the IHS is recommended for an increase of $63 million. This is in sharp contrast to a reduction in excess of $500 million for the Centers for Disease Control and Prevention, a reduction in excess of $400 million for the Administration for Children and Families, and a reduction in excess of $800 million for Health Resources and Services Administration, to name but a few.

The proposed IHS budget authority for FY 2006 is $3 billion. This is a $63 million, or 2.11%, increase over the FY 2005 enacted budget level. Adding in funds from health insurance collections estimated at $642 million, designated diabetes appropriations of $150 million, and $6 million for staff quarters rental collections, increases the proposed budget for the IHS to $3.8 billion in program level spending.

Another issue of concern to all of us in Indian country is the status of the reauthorization of the Indian Health Care Improvement Act (IHCIA)

During the second session of the 108th Congress, the IHS and the Department worked with the congressional committees to resolve areas of concern with the pending legislative proposals. Time ran out before a bill could be finalized that would address the Department's concerns.

In the 109th Congress we have a new Chairman of the Senate Committee on Indian Affairs, Senator John McCain of Arizona, and a new Vice-Chairman, Senator Byron Dorgan of North Dakota. I have met with Senator McCain and he understands the importance of passage of a reauthorization bill, and considers it a priority for the committee.

On April 13th, the Senate Committee on Indian Affairs held a hearing on the status of health among American Indians and Alaska Natives, and I presented testimony on behalf of the IHS and the Department. The witnesses included the National Steering Committee on the Reauthorization of the Indian Health Care Improvement Act, the National Indian Health Board, the National Council on Urban Indian Health, and the Navajo Nation. Based on this hearing, Senator McCain decided on what provisions to include in a bill to reauthorize the IHCIA.

Senator John McCain and Senator Byron Dorgan, re-introduced the IHCIA reauthorization on May 17th as S. 1057. The first Senate hearing on the bill was held on July 14. It was held jointly by the Senate Indian Affairs Committee and the Health, Education, Labor, and Pensions Committee. I testified at the hearing on the importance of reauthorizing the IHCIA. We also discussed some of the ways the bill could be improved to better address concerns raised by the Administration.

We understand that there may be a second Senate Indian Affairs Committee hearing, perhaps in September, of this year. The committee is assuring everyone that moving this bill forward for Senate passage and to the House for its consideration is a top priority.

We are committed to working with the Congress to achieve passage of this very important bill.

In July of 1955, the Indian Health Service was officially transferred from the Bureau of Indian Affairs to the Public Health Service, making FY 2005 the 50th anniversary year for the Indian Health Service, an important milestone in the history of the Indian Health Service.

In FY 2005 we have embarked on a special year of celebrations and special events. A 50th Anniversary reference library of historical documents and photographs is being compiled, which will be available on the IHS website. Also, we are publishing a special edition of the "Gold Book," which was first published in 1957 as a comprehensive report to Congress on the status of the health of American Indians and Alaska Natives around the time of the transfer. The new version will show the progress made in the last 50 years, and our plans for facing the challenges of the next 50 years.

I hope all of you here will join us as we recognize this important date in the history of the Indian Health Service.

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In closing, I would like to thank all of you for the ongoing work you do on behalf of the health and wellness of American Indian and Alaska Native people. The improvements we have made and the milestones we have reached so far in Indian health would not have been possible without your help, and I look forward to continuing our partnership efforts far into the future.

Thank you.

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