National Indian Health Board Conference

"Uniting for One Cause: Coming Together for the Greater Good"
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"Addressing Health Disparities with One Voice"

by
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Good Morning. It is a pleasure to be here today at the National Indian Health Board Conference, and to be home again in the great state of Oklahoma. I would like to first of all say a heartfelt thank you to all the members of the National Indian Health Board (NIHB) for the exceptional work you have done throughout the years to improve the health and welfare of American Indian and Alaska Native people. I would like to especially recognize Sally Smith, the Chair of NIHB; John Blackhawk, the Vice-Chair; J.T. Petherick, the Executive Director of the Board of Directors, and all the other members of the NIHB here today.

The NIHB has been involved as an important advocate for Tribes in many different activities, including, most recently, the reauthorization of the Indian Health Care Improvement Act and implementation of the Medicare Modernization Act, both important issues for Indian health care. Their move in 2003 to the Washington, D.C., area increased their access to Congress, Federal agencies, and other major Indian organizations, and they have taken full advantage of this proximity to establish close working relationship with those in positions to help advocate for and make decisions affecting American Indian and Alaska Native people.

Across our nation, and around the world, we are recognizing more and more the importance of healthy lifestyle choices in promoting and maintaining individual health. Related to this awareness, we are currently witnessing a shift in the nation's healthcare focus from disease control to disease prevention. In Indian Country, we have for some time recognized the importance of focusing on healthy communities and individual wellness. We know the future of Indian healthcare relies on our recognizing and addressing the fact that most of the leading causes of chronic illness and death among our people today can be linked to unhealthy behaviors. It is therefore vital that we have programs in place to assist our people in making and sustaining healthy lifestyle choices.

The text is the basis of Dr. Grim's oral remarks at the Direct Services Tribes Conference on June 2, 2004 in Phoenix, AZ. It should be used with the understanding that some material may have been added or omitted during presentation.

That is why I have formally established the Indian Health Service's (IHS) Health Promotion and Disease Prevention Initiative. We must actively pursue all available effective health promotion and disease prevention methods in helping us eliminate the health disparities experienced by our people compared to the rest of America. These health disparities are in areas such as diabetes rates, which are 2-3 times higher for American Indians and Alaska Natives than for all adults in the United States, and chronic liver disease, where the mortality rate is also twice as high. Unintentional injury rates are also up to two times higher for the Indian population than for all other races, and are in fact the leading cause of death for Indian youth. These are only a couple of examples of behavior-related disparities that we are addressing with our Health Promotion and Disease Prevention initiative. We are dedicated to eliminating these disparities. But we cannot do it alone.

The Tribes, the Department, and others dedicated to improving Indian health must work in concert, if we hope to succeed in eliminating these unacceptable disparities that have afflicted our people for far too long. We must speak with one voice, strongly and in unison, if we hope to be heard. And we must be heard. The statistics I have quoted are just cold numbers; it is the human suffering behind the numbers, the faces of our friends and loved ones, in pain and dying of illnesses and conditions that should be and are preventable, that we must keep before us as we work together to meet our mutual goal of raising the health status of American Indian and Alaska Native people to the highest level possible.

Over the last several years, IHS has shifted its strategic focus in the area of behavioral health. Currently over 97% of the Alcohol and Substance Abuse budget and 80% of the overall Mental Health and Social Services budget go directly to Tribes operating programs under Indian Self-Determination Act awards. This trend of Tribes taking responsibility for their own programs has resulted in IHS redirecting our priorities in the area of behavioral health from providing direct services to supporting Tribes delivering those services.

The importance of community input, ownership, and control of health promotion programs in the IHS, Tribal and Urban health system cannot be overemphasized. We must all work together, with a common goal and a united voice, to best address these issues. Studies on primary prevention show that the most important predictor of the effectiveness of a prevention intervention is the degree of community ownership and control. Studies have also shown that establishing culturally relevant health programs at the community level is more effective than having a generic program imposed on a community.

A shift in strategic focus began in fiscal year 2004, after Tribal consultation, and a detailed analysis of the continued trend toward Tribal contracting and compacting, funding patterns, statutory responsibilities, and national service delivery across the treatment and prevention spectrum. A 5-year strategic plan was developed and the resulting focus areas reflect these changes. I will highlight a few of the key focus areas of the strategic plan.

Leadership development is a key success factor in the advocacy of behavioral health issues and in addressing health disparities in Indian communities. Communities must first identify local leaders and utilize them as educators and as representatives on local, regional and national committees. Leadership must include those qualities and characteristics that support the cultural values of their respective communities and provides positive role models for substance abuse healing and recovery. To help promote healthy communities and lifestyles, the IHS has developed, and continues to support, partnership programs for training community

leaders and community members in wellness planning and motivation skills, so they can develop their own plans based on local priorities, needs, and resources.

Health Information Technology is another major focus area, not just for the IHS but for all of HHS and in fact, for the entire nation. The President has identified health information technology as "one of the most important new technology areas for America's future," and the Secretary, at the recent Health Information Technology Summit, gave his full support for the development and enhancement of health data collection and electronic health care record systems.

The IHS has been busy developing and enhancing its health information technology for many years. The deployment of the IHS Electronic Health Record is one of our major information technology priorities for 2005. The Electronic Health Record of the Resource and Patient Management System builds on the IHS's 20-year record of maintaining a database of patient and population-centered clinical information in the interest of improved quality of care and public health. It is the product of an ongoing partnership with the Veterans Administration. 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 improved electronic security;
- Improved quality of care through point of care clinical decision support; and
- Improved cost recovery through better documentation of services provided.

By the end of this year there will be 20 sites using the Electronic Health Record, and by 2008 all of our interested health facilities will use it.

The Resource Patient Management System (RPMS) has received high marks from the Department and the Office of Management and Budget's Program Assessment and Rating Tool analysis 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.

Partnerships and collaborations are also key focus areas. In order to end health disparities among Indian people, the Indian health system must continue to work in unison with other Federal agencies and private foundations, universities, and organizations to bring all possible resources to bear on Indian health issues. Health status is not determined just by the availability of health services. It is the result of an interwoven tapestry of factors such as socioeconomic status, educational status, community and spiritual wellness, cultural and family support systems, and employment opportunities, to name a few. The IHS, Tribes, and urban Indian health organizations have begun to weave a network of support systems and partnerships that will help to address all these contributory factors to the health and well-being of American Indians and Alaska Natives. Through partnerships with American Indian and Alaska Native people, and with other Federal agencies and private entities, opportunities and options to make healthy lifestyle and behavior choices will be increased.

Within the Department of Health and Human Services, under Secretary Thompson's leadership, we have seen this goal of uniting resources and forming partnerships being actively addressed and pursed. 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.

Within the H-H-S, many effective partnerships have been established in the recent years, including with:

- the Administration for Children and Families and their Head Start program;
- the National Institutes of Health, resulting in the establishment of Native American Research Centers for Health and support for the Tribal Epidemiology Centers;
- the Centers for Disease Control and Prevention and the National Institutes of Health in the areas of diabetes research, treatment, and prevention;
- the Substance Abuse and Mental Health Services Administration in the area of alcohol and substance abuse prevention;
- the Administration for Native Americans, which resulted in IHS issuing 20 grants for developing long-term care services for the elderly, and emergency preparedness training programs for Community Health Representatives; and
- also, in partnership with the IHS Children and Youth Initiative, the Administration for Native Americans will fund 22 children and youth grant projects over the next 3 years.

The commitment of the Secretary to having "One Department" when it comes to Tribal issues has resulted in many significant gains in intradepartmental alliances and consultative efforts. One of most significant accomplishments of the past year has centered on the Medicare Modernization 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. This important legislation contains four new authorities that are responsive to Tribal legislative priorities and will increase our ability to provide heath care to American Indians and Alaska Natives:

1. The Prescription Drug Discount Card is a major component of this legislation and Tribal staff have been working with CMS staff and drug card sponsors, Criterion Advantage and Pharmacy Care Alliance, to implement the program.
2. The new authority to bill/collect for all Medicare Part B services will enable IHS and eligible Tribes to participate fully in the Medicare Part B program.
3. The authority to use Medicare-like rates when negotiating health service contracts for our patients is expected to reduce contract health payments for hospital services and to use such savings to increase services to Indian people.
4. And finally, the authority to seek federal reimbursement for emergency health services furnished to undocumented aliens is an important potential resource generator.

A second major accomplishment of the Secretary's One-Department initiative has been the creation of the Centers for Medicare & Medicaid Services (CMS*)* Tribal Technical Advisory Group, which was established in response to Tribal leader comments at the regional Tribal consultation session. The first formal meeting was held on February 10, 2004, in Washington, D.C. They met again on May 27, 2004. I understand that they have also conducted two conference calls with CMS staff. I have been kept informed of the contributions that the advisory group is making to ensure that the needs of Indian people are fully considered as CMS

moves forward on implementation of these important legislative changes. I am especially proud of the recent input of the advisory group as it relates to progress on the implementation of the Prescription Drug Discount Card and Medicare–like rates. To date, working together, we have:

- Distributed a draft guide on the Prescription Drug Discount Card to Indian Health Service/Tribal/Urban (I/T/U) pharmacists,
- Developed general guidance about the Medicare Drug card for I/T/U staff, which is expected to go out at the end of the month,
- Completed an Interagency agreement between CMS and IHS for outreach and training. Currently, each Area has scheduled train-the-trainer training with CMS Regional staff for August and September 2004.
- Worked with Criterion Advantage and Pharmacy Care Alliance to develop Draft IHS and Tribal pharmacy contracts. These contracts are expected to be finalized in the next 2-3 weeks. The IHS will sign national contracts for all IHS sites, and Tribes and Urban programs will be able to sign individual contracts negotiating any additional changes as needed.
- Developed guidelines on Medicare-like rates and forwarded them to CMS to facilitate the issuance of effective regulations by December 8, 2004.

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.

Partnerships between government and private industry are another way to meet the health needs of our people. For example, one crucial focus area in Indian communities is on the health of our young people. Indian youth suffer rates of illness and death in nearly all age groups that are significantly higher than the rates for U.S.-all races. We must not only treat the illness, but also explore ways to prevent the onset of illness through the promotion of healthy lifestyles. To this end, 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 Sudden Infant Death Syndrome (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.

We have also entered into a partnership effort with the NIKE Corporation that focuses on the promotion of healthy lifestyles and healthy choices for all American Indians and Alaska Natives. The Memorandum Of Understanding (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.

We have also established an international collaboration in support of Indian health issues. A Memorandum of Understanding between the United States and Canada was signed in May 2002, to further collaborative efforts between our two countries specifically centered on Native health. Suicide prevention has been chosen as one of the primary areas for direct collaborative efforts under this MOU.

One topic that has been an issue of interest for IHS and Tribes is the IHS restructuring efforts. Recently I presented my reorganization plan, which was based on the Tribal/IHS Restructuring Workgroup recommendations, to the Secretary and gained his approval to move forward with implementation. This year there will be changes that will begin at Headquarters. These changes are intended to improve our support of those in the field, enhance our responsiveness to the Department and Congress, and achieve the management and performance goals of the President and the Secretary. The new structure will reflect current and emerging priorities of the Agency, and will flatten the management structure by eliminating an entire layer. 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. The 10 offices will have greater visibility, more natural communications lines, and additional cross-cutting responsibilities.

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 three 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. This restructuring effort will be an evolutionary, not revolutionary change, and most HQ functions will continue, with expanded emphasis on resource access, collaborations, and security functions. The workforce at HQ is projected to return to 2003 levels. The actual number of employees is contingent upon appropriations and the extent of Tribal contracting and compacting.

The IHS budget is another issue of ongoing concern for us all. 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 1 percent. 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 for FY 2005 is 1.6 percent.

One highlight of this increase is 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 $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 House Interior Appropriations Committee has completed its action on H.R. 4568 and ready for conference. Its counterpart in the Senate has not taken any action at this time; it is expected they will do so after the August recess and Labor Day. The House mark is $112 million (or 3.82%) over the FY 2004 enacted and $92 million over the President's budget request. The changes between the President's Budget and the House mark is an increase of $15 million for Indian Health Care Improvement Fund, a restoration of $52 million to the

Health Care Facilities Construction base, and a decrease of $10 million in Sanitation Facilities construction.

The House Mark includes $99 Million for Health Care Facilities Construction -- $57 million above the FY 2005 President's request for Health Care Facilities Construction. The extra $57 million includes:

- $19.3 million to complete the Clinton, Oklahoma, Health Center,
- $1 million for planning,
- $4 million for the PIMC system – (design of the Southeast and Southwest Ambulatory Care Centers),
- $18.3 million to begin construction of the Eagle Butte, SD Health Center,
- $2.7 million to begin the Southern and Northern California Youth Regional Treatment Center projects,
- $4.8 million for Joint Ventures with Tribes,
- $6 million for the Small Ambulatory Program, and
- $1.5 million for dental units.

The FY 2006 budget is also in process. We submitted our preliminary request to the Department in early June, and had our meeting with the Secretary's Budget Council last week (July 19).

In closing, I would like to remind and encourage all of you here today to attend the upcoming Indian Wellness summit, being hosted by the IHS, which is being held in Washington, D.C., from September 22-24 of this year. The focus of this wellness conference is on uniting our efforts with those of our public and private partners in order to bring together information regarding successful prevention activities at the local, regional, and national levels.

This Summit is another important opportunity for all of you here to meet and join forces with your fellow health care professionals, to share your knowledge and to form alliances that may lead to further partnership efforts on behalf of American Indian and Alaska Native health issues. These conferences are vital to our efforts in uniting all possible resources to address disparities in Indian Country and forge a healthier future for our children and our children's children.

Thank you for the opportunity to speak with you today, and for your participation in this important conference.

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The text is the basis of Dr. Grim's comments at the National Indian Health Board conference in Oklahoma City, Oklahoma on August 9, 2004. It should be used with the understanding that some material may be added or omitted during presentation.