Direct Services Tribes Annual Meeting

June 26, 2007

Indian Health Priorities

by

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

Thank you for inviting me to speak at this important conference and for the opportunity to tell you about some significant health priorities of the Department of Health and Human Services (HHS) and the Indian Health Service (IHS), and about how they will impact on all of Indian Country, including Direct Service Tribes.

The Department and the IHS are focusing on building a better health care system in support of the goal of a safer, healthier, and more compassionate nation. The IHS, together with other HHS agencies, is working in partnership with Tribal Nations and tribal organizations to institute innovative and effective health care delivery techniques to help provide access to high-quality health care and prevention services for American Indian and Alaska Native individuals and communities.

For instance, innovative new models of care delivery through telemedicine are now a reality. Many different types of telemedicine are helping IHS and tribal health care teams provide quality, cost-efficient care in a timely fashion. Examples of telemedicine innovation include:

- Increased behavioral health services, including tele-psychiatry
- Care coordination outreach for patients with heart failure and other chronic diseases
- Tele-nutrition counseling, and
- Ophthalmology through the Joslin Vision Network.

The text is the basis of Dr. Grim's oral remarks at the Direct Services Tribes Meeting on June 26, 2007. It should be used with the understanding that some material may have been added or omitted during presentation.

Growing telemedicine collaborations with Tribes and other federal agencies − such as our partnerships with the Alaska Native Tribal Health Consortium and with the Veterans Administration − also help extend critical infrastructure and service delivery capabilities for many IHS and tribal facilities.

The IHS is also working to expand access to health care for American Indian and Alaska Native people though strengthening our collaborations with programs such as Medicare and Medicaid, as well as State programs.

The IHS continually strives to maximize its Medicare and Medicaid and other third-party collections and enrollments to supplement resources available for health care. Enrollment in the Medicare Prescription Drug Benefit continues to grow in Indian Country. And the IHS continues to work 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.

The IHS also works to ensure Indian people receive the maximum benefits they are entitled to from state health resources and programs. The IHS reviews state health reform initiatives for any legal or policy implications they might have on the IHS, tribal, and urban Indian health care system, and to determine the impact on access to health care for the Indian population of the state.

And I am pleased to report that on July 5, regulations will be in place that require Medicare-participating hospitals to charge no more than "Medicare-like" rates as payment in full for items and services furnished to eligible individuals referred by our Contact Health Services program.

This is great news for our efforts to maximize our health care resources. These regulations will allow Indian health programs to pay lower rates for many referred health services. This will directly benefit the health of American Indians and Alaska Natives, as the financial savings from the new payment system will allow Indian health programs to offer more health services to their beneficiaries.

Another priority of the IHS and HHS is focused on addressing the need for health insurance for low-income children through the State Children's Health Insurance Program, or SCHIP. The goals of this initiative include having the SCHIP program renewed for another 5 years with appropriate funding, as well as a continued focus on children in need.

Staff from IHS and the Centers for Medicare and Medicaid Services, or CMS, meet regularly to ensure close coordination of policies, foster increased state/tribal innovation, and develop ways to improve access to care for Indian people. The IHS has also provided assistance to CMS in its efforts to improve communications with tribal and state governments in the implementation of SCHIP. As part of this effort, IHS is currently working with CMS to provide outreach and education to Tribes on SCHIP and other CMS programs. Training sessions are to conducted across IHS Areas in FY 2007 and FY 2008.

Prevention is an important part of building a healthier nation and healthier Indian people. The underlying principle of prevention in the IHS is that the best health promotion programs are those that are developed in consultation with our key stakeholders, the American Indian and

Alaska Native people**.** We know that listening to those who are most affected by the outcomes helps us to best target the specific needs of each community.

Building on the existing strengths and assets of Indian people, families, and communities ensures the most effective use of resources and yields the best possible results, whether we are dealing with ongoing chronic conditions or emerging infectious diseases.
Prevention is also a key issue in the behavioral health field. As you well know, suicide prevention is an area of great concern to the IHS and Tribes:

- Suicide rates are from 1.5 to 3 times higher for American Indians and Alaska Natives.
- Suicide is the second leading cause of death for Indian youth ages 15-24.

To help address this alarming problem, IHS and tribal programs have been working at the local and national levels to develop effective preventive approaches. At the national level, the IHS is supporting the HHS National Strategy for Suicide Prevention. We are working to:

- Promote awareness that suicide is a public health problem that is preventable.
- Implement training to aid in recognizing at-risk behavior.
- Develop and implement community based suicide prevention programs.
- Improve and expand surveillance systems.

At the local and Area level, many innovative programs are being instituted throughout the Indian health care system to address this devastating problem. For instance, in order to alleviate some of the problems of accessing mental health services in rural areas, the IHS California Area is integrating tele-psychiatric consultation into primary care clinics. Twelve rural tribal health clinics in the California Area now have the ability to access psychiatric consultation services via teleconferencing technology. The California Area Office plans to continue to expand this service to all rural sites over the next few years.

Alcohol and Substance Abuse also continue to be severe behavioral health problems in Indian Country. A recent study by SAMHSA indicated that American Indians and Alaska Natives were about 1.5 times more likely than other ethnic groups to have a past year alcohol use disorder and to use illicit drugs. They also have the highest rate of tobacco abuse of any group in the U.S.

One initiative underway to address the alcohol abuse issue and injury prevention, another major related issue in Indian Country, is the Alcohol Screening and Brief Intervention, or ASBI, program. This intervention program is aimed at breaking the injury-alcohol cycle by taking advantage of the "teachable moment" when an injury patient presents at an IHS or tribal facility as a result of possible intoxication.

This innovative program, which includes collaboration with SAMHSA, is currently being implemented system-wide in all IHS and tribal hospitals. We will also soon be implementing it in referral trauma level I and II centers, and by next year, we will have the ASBI program in all primary care and behavioral health clinics.

One other crucial substance abuse and behavioral health issue that I, and many other Indian health leaders, are very concerned about, is addressing the alarming increase in the use of methamphetamine in Indian Country.

- Beginning in 2000, marked increases have been noted in patients presenting at IHS and tribal clinical sites for amphetamine related problems;
- The number of patient services related to amphetamine abuse almost tripled in the 5-year period from 2001 to 2006, increasing from about 3,000 contacts in 2001 to over 8,800 contacts in 2006;
- And a recent study by the National Institute of Drug Abuse found that "Native Americans were 4.2 times as likely as Whites to use crystal methamphetamine."

I am sure many of you here today have either heard about or seen firsthand the deadly impact of this drug and its devastating effects on our young people and their families, and on the entire community. I believe more extensive information is needed on this problem, and that is why we are working with Tribes to collect reliable data to measure the extent and severity of Meth abuse in Indian Country.

There is some good news: The HHS recently awarded $1.2 million to the American Association of Indian Physicians to address meth abuse in Indian Country. Indian organizations and Tribes will share in this award. And the IHS and the BIA have joined forces to address this epidemic from both a public health and a law enforcement prospective. There are also many tribally owned and operated programs that are doing great things to address this heartbreaking issue.

And Congress is aware of our concerns about meth abuse. The House Interior, Environment and Related Agencies Subcommittee marked up its FY 2008 spending bill in mid-May. The Subcommittee recommended that IHS receive $15 million above the President's request for the prevention and treatment of meth abuse in Indian Country. We will follow that closely.

In order to better institutionalize preventive health care techniques in the Indian health care system, the IHS has developed an innovative program using the Chronic Care Model at pilot sites across Indian Country. The purpose of these pilot sites is to demonstrate that changing the way we deliver care can improve patient outcomes for a variety of chronic illnesses in a cost-effective manner. The pilot program will also support other innovative efforts within the Indian health system to address chronic conditions, especially those that integrate behavioral health and health promotion principles. Each IHS Area has at least one pilot site. Eight federal pilot sites, five tribal sites, and one urban site have been selected.

So far, eight federal pilot sites have been selected at:

Gallup Indian Medical Center –Albuquerque Area
Albuquerque Service Unit – Albuquerque Area
Warm Springs Service Unit – Portland Area
Chinle Comprehensive Health Care Center – Phoenix Area
Wind River Service Unit - Billings Area
Sells Service Unit – Tucson Area
Whiteriver Service Unit - Phoenix Area
Rapid City Service Unit – Aberdeen Area

Also, five tribal sites were recently added:

Indian Health Council, Inc. - California Area
Cherokee Nation Health Services - Oklahoma Area

The Choctaw Health Center – Nashville Area
Eastern Aleutian Tribe - Alaska Area
Forest County Potawatomi Health and Wellness Center - Bemidji Area

We also have one urban program site at the Gerald L. Ignace Indian Health Center in the Bemidji Area.

As I mentioned before, in order to effectively combat chronic conditions, we must address a host of factors. This requires active partnerships between tribal, federal, state, and private organizations. This is why the IHS and Tribes have worked hard over the years to establish partnerships with private and public entities, including the ones you see here.

One important collaboration I would like to highlight is the IHS/Veterans Health Administration (VHA) partnership, which has resulted in several initiatives of value to Indian veterans. One outcome of this partnership has been the IHS/VHA website collaboration. This website contains important information specifically for Indian veterans, including key points of contact for IHS/VHA services, updated information on various programs that are offered, and answers to questions frequently asked by Indian veterans.

Other examples of IHS/VHA partnership initiatives include areas such as patient safety, health information technology, diabetes prevention, and behavioral health. This includes 64 training programs provided by VHA to IHS staff and the tribal community through satellite and web based technology. These programs saved the IHS an estimated $3 million in training costs.

There is also an important program called "Seamless Transition" that is currently underway to address issues for all veterans, including Indian veterans, who are returning from recent and current conflicts abroad.

The IHS has also recently begun an important chronic care management collaboration with the prestigious Institute for Healthcare Improvement, or IHI. The IHI is a not-for-profit health care organization that provides a source of expertise and knowledge to improve health care worldwide. The IHI has a strategic partnership network that includes other organizations such as large hospitals and HMOs. Their mission is to improve healthcare by working with different hospital and health-based groups using evidence-based care.

They are specifically working with us on all the elements of implementing and evaluating the Chronic Care Management Initiative, which will help address some of the most pressing health care needs in Indian Country.

In order to better ensure a safe nation, HHS has developed a Pandemic Influenza Implementation Plan based on the actions outlined in the *White House Homeland Security Council's Implementation Plan for the National Strategy for Pandemic Influenza.*

This priority focuses on ensuring that:

- The capacity to rapidly produce vaccine is increased.
- National stockpiles and distribution systems are in place.
- Communication and disease monitoring systems are expanded.

- Local preparedness has been dramatically enhanced.
- Planning and preparedness encompasses all levels of government and society.

In order to be as prepared as possible to deal with such a disaster, the IHS has developed an agency pandemic influenza plan. It supports the HHS Pandemic Influenza Plan, which, in turn, supports the National Strategy for Pandemic Influenza. It is included in the high-level HHS operational plan, which includes plans for all the HHS agencies.

To assist local pandemic influenza plans, the IHS planning efforts include a "workbook" that is designed specifically for use at the local levels to gather specific details. The detailed plan may also serve as a template for Tribes to use in developing tribal-specific plans.

I also have some news on a couple of other issues of interest to us all – first of all, the Healthcare Facilities Construction Priority (HFCP) System. The Healthcare Facilities Construction Priority System, or something similar, has been used by IHS since the early 1980s to identify high priority facilities construction projects. The revised system, as requested by the FY 2000 Congress and developed through the tribal consultation process, is now ready for implementation. The revised system:

- Will identify for the first time the full scope of need for health care facilities construction, including the need for flexibility to address new directions.
- Is a two-phase approach composed of 5 integrated criteria factors rather than three, as used in the previous HFCPs.
- Includes an Area-based funds distribution that will address small, priority health facility projects in each Area, depending upon congressional appropriations

We are closely watching the Indian Health Care Improvement Act (IHCIA) reauthorization, particularly Title III, which concerns the HFCP.

Which brings me to the next issue I would like to address -- the current status of the reauthorization of the Indian Health Care Improvement Act. To summarize:

- On April 24, the Senate Committee on Indian Affairs introduced S. 1200, a bill to reauthorize the Act, and reported the bill on May 10. The other committee of jurisdiction is the Senate Committee on Finance.
    - The Finance Committee is scheduled to mark up Title 2 of S. 1200 soon. Title 2 contains amendments to the Social Security Act (Medicare, Medicaid & SCHIP).
    - The Finance Committee also held a hearing on Indian Health and Child Welfare on March 22 that focused on the IHCIA and the need to reauthorize it this year.
- The House Committee on Natural Resources introduced H.R. 1328, a bill to reauthorize the Act, and reported the bill on April 25. On June 7, the Health Subcommittee of the Committee on Energy and Commerce held a hearing on H.R. 1328**.** Other committees of jurisdiction are *Energy & Commerce* and *Ways & Means*.
- Key Issues:
    - Elevation of the IHS Director to Assistant Secretary for Indian Health.
    - Extension of the Federal Torts Claims Act to non-eligibles and certain provision related to its extension to home/community based health care.

- o Requirements for use of negotiated rule-making and for consultation in parts of the bill.
- o Need for flexibility so that Secretary has discretion to fund and implement programs and activities authorized in the bills (Medicaid/SCHIP co-pay exemptions).

Now for a topic that is always on our minds . . . the IHS budget. The enacted budget for fiscal year (FY) 2007 is $3.2 billion in budget authority. This is a $135 million, or approximately 4.4%, increase over the FY 2006 enacted budget level. Adding in an estimated $700 million in health insurance collections, diabetes appropriations of $150 million, and staff quarters rental collections of $6 million increases the enacted budget to $4 billion in program level spending.

The final increases appropriated to the IHS for FY 2007 include $1.5 million for the Chronic Care Initiative and $1 million for injury prevention. Funds are included for the completion of the construction of the SW Ambulatory Care Center, Phoenix Indian Medical Center, in Komatke, Arizona. Funds are also included to begin construction of the Kayenta and San Carlos Health Centers in Arizona, and for new Joint Venture projects. Funds are also included to staff and operate four outpatient facility projects at Sisseton, South Dakota; Red Mesa, Arizona; Clinton, Oklahoma; and St. Paul, Alaska. I am very pleased to report that the 2007 budget includes funding for the Urban Indian Health Program.

The proposed budget authority for the IHS for FY 2008 is $3.3 billion. This is a $91 million, or approximately 3%, increase over the FY 2007 enacted budget. Adding in health insurance collections estimated at $700 million, diabetes appropriations of $150 million, and staff quarters rental collections of $6 million increases the proposed budget to $4.1 billion in program level spending. Funds will go primarily ($2.4 billion) to Clinical Services.

The FY 08 budget request addresses the funding of pay raises, inflation, population growth, and staffing for new facilities. These are health care needs that tribal testimony identified as critical during the budget consultation process. The request also includes:

- $19 million to staff and operate one joint venture project at Muskogee, Oklahoma, and a Youth Regional Treatment Center located at Pyramid Lake, Nevada.
- $227 million to help address behavioral health issues in Indian communities, including substance abuse and suicide prevention.
- $136 million to provide much needed dental health care services - Compared to the general U.S. population, American Indian and Alaska Native dental patients experience significantly more oral disease, including both tooth decay and periodontal disease.
- $150 million for diabetes prevention and treatment grants. The IHS has awarded $850 million in Special Diabetes Program for Indian (SDPI) grants over the past 6 years to over 300 Tribes and Indian organizations to support diabetes prevention and disease management at the local level.
- And some good news here– HR 2762, a bill to reauthorize the SDPI was introduced on June 18.

And just a few words on the FY 09 budget process: Within IHS, the tribal budget recommendations and health priorities have been completed for FY 2009, and will be the guide for IHS budget decisions throughout the FY 2009 budget formulation process.

Thank you for your time and attention as I talked about my favorite topic, Indian health care, and about the challenges and successes we face as we pursue our goal of raising the health status of American Indian and Alaska Native people to the highest level possible.