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"Indian Health in Transition: Initiating and Implementing Change"

by

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Good Morning and welcome to our 2006 National Combined Councils Annual Conference. Today I have a critical and timely message for you about the future of the Indian Health Service.

2005 marked the 50th anniversary of the Indian Health Service and allowed a welcome and needed period of reflection for all of us. We celebrated the successes of the IHS and assessed the tremendous challenges in Indian health that confront us today and for the foreseeable future.

As we enter the next half-century of the IHS, there are many challenges we can't possibly envision yet, and some challenges, such as a possible pandemic, we are doing our level best to anticipate and plan for. I will certainly speak more about this planning effort a bit later.

Now, in this new year, we are starting our work on behalf of Indian people during this second and very important period of the IHS. There is not a moment to waste in planning for these next five decades.

The Native concept of considering every important decision in the context of how it will affect the next seven generations is, I strongly believe, wise leadership indeed. I want to challenge you to adopt this way of forward thinking in carrying out our work on behalf of Indian communities. I know that many of you already are practicing this philosophy in many aspects of your programs and daily work. Just to illustrate a few examples, I'd like to cite the team-centered work of Dr. Jim Galloway in cardiovascular;

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Dr. Kelly Acton in Diabetes; and Dr. Charlton Wilson in Internal Medicine. As we practice medicine and advocate for better health in Native communities that are frequently struggling with some of our nation's worst problems, I can't emphasize enough how important it is to link our facilities to the core and spirit of the community and back again. This circle of continuity, bolstered by a team-oriented approach, ultimately will bring about the most cost-efficient, effective, and long-term improvements in the overall well-being of our patients. Whether it's the importance of having a medicine man as an integral part of the Crownpoint Comprehensive Health Care Facility or including traditional herbal medicine at the Winslow Health Care Center, being attuned to your community's needs and providing them is a key step into the circle of wellness.

A number of our programs, such as the partnership with the Boys and Girls Clubs of America, are deeply rooted in this concept of improving life for future generations in Indian communities. By helping our children see the value of exercise, healthy living, community involvement, and respecting and valuing others, we are indeed looking ahead and planting the seeds for new generations of healthier American Indians and Alaska Natives. Other IHS programs, such as our Division of Diabetes Treatment and Prevention, are renowned models for treating chronic diseases and speaking to the future by changing present habits. It's clear through these and other excellent program examples within the IHS that we have excellent frameworks and reference points to embark on a new IHS-wide way of doing business.

Today I want to present a new vision for the IHS and how we consider and relate to our patients, their families, and their communities. It is now time to develop an IHS-wide system of holistic care for each and every patient. By this I mean that we must look carefully at each of our patients and how we can best improve their mental, physical, social, and spiritual health throughout your hospital, clinic, or center. We must take that extra moment to connect our patients and their needs to our full range of existing services and evaluations. We must help each patient in the fullest way and not treat them as individual "silos" of care. As a patient leaves your examining room, are you sure that they are connected to related and logical services within your facility or their community? Does the patient have family members being treated for similar health issues such as obesity or diabetes? Treating the whole patient and his or her family in the context of their Native community is far and away the most effective, efficient, and long-lasting prescription for treating chronic illness.

Essentially, we want to systemize this holistic view throughout the IHS and, of course, evaluate its effectiveness at each step along the way. I know that many of you are burdened by numerous challenging conditions, and may wonder about taking on any additional tasks, much less a new initiative. My response is twofold. First, in this era of declining Federal resources and staggering rates of chronic disease, we have no option except to take action to achieve future wellness. Second, as a career IHS medical professional, I can truly say I know the realities you face and am extremely understanding of these difficulties. But, again, I must stress that we all must work immediately toward instituting our new approach. You must not feel frustrated or alone

in this process. This will be a service-wide initiative and we will lend all the support and advice possible.

As you know, I already have established the Director's three initiatives of Health Promotion/Disease Prevention, Management of Chronic Disease, and Behavioral Health. These initiatives are linked together and have the potential to achieve positive improvements in the health of Indian people.

Our Chronic Care Workgroup has identified five related key tasks to care for chronic diseases that I believe are the basis of holistic patient care. They are:

- New ways of working, new ways of thinking, and new designs for the delivery of care.
- Optimal use of technology.
- The empowerment and full engagement of individuals, families, and communities in health care.
- Utilization of all of our professional and lay health personnel resources in the most creative and effective ways.
- A focus on the risk factors and underlying causes of chronic illness.

In terms of optimal use of technology, we are fortunate to have the IHS Electronic Health Record System to monitor our patients and to help us understand their health needs more fully.

The Indian Health Service has been a pioneer in the use of computer technology to capture clinical and public health data. The IHS Resource and Patient Management System (RPMS) has been widely recognized as an innovative and model program. In a 2004 program performance review by the Office of Management and Budget (OMB), the RPMS received top ratings. NASA recently has chosen the IHS RPMS system as a model for developing its health information system.

We are proud of our Information Technology staff members who are making this effort successful, and who have helped make the IHS one of the recognized leaders in information technology and management systems.

The Clinical Reporting System (CRS) is a component of RPMS that was developed within IHS specifically to assist providers, health care teams, and hospitals monitor their clinical and preventive health indicators. It is designed to eliminate the need for manual chart reviews.

In recognition of the IHS role in health information technology development, the CRS was recently selected by the Healthcare Information and Management Systems Society as a recipient of the prestigious National Public Health Davies Award.

I believe that electronic health information records (EHR) are critical to ensuring the provision of timely, safe, and effective health care services. That is why I have directed that the RPMS EHR will be in use at all federally operated IHS facilities by the end of 2008, and have invited as many Tribal organizations as are interested to adopt it as well.

Another application component of the RPMS system is the Integrated Case Management Application, or iCARE. This is an exciting new tool designed to integrate multiple perspectives on clinical and community care in a single software application. It will help clinical teams understand community and population context for the people they serve. It will include other registry type functions, and offer health care providers new views on community health, including data such as water fluoridation, housing, and community-based resources.

As always, a close working relationship with our Tribal communities and their leaders is an optimal goal in our work. Tribal leaders who are engaged in improving the health and well being of their citizens are our leading allies in creating the change I have just spoken about. Just a few weeks ago I was very moved while reading a news story focusing on how Tesuque Pueblo Governor Gil Vigil is challenging his people to make better use of a new health facility that has a gym, weight room, senior center, and afterschool programs. At 23,000 square feet and a cost of $4. 6 million, the new center is a testament to the Tesuque Pueblo's resolve for a healthier future. Yet it took Governor Vigil to encourage the community to "just move it" as we like to say. We wish him great success in achieving full community participation.

For many communities, such an extensive facility just isn't financially possible. But there are many other ways to stay healthy, including healthy walks, fun runs, and easy to understand guidance on healthy diets. Even the poorest Native community can take positive steps to lead tribal members back to the healthy life habits of their ancestors.

The annual Government Performance and Results Act (GPRA) evaluation and the Diabetes Audit are just a couple of measures that are used to assess our performance. Thanks to your highly successful work, the IHS continues to be a standout in this reporting. The GPRA requires the use of performance-based budgeting and performance measures to demonstrate the agency's effectiveness in meeting its mission. The IHS met or exceeded 29 of the 35 GPRA performance measure targets we reported on in 2005. Out of 21 clinical measures, the IHS met 19 target levels; and 12 of those exceeded their targets. Out of 14 non-clinical measures, 10 met or exceeded their targets.

In accordance with the "One HHS" 10 Department-side Management Objectives, the Indian Health Service is committed to implementing results-oriented management by achieving a 10 percent relative increase in program performance by FY 2007 in four distinct measures: Pneumovax Immunization, Domestic Violence/Intimate Partner Violence (DV/IPV) Screening, Fetal Alcohol Syndrome (FAS) Screening, and LDL Screening in patients with diabetes. The 2005 GPRA results show a significant increase in rates for two of these four measures, DV/IPV and FAS. The 10% relative increase for these two measures was met and exceeded in 2005.

One other important measure is the Performance Assessment Rating Tool (PART) used by OMB, which is composed of assessment criteria on program performance and management. The IHS results on this rating tool have also been a credit to our agency. Again, many thanks for a job well done.

Let me now move to an update on our reorganization plan. I am happy to say that the IHS Headquarters reorganization is now complete and already has improved our

support of those in the field, and our responses to the Department and Congress. I have filled key Headquarters positions, beginning with the selections of Robert McSwain as the IHS Deputy Director, Mary Lou Stanton as the Deputy Director for Indian Health Policy, and Phyllis Eddy as the Deputy Director of Management Operations for the IHS.

I'd like to take a moment to say that IHS pandemic planning under the leadership of Dr. Church is proceeding very well with many important goals already met. I recently sent a letter to all Tribal leaders informing them of all the steps taken by the IHS to plan for this threat and care for their communities. The HHS Pandemic Influenza Plan was released in early November. In addition, HHS Secretary Leavitt is preparing an additional phase of the plan that will include general operational planning information from each of the Operating Divisions, including the IHS. This phase of the operational plan is a high-level document focused primarily on continuity of operations. The IHS has begun to build upon the HHS plan to develop a more detailed operational plan that can be used across the IHS at the local level. This plan can also be used by Tribal programs to develop their own specific plans. I have established an IHS core Pandemic Influenza planning group to develop a draft by March 1 so it can be distributed widely for review and comment. The final plan can be available for use by the end of June 2006.

Secretary Leavitt has initiated pandemic influenza summits to be held in each of the 50 states over the next 120 days. Visits to some of your states already have been completed. Representatives from HHS will go to each of the states to participate in these summits. A major purpose of these meetings is to reach appropriate individuals (other than public health officials) who will be instrumental in pandemic planning. For remaining state meetings, I urge you to encourage representatives from your locality (including IHS, Tribal, and Urban programs) to attend your respective state's summit. The Association of State and Territorial Health Officers has a specific link to the HHS/state summits.

Now I will welcome your comments and questions about how the IHS can best move forward in creating healthier Native communities.

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