Indian Health Service

2005 Self-Governance Fall Conference

"HHS/IHS Keynote Address"

by

Charles W. Grim, D.D.S., M.H.S.A.
Assistant Surgeon General
Director, Indian Health Service
October 13, 2005

Thank you for the warm welcome, which is much appreciated. I am impressed with the Self-Governance conference program for this week and how it reflects the innovative and steady progress at the Tribal level in delivering health services to American Indians and Alaska Natives. As always, the Indian Health Service stands ready to assist Tribes and Alaska Native communities in making their Self-Governance efforts as successful as possible. We all have a major professional and personal stake in improving the health of our Native communities.

I would like to note this past July 8th marked the 35th anniversary of President Richard Nixon's special message to the Congress of the United States that laid the foundation for the Indian Self-Determination and Education Assistance Act. As a result of this Act, new policies adopted by the U.S. government have had far-reaching benefits for Indian Country. The policies of Indian self-determination, without termination, continue to evolve and strengthen Tribal governments throughout the country as they assume a stronger role in the design and administration of federal programs in the IHS and the Interior Department for the benefit of their own citizens.

Today I'd like to present an update on many important HHS and IHS developments including the budget, legislative matters, OMB's PART for Tribal programs, and the Medicaid Commission.

Secretary Mike Leavitt and Deputy Secretary Alex Azar asked me to extend their greetings to you and to express their regrets that they cannot attend today. Secretary Leavitt is

The text is the basis of Dr. Grim's oral remarks at the 2005 Self-Governance Fall Conference on October 13, 2005. It should be used with the understanding that some material may have been added or omitted during the presentation.

currently traveling abroad to meet with national leaders and health and agriculture officials of Southeast Asian nations to discuss the Avian influenza threats and protection measures. Let me quote Secretary Leavitt directly on this critical topic:

> *I have a personal breakthrough priority. Tomorrow, I will be traveling to East Asia to the areas most impacted by the avian influenza -- something more commonly referred to as the bird flu, or the H5N1 virus. The virus is spreading rapidly among poultry -- 140 million have already died. To date, more than 115 humans have been infected and half of them have died. We have no pre-existing immunity to this deadly virus. Let me restate that: no pre-existing immunity. NONE. . . . As Secretary of Health and Human Services I feel an urgent need for improved bio-surveillance in this country to help protect us from both pandemics and bioterrorism. Preparation for these threats must become a national priority.*

I would also like to present a quick overview of Secretary Leavitt's 500-Day Plan for the Department of Health and Human Services. The key initiatives are to:

- Transform the Healthcare System
- Modernize Medicare and Medicaid
- Advance Medical Research
- Secure the Homeland
- Protect Life, Family, and Human Dignity
- Improve the Human Condition Around the World

Concerning the bill to reauthorize the Indian Health Care Improvement Act, the Senate Committee on Indian Affairs staff has advised us that the mark-up on this bill has been scheduled for October 20. The Department does not yet have a formal position on S. 1057. The Department and the IHS continue to work with the Senate Committee on Indian Affairs to resolve areas of differences that exist with S. 1057 as drafted. I'd like to thank the National Steering Committee for their work on the reauthorization of the IHCIA as well as the National Indian Health Board and others. I know the events related to Hurricanes have delayed work on the reauthorization efforts, but I remain optimistic that a reauthorization bill can be enacted that is supported by the Tribes.

The FY 2006 Budget included approximately $3.1 billion in budget authority for the Indian Health Service. This is an increase of $91 million or 3 percent over the FY 2005 appropriation. The increases are for items that will help IHS, Tribal, and Urban programs maintain their base programs and the health care services provided, which correlate directly to the highest Tribal priorities for the FY 2006 budget.

Nearly 90 percent of the $3.1 billion has already been allocated to the Areas, including their recurring base funding and the pay increase, the funding for new staffing for new facilities, and the population growth increase. Once the funds are distributed to the Areas, they have some flexibility in determining allocations within each Area, i.e., most Areas have an agreement with their Tribes on how to allocate these funds within the Area, so if distributions haven't been made within the Area yet, they should be done very soon. The allocations of the remaining increases are at Headquarters pending additional information, but we are committed

to making a determination and allocating the funds as quickly as possible. Federal budget concerns will very likely bring a second round of rescissions, but details are not known at this time.

Regarding the FY 2007 budget, the Department's budget request is currently under review at the Office of Management and Budget. The President's budget request for FY 2007 will be released on February 7, 2006. From the budget formulation consultation process, the Tribal priorities were very similar to last years, i.e., funding of current services items remains as the top priority. Programmatically, the Tribal priorities focus on chronic diseases, behavioral health, and health promotion/disease prevention, which of course mirror the initiatives recently implemented within IHS. It's clear from the FY 2006 budget that a unified message across Indian country has an impact—I am hopeful a cohesive focus on these priorities will mean improved health for American Indian and Alaska Native people.

In July 2005 the Facilities Appropriation Advisory Board made 12 recommendations to the Director of OEHE on implementation of the revised Priority System based on the comments received during Tribal Consultation. The recommendations included advice for dealing with criteria weighting, projects currently in the planning pipeline, scoring of Tribal innovations, and other issues.

I have been briefed on these recommendations and will make a decision soon on which recommendations to include, in full or in part. Where recommendations cannot be incorporated into the Priority System, we will look for other ways they may be addressed to achieve a desirable outcome for the Tribes and the Federal Government. Realistically, in order to be effective, the priority system must be consistent with and an acceptable part of the budget process. I appreciate all the hard work that has gone into revising the current priority system for health care facilities construction, and hope to see positive results.

I know that many of you have a strong interest in Medicare Part D issues. 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. Therefore, Tribes may still be able to pay such premiums out of other sources of Tribal revenue. The IHS staff will be working 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. Information about these agreements will be posted as soon as it is available on the IHS website at www.pharmacyissues.ihs.gov. Click on "Medicare and Medicaid."

Moving on to the IHS Tribal Consultation Policy, for the last year the IHS and Tribal representatives have been involved in a process to revise and improve the IHS Tribal Consultation Policy. I am pleased to announce that the Tribal Consultation Policy Workgroup has completed its work and has forwarded to me a proposed new consultation policy for adoption by the IHS. I anticipate signing the new IHS Tribal Consultation Policy this month.

Representatives of several Self-Governance Tribes played an important leadership role in the policy revision process. We appreciate the work of President Pearl Capoeman-Baller of Quinault, Chairman Ron Allen of the Jamestown S'kallam Tribe, and Mickey Peercy from the Choctaw Nation of Oklahoma.

Since June 2005, the IHS has received claims from Tribes filed under the Contract Disputes Act alleging they are entitled by statute and the terms of their funding agreements to

additional contract support costs. To address these claims in a timely and consistent manner, the IHS has established a new Headquarters review team, the Contract Disputes Act Review Group, which is chaired by the Deputy Director of Indian Health Policy. Members include representatives of the Division of Regulatory and Legal Affairs, Office of Tribal Self-Governance, and the Office of Tribal Programs. The Review Group will review calculations of CDA claims concerning CSC and make recommendations to me for all Title V claims and clear the responses of Area Contracting Officers for Title I claims.

The first meeting of the Direct Service Tribes Advisory Committee is scheduled for November 15 - 17 in Albuquerque, with formulation and determination of its priorities as the primary agenda item. The charter for this new committee was signed on April 26, 2005, during the 2nd Annual DST Conference in Albuquerque. It authorized the formation of a nine-member committee of Tribal Leaders to provide advocacy and policy recommendations relative to the direct service Tribes to myself as the Director of the Indian Health Service.

The nine-member advisory committee represents the IHS direct service Areas of Aberdeen, Albuquerque, Bemidji, Billings, Navajo, Oklahoma, Phoenix, Portland, and Tucson. The committee membership for the DSTAC has not yet been fully appointed. In July Ms. Rae Jones, an enrolled member of the Seneca Nation, was selected as the Associate Director for Direct Services in the IHS Office of Tribal Programs. Ms. Jones will coordinate our effort for improvement in health services for the Direct Service Tribes who now have a seat at the table along with the Tribal Self Governance Advisory Committee in providing recommendations to me as the Director of the Indian Health Service.

I encourage the TSGAC and the DSTAC staff and members to develop and maintain communication and eventually perhaps collaboration on issues pertinent to health on behalf of all Indian people.

I'd like to take a moment to commend the extraordinary partnership effort demonstrated by the Tribes and IHS staff members and departments in responding to the terrible aftermath of Hurricanes Katrina and Rita. Our legendary Indian generosity has come to the fore once again to help Tribal and non-Tribal people in need. More than 300 Indian Health Service Commissioned Officers were deployed to various assignments in the Gulf Region to assist with medical, environmental, and other needs following the devastation of Hurricane Katrina and Hurricane Rita. Overall, approximately 500 IHS officers have been a part of the deployment effort.

As many of you know, the OMB has developed the Program Assessment Rating Tool known as PART to assess and improve program performance so that the Federal government can achieve better results. A PART review helps identify a program's strengths and weaknesses to inform funding and management decisions aimed at making the programs more effective. All factors of a program's performance are reviewed including purpose and design; strategic planning; program management; and program results and accountability. Ratings under PART are scored as adequate at 50 to 69; as moderately effective at 70-84; and as effective at 85 to 100.

I am very proud to say that 64 percent of Tribes report GPRA data. Challenges facing Tribally Operated Health Programs include continuing to meet or exceed annual and long-term performance measures; increasing the number of locations that report GPRA data to the IHS;

and increasing the number of facilities that are licensed or accredited. Currently Tribes control over 54 % or $1.6 billion of the IHS budget. This represents a total of 334 Tribes and Tribal Organizations that have Contracts and Compacts with the agency.

This has been a very proud and significant year because the IHS passed the half-century mark on July 1. As we reflect on those years and how we can best plan for the next 50 years, we recognize that the unmet needs in Indian Country have always been greater than the available resources to address them. But as we look back on the history of Indian health, we can see that our predecessors, Tribal and IHS, have not let any obstacles stand in their way of meeting our mutual mission of raising the health status of American Indian and Alaska Native people. Great strides have been made in Indian health since the Transfer Act established the IHS as an official entity in 1955.

We have come a long way in 50 years, thanks to the dedication and hard work of many IHS, HHS, Tribal, and Urban Indian health program staff members, and the support and advocacy provided by Tribal leaders across the nation. The Indian health model and the participation of Indian people in decisions affecting their health have produced significant health improvements for Indian people.

Fifty years ago, most people would have assumed that Indian health care was the exclusive responsibility of the newly created IHS. Today, many HHS agencies and programs make vital contributions to improving the health of Indian people. IHS remains preeminent among HHS programs working to better the lives of American Indians and Alaska Natives. And by coordinating programs with partnerships between IHS, other HHS agencies, Indian Tribal governments, and the Indian people, we will achieve the best prospects for continuing the accomplishments of the past 50 years.

It has become obvious to all of us in Indian health that the health disparities experienced by American Indians and Alaska Natives cannot be addressed solely through the provision of health care services. Chronic disease has replaced acute disease as the dominant health problem in our nation and in Indian Country, and is now considered by many to be the principal cause of disability and use of health services. Changing behaviors and lifestyles and promoting good health and a healthy environment are critical in preventing disease and improving the health of American Indian and Alaska Native people.

To address these main focus areas, I have established three closely related Director's initiatives for the IHS:

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

Addressing behavioral health and mental health issues in our communities is crucial. We 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.

There are many, many other innovative health and fitness projects underway in Indian communities across the nation that are being initiated at the local, regional, and national levels. And we are continuously working with Tribal and Urban Indian programs and organizations to

increase our efforts to supply the ways and means to promote healthy lifestyles among our people.

A multidisciplinary IHS team has been tasked with looking at Chronic Disease models that would best meet our needs and could be adapted to our programs. Within the IHS, our model of care for chronic disease will prioritize health promotion and disease prevention, behavioral health, and chronic disease management.

Working together with Tribes and in concert with the principles of Self-Determination and Self-Governance, we can use these new tools to make a real difference in the health and well-being of our patients, families, and communities.

If we hope to successfully combat chronic conditions such as diabetes and cardiovascular disease, we must address a host of inter-related factors and illness contributors – the "causal web" – and we must do so in partnership with many other Tribal, Federal, state, and private organizations that are targeting these issues. Health status is not just a health care issue.

It is about ensuring that there are educational opportunities; it is about ensuring that we have safe communities; it is about ensuring that adequate housing is available; and it is about ensuring adequate economic and employment opportunities. These factors, and more, all work in concert to affect health status. It is therefore vital that all available resources, Federal, state, and private sector, be brought to bear on Indian health issues.

Good leadership at every level is important not only to our current efforts to ensure quality health care delivery, but also to the future effectiveness of the Indian health system.

I commend all of you for the continuing dedication that you deliver to our Tribal communities each day. Our partnership, dedicated to the tradition of caring and curing is in very good hands as we prepare for our next 50 years. Thank you for your kind attention.

The text is the basis of Dr. Grim's oral remarks at the 2005 Self-Governance Fall Conference on October 13, 2005. It should be used with the understanding that some material may have been added or omitted during the presentation.