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"Renewing the Indian Health Care System"

by

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Greetings and welcome to National Indian Health Board's 25th Annual Consumer Conference. My remarks today will focus on ideas for improving and renewing the Indian health system. It is not that our system is "broken" but that that our system needs to able to adapt readily in response to serious present and future challenges.

Powerful forces have at been at work over the past few decades that have shaped and changed the face of health care in this country. I am sure all of you here today are aware of many if not all of these forces: escalating medical costs; rapid technology advances; the emergence of chronic health condition as the pervading health issue of our times; and increased service populations, to name a few.

We are getting set to transition in a new administration. It is a time of change for the nation and I think it is a time to consider change in the Indian health system. We need to start positioning ourselves now to adapt and improve our system to meet the needs of the future. We want to focus on changing what is not working as well as it should, while preserving what does works well.

I want to emphasize that nothing has been decided yet. I will present some ideas we might want to explore, together with our tribal partners, in order to be ready for the future of Indian health. We didn't decide just this month to examine our system. We've been watching and listening for a long time. We heard about both successes and failures. Some voices we've heard:

- From nurses about the national nursing shortage – especially in critical care.
- From doctors about risk of deferred care, recruitment in crisis, shortages in family practice.

The text is the basis of Mr. McSwain's oral remarks at the National Indian Health Board Consumer Conference on Sept. 23, 2008. It should be used with the understanding that some material may have been added or omitted during presentation.

- From pharmacists about accelerating drugs costs, insufficient time to counsel patients.
- From patients about denials and losses to creditors because CHS could not pay bills.
- From communities worried about facility closure or desires for a new facility
- From tribal leaders, some who say our system is floundering and ask us to try something different.
- From CEOs who wonder if some sites will remain sustainable in 5 years.
- From employees who are stressed by mounting work and are concerned about jobs.
- From patients who say they can't get appointments and who ask: "Why can't IHS pay for care my doctor says I need?"
- From elders about waiting rooms filled with descendents less connected to the community.
- From community members questioning "Why isn't more done for kids to preserve their health?" or "Why are scarce CHS dollars spent for chronic alcohol abusers?"
- From business partners who want to work with us, but can't if we can't pay for their service.

We've been considering what we saw and heard. We have formed some initial ideas we want to discuss with you. Some of our ideas are pretty clear. Other ideas are sketchy. You may be able to help clarify or offer better ideas. We hope to give a fair picture of the condition of our system so that you may provide well informed ideas of your own. I think we need to start by examining what works well and what doesn't in our present system. And a good place to start is by observing the encouraging signs.

Total healthcare services provided by the Indian health care system have gradually expanded over decades. Our system serves more American Indians and Alaska Natives today than ever before. And like medical trends nationwide, our services have evolved to include less hospital care and more comprehensive ambulatory care.

Congress has continued to support IHS programs, although major budget increases in recent decades have been rare. It is worth noting that our model has a high reputation both within the U.S. and internationally.

Our programs are geographically spread out and our facilities are often on or near reservations. Because our model is the only source for services in many isolated places, this accessibility factor is an important feature.

A broad spectrum of programs and services are provided that include medical services to individuals and also public health and environmental programs that benefit communities.

Our healthcare model is focused on American Indians and Alaska Natives – their unique needs, cultures, and circumstances. We place a high importance on respecting traditional beliefs and integrating traditional healing practices with recent medical science. This has resulted in a medical environment that is more comfortable and welcoming to all Indian people.

Our healthcare system has contributed to spectacular health gains in health status in many ways, especially in establishing access to primary care services located in the Indian communities, lowering the high rates of infectious disease, and improving safe water and community sanitation facilities.

Our programs are operated with a large degree of local autonomy while sharing administrative and support functions through Area and national offices. Even more autonomy is

achieved through self-determination, which has been very successful in the Indian health system, with about half of the IHS budget currently being administered by Tribes.

Advances in technology, transportation, and communications are reducing some of the delivery problems linked with isolation. Innovations in tele-health, remote sensing, and online linkages among healthcare sites are improving both cost efficiency and quality of care.

People are a core asset of our model. To put it simply, we have great people working for us! Their commitment to Indian people and our mission has been extraordinary even under stressful and trying conditions. One important aspect of our workforce is that it is predominantly Indian – 71% of our entire workforce is Indian, and the percentage of American Indians and Alaska Natives in our medical professions continues to rise.

Turning our attention from encouraging to troubling signs: Many sites through out our system are experiencing difficulties making financial ends meet. Financial troubles are, of course, prevalent throughout healthcare in the U.S. But the immediate consequences to Indian people are more pressing because many Indian people have few fall-back options. Couple this with an ever-increasing service population and drastic inflation in medical costs, and you have a severely strained system. The results of this can be as drastic as temporary shut-downs of facilities and cut-backs in services.

Payments are strictly limited by law to available CHS funds, which results in thousands of patient referrals without any source of payment. CHS funds regularly run out before year end. This produces hardships for patients and undermines relationships with hospitals and other providers.

At many sites in our system, essential services are unavailable. If available, limited staff, equipment, and facility space often result in deferring services. These deficiencies contribute to backlogs that result in more severe health problems over the long run. And the inequity of services across the system is an issue that needs to be addressed.

Another troubling sign: clinic space and equipment use in our facilities are often strained beyond capacity, especially in ambulatory care. The space for exam and treatment rooms, staffing, equipment, etc., are especially limited in ambulatory settings. Our overall space configuration was created in an era when hospital admissions were the norm, which is a mismatch for the high-volume ambulatory care practices of today.

Recruitment and retention of a highly skilled medical workforce has always been challenging due to geographically dispersed and remote sites. We simply cannot fulfill our mission without them, so we need to find ways to remove barriers and increase incentives for hiring and retention of qualified professionals.

Strained relations with partners outside our model are rising. Some are a legacy of racial and community tensions. But other strains are directly related to referrals without means of payment.

Although we strive to serve any Indian person who seeks services without regard to tribal affiliation, the shear volume of demand and the incapacity to meet it have forced some Tribes to reconsider whom they can serve.

Other troubling signs are more directly health-related. Rates of obesity and problems linked to lifestyle are epidemic in America. Too often such problems are more pronounced among Indian people. These trends point to grim prospects for declining health and even greater demands on our already over-extended healthcare system.

Perhaps the most troubling sign is that the overall health status of Indian people remains below that for most Americans, and in some places that gap appears posed to widen further. Recent studies have detected rising rates of diabetes, heart disease, and cancer among Indian people, which are almost certainly related to changing lifestyles and environments. For decades, significant advances in raising health status have been documented in our statistics. Now it is clear our model is no longer producing the big gains it once did, largely because of the shift in health problems from infectious disease and sanitation control patterns to lifestyle-related chronic conditions.

We have just examined some of the strengths and weaknesses of our present health care system. We now turn to some ideas for renewing this system, which I hope we can consider together as we prepare ourselves and our health care model for a historic transition period. Please realize that we are not considering a dismantling of the present system, but a variety of ideas for renewing and strengthening it.

It is important to keep in mind that both tribal and federal sites experience the conditions and forces that we have discussed, often in tandem. Equally important, Self-Determination law recognizes that tribally-operated sites may respond to these conditions differently than the IHS may respond. We encourage all Tribes to fully consider all the ideas for renewal. Self-Determination allows tribal sites to choose to participate or not participate. Participation by tribal partners in renewing and adapting our system is welcomed but not required.

This partnership effort will also include the active participation of patients with the entire health system as we renew our common vision for a patient-centered, compassionate, comprehensive, and culturally appropriate model of health care. Before we talk about some ideas for renewal, we need to restate some essential principles and goals that may guide us in thinking about these ideas. These include:

- Securing a healthcare system for Indian people that fulfills our mission, goal, and foundation;
- Strengthening our core model of a community-oriented primary care;
- Transforming but not diminishing services;
- Equalizing access to healthcare services;
- Seeking consultation on policies that affect Indian people; and
- Honoring tribal choice.

The future of our health system requires continuing evolution and adaptation to historic and emerging health challenges. Before discussing new ideas, it is important to acknowledge renewal efforts that are already underway and making impressive progress.

Many individual sites in our system have launched efforts to more successfully adapt clinical and administrative operations to local conditions. I endorse these important, often innovative, efforts. For instance, pilot projects underway in the “Chronic Care Initiative” are producing some exciting results. I will not offer more details on these locally driven efforts this morning, but much more information is available upon request.

Rather, I will focus the balance of my talk on ideas for renewal of our system as a whole, for as we have seen, many of the forces that stress individual sites go well beyond local boundaries. Even sites with the most favorable local conditions can not effectively address all of

these issues. That is why it is timely for all of us to have a national dialogue about the whole Indian health care system.

The patient is at the center of our ideas for renewal. The key idea is a package of services that surrounds every patient. This concept, which is based on the Indian health system already in place now, includes:

- Core services – Community oriented primary care is the central core of the service package. Core services should be accessible in or near Indian communities to maximize their effectiveness. We think primary prevention services should have highest priority because we see them as providing the greatest contributions to improved health status for the entire Indian population now and in the future. The core package combines primary care services that are focused on individuals with essential public health programs that are focused on the community.
- Intermediate and advanced medical services for individuals would be delivered through regional/in-network referral facilities that can provide high quality care efficiently. Most advanced services would be purchased.

A closely connected idea is an integrated delivery system in which each type of service is provided in manner that is most efficient and effective.

Core primary care services should be broadly available and accessible in or near Indian communities. This includes routine ambulatory, screening, diagnostic, and treatment services; basic preventive care; covered prescription medications; some dental services; and some mental health and substance abuse services. Much of the success of our model can be linked to these types of services. These services usually would be delivered in a Monday-Friday clinic in or near the community.

Intermediate services include 24/7 inpatient professional services, advanced ambulatory screening, diagnostic and treatment services, vision, hearing, PT, orthopedic, and both non-complex ambulatory and inpatient surgery. Intermediate services would be provided through an interlocking network of centers that accept and support the core community sites.

Advanced services such as highly specialized diagnostic, surgical, and treatment services include transplants and sophisticated surgery. These would usually be purchased from centers of excellence to the extent that funding allows, or in some cases maybe obtained from in-network medical centers.

We have a firm idea of the overall integrated framework, which builds on and extends successful features of our present system, but there are many details that require study:

- Timing - Even though this integrated concept builds on our present model, we realize this involves transformation of frontline sites as well as behind the scenes support systems. This is not a quick fix. We think it will take a long time to fully achieve.

- Thresholds for facilities - As we try to enhance community access to core services, we also need to consider costs when establishing community size thresholds for core sites and we need to consider realistic and practical groupings for referral networks.

- HFPS - we need to see if the Health Facilities Priority System is aligned with this framework.

- Resource Formula - We may need to align budget and resource allocation formulas.

- Reimbursement - We think that spreading costs of secondary services through a referral system offers significant gains in efficiency and quality. But we will need a way to fairly reimburse the in-network referral centers for costs.

- Conversion Costs - We know there will be one-time costs for converting. We must estimate conversion costs and options.

- Infrastructure - These costs may include investments in infrastructure such as Electronic Health Record, beneficiary ID, communications and transport capacity, etc.

For the integrated model to function coherently and fairly, CHS funded services and policies should be aligned to fit. One challenge involves authorization policies known as CHS medical priorities. CHS funds could be used to fill some gaps in core services to promote wider and more consistent availability of primary care services. Currently, the CHS policy prioritizes urgent medical treatment over primary and prevention services.

Eligibility rules differ for CHS and direct care. We think eligibility should be consistent for both. We need to decide if the uniform eligibility should follow the CHS model, the Direct Services model, or some other. CHS funds have long been treated as fixed, immovable, and tied to sites. There is no inherent reason to bind CHS funds to particular sites, particularly as we move towards a more integrated, mutually supporting network. We should consider aligning CHS management, authorization policies, and funds within the integrated framework. This could involve aligning some CHS funds within core community sites to plug gaps in primary and preventive services and align other CHS funds at a regional (or Area) level for intermediate and advanced services. Some issues that need to be addressed include:

- Integrating Services - The implications and impacts of an integrated service package on the CHS medical priorities must be considered as well as affects on present CHS users.

- Balancing Priorities – While everyone can support the idea of expanding availability and access to core primary services, if CHS spending on core services reduces funds for urgent care, some people may find such a tradeoff disturbing. We will need to thoroughly consult on this complex ethical issue.

- Eligibility - We need more exact numbers for unifying direct services eligibility rules and CHS eligibility rules. Roughly, 250,000 persons are direct service users in our present system who are not CHS eligible. Most of these reside in cities and counties adjacent to reservations but are not members of the local Tribes.

- Budget - We also need to forecast budget implications for the eligibility unification options. Expanding CHS eligibility could create addition funding needs.

- Management Options - Realigning management of CHS to reflect an integrated layered delivery system has logical appeal, but we have not yet explored operational implications. It should be noted that a previous attempt to apply CHS uniformly for an entire state (Arizona) could not be fully implemented because of insufficient funding.

The future of our health system requires continuing evolution and adaptation to historic and emerging health challenges. Our vision is to work in partnership with tribal governments; Indian people; and federal, state, and local governments to respond in every way possible to preserve and improve our health system for future generations of Indian people.