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Indian Health Service Overview

by

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Good afternoon. It is a pleasure to be here with you today to share information on how the Indian Health Service (IHS) is working to improve the health and welfare of American Indian and Alaska Native (AI/AN) people.

It is great to be back here at Harvard Medical School – seems like a long time since my residency. I am very grateful that I had the opportunity to do my residency training here, particularly in the primary care residency program. It was great training for all that I have done so far – especially leadership/management training and the opportunity to do clinical work out at Medford. Again, I am very grateful for this opportunity to come back and say thank you.

First, I would like to begin with some brief background information about the Indian Health Service:

- The IHS Mission, in partnership with American Indian and Alaska Native people, is to raise their physical, mental, social, and spiritual health to the highest level.
- The IHS provides services for approximately 1.9 million American Indians and Alaska Natives through a comprehensive primary care network of over 600 hospitals, clinics, and health stations on or near Indian reservations.
- Our facilities are managed by IHS, tribal, and urban Indian health programs.
- We provide a wide range of clinical, public health, and community services.
- The IHS serves members of 565 federally recognized Tribes.
- The IHS FY 2010 appropriation was approximately $4.05 billion.
- The IHS has a total of about 15,700 employees. The IHS clinical staff consists of approximately 2,700 nurses, 900 physicians, 400 engineers, 600 pharmacists, 300 dentists, and 300 sanitarians.

- The IHS system consists of 12 Area offices, which are further divided down into 161 Service Units that provide care at the local level.
- The IHS is predominantly a rural primary care system, although we do have some urban locations.

My first job after residency was in a rural setting at the San Carlos IHS hospital in Arizona, which is in the IHS Phoenix Area. Even though I grew up as a patient in the IHS, working as a provider was an entirely different experience. The challenges our providers encounter daily are enormous. However, the IHS has made significant progress in improving the health status of AI/AN people since it was established in 1955. For example, since 1973, mortality rates have decreased about 89 percent for tuberculosis, 79 percent for cervical cancer, 38 percent for maternal deaths, 56 percent for accidental deaths, and 66 percent for infant deaths.

Despite this progress, IHS continues to faces significant challenges as we work to fulfill our mission, and health disparities continue to persist for AI/ANs compared to other populations. For instance, diabetes mortality rates are still nearly three times higher for AI/ANs than for the general U.S. population, and suicide rates are nearly twice as great.

Addressing these disparities is complicated. In addition to the challenges of delivering health care in a primarily rural location, the Indian health care system also faces a number of other challenges that are driven by a host of medical, cultural, and socio-economic factors, including:

- Population growth, which results in an increased demand for services;
- Medical Inflation, with the rising costs of delivering services – especially in rural areas;
- Difficulty recruiting and retaining medical providers, especially in our remote sites;
- Increased rates of chronic diseases – such as diabetes and cancer, which are more complicated to address;
- Old facilities and equipment;
- Lack of sufficient resources to meet demand for services; and
- Balancing the needs of patients served in our diverse network of IHS, tribal, rural, and urban Indian health programs.

I saw all of these in my time in IHS – it is very challenging. Some of you who have volunteered or worked in IHS know what I am talking about. I was often the only physician on call in the ER – delivering babies, suturing wounds, evaluating febrile infants, triaging trauma victims. No one else there to do it but me, the BWH trained Internist! But under those circumstances, out in a rural area, you do what you have to do with few resources.

A lack of adequate resources is also a huge barrier to fully meeting the mission of the IHS and reducing health disparities. For example, per capita expenditures for IHS are much lower than those for other federal healthcare sources, such as the Department of Veterans Affairs (VA) and the Centers for Medicare and Medicaid Services.

So, there are some who have asked me – why would you want to be the Director of IHS, given all these challenges?

Well, prior to this I had been in academics for 10 years in Arizona – continuing my original goal of improving the quality of healthcare for AI/ANs. When I was asked to be the Director of the IHS, I had to think about it – but when else would there be so much support for the IHS? The President has said many times he is committed to honoring the treaties and the federal government's responsibility. There has never been a time where there has been so much support for improving the IHS.

At my Senate confirmation hearing, I described my priorities to help improve the IHS and address health disparities among the AI/AN patients we serve.

- The first priority is to renew and strengthen our partnership with Tribes;
- Our second priority is, in the context of national health insurance reform, to bring internal reform to IHS;
- The third priority is to improve the quality of and access to care for patients who are served by IHS; and
- The fourth priority is to have everything we do be as transparent, accountable, fair, and inclusive as possible.

After almost two years in this job, I can say that we are making some progress on these priorities; however, much of this work involves fundamental changes in how we do business in the organization, so the change will take some time. I will now share some of that progress.

Our first priority is to renew and strengthen our partnership with Tribes. I truly believe that the only way we're going to improve the health of our communities is to work in partnership with them. The IHS cannot do its work in isolation – we have evidence throughout our system that we work better in partnership with our communities.

Many of our communities' health problems cannot be solved with efforts that just focus on our clinics or hospitals. Some of the biggest problems we face – diabetes, obesity, suicide, domestic violence, cancer, mental health issues – are influenced by factors in our communities such as education, unemployment, law enforcement, housing, etc. IHS cannot solve these problems alone.

Our Tribes, as sovereign nations, are responsible for the health and wellbeing of their members, and we can accomplish so much more if we work in partnership with them. So we are grateful that with this new administration, tribal consultation is a priority.

Tribes also manage about half of our budget as they have increasingly taken over the management of our health programs since enabling legislation in the 1970s. We must partner with the Tribes we serve.

The President has held two White House Tribal Nations Conferences so far and held a historic meeting with Tribes in the Roosevelt Room of the White House last month. Secretary Sebelius, my boss in the Department of Health and Human Services (HHS), is committed to helping to improve the IHS. She recently signed an updated HHS Tribal Consultation Policy with her new Tribal Advisory Committee – the first Cabinet level Tribal Advisory Group.

Tribal consultation is not just required – it is the right thing to do – and relates to how we are centering our care on the patients and the Tribes we serve.

As I said earlier, tribal consultation is one of our highest priorities. In the past year, we have consulted with Tribes on improving the tribal consultation process, improving our Contract Health Services (CHS) program, priorities for health reform and implementation of the Indian Healthcare Improvement Act, and the IHS fiscal year 2012 budget. We are beginning to implement recommendations from these consultations.

For example, we're improving the consultation process by making the information on consultations more widely available, giving more time for response, considering options to ensure consultation with all Tribes, and building a website to document progress on our consultation activities and workgroups. And our CHS consultation, listening sessions, and best practices meetings are generating a lot of great ideas to improve the way we do business in CHS.

I plan to formally consult on other topics this year, such as health facilities construction and improving the quality of and access to care, which is our third priority.

I have also held extensive listening sessions with Tribes, have conducted more than 270 Tribal Delegation Meetings since being sworn in over a year ago, and have visited all 12 IHS Areas.

I spend a lot of my time in tribal delegation meetings hearing tribal priorities and requests. During my Area Listening Sessions, I met with all the Tribes in the morning session and discussed issues impacting the Area in general. During the Area listening sessions, I also met individually with tribal leaders to hear about their priority issues and recommendations from a local perspective.

I have found these visits to be very helpful in understanding broad themes as well as specific Area and tribal needs. Because not all Tribes can afford to travel to Washington, D.C., these Area visits are critical to ensuring that all voices are heard. For 2011, we plan to hold videoconferences with all the Areas to further increase accessibility for Tribes and to reduce travel costs in support of President Obama's federal budget streamlining.

It's important that we strengthen our partnership and that Tribes help create the vision for IHS reform. For every decision I make, I always consider the input I have received from Tribes.

Our second priority is "in the context of national health insurance reform, to bring reform to IHS." This priority has two parts –the first part includes passage of the health reform law, the Affordable Care Act, and the Indian Health Care Improvement Act (IHCIA).

We are grateful for passage of the Affordable Care Act because it will make quality, affordable healthcare accessible to all Americans, including our First Americans. It is designed to increase access to health insurance, help those who have insurance, and reduce healthcare costs. It also contains the permanent reauthorization of the IHCIA, which is our authorizing legislation and which provides new and expanded authorities for a variety of healthcare services.

Both laws have the potential to positively impact AI/AN individuals; Tribes; and IHS, tribal, and urban Indian health programs in a variety of ways. We are consulting with Tribes on an ongoing basis on the implementation of these new laws. I am participating in implementation of the Affordable Care Act within HHS, and IHS leads the implementation of the IHCIA. We are working quickly to implement tribal priorities among the many provisions in these laws.

The IHCIA was included in the Affordable Care Act – which is great for Indian Country because this law is the main legislation that authorizes Congress to fund health care services for American Indians and Alaska Natives. The IHCIA updates and modernizes the IHS. The provisions are numerous but many of them give IHS new authorities. This includes:

- Authorities for the provision of long-term care services;
- New and expanded authorities for behavioral health prevention and treatment services;
- New and expanded authorities for urban Indian health programs;
- Authorities for various demonstration projects, including innovative health care facility construction and health professional shortages;
- The authority for provision of dialysis services;
- Authorities to improve the CHS program;
- And authorities to improve facilitation of care between IHS and the VA.

These are just examples of what is in the new law.

The next part of our second priority is about bringing internal reform to the IHS. This involves how we are changing and improving the organization. Those of you who have volunteered or worked in IHS know how much improvement is really needed – in many fundamental ways.

In order to get the support we dearly need, the IHS must demonstrate a willingness to change and improve. It is clear that Tribes, staff, and our patients want change.

By internal IHS reform, I mean we need to look at what we do well, and be honest about where we need to improve.

We requested and received input last year on tribal and staff priorities for how to change and improve the IHS. Tribal priorities for internal reform included:

- More funding for IHS, including a review of how we allocate funding;
- Improvements in our CHS program; and
- Improvements in the tribal consultation process.

We're working on these priorities, as I have already described. We're also making progress on the top staff priorities for internal IHS reform. Overall, staff emphasized improving the way we do business and how we lead and manage our staff. I have set a strong tone at the top for how we will conduct business, with an emphasis on customer service, ethics, professionalism, and performance management.

To improve the way we do business, we're working with the Department of Health and Human Services and our Area Directors to improve how we manage and plan our budgets and improve our financial management. We're working to make our business practices more consistent and effective throughout the system.

To improve how we lead and manage staff, we're working on specific activities to improve and streamline the hiring process by making it more efficient and proactive, and less time-consuming.

We're also working on improvements in pay systems and strategies to improve recruitment and retention. It has been historically difficult for the IHS to recruit and retain healthcare providers, due to remote locations and noncompetitive salaries. We need to make sure the way we do business is not causing us to lose the opportunity to hire and keep good staff.

I recently met with most of my senior leadership (deputies) and 12 Area Directors, and I am working with them to promote better teamwork throughout the senior leadership of the agency.

In relation to our third priority, to improve the quality of and access to care, I started by identifying the importance of customer service – how we treat our patients and how we treat each other. I am now starting to see activities to improve customer service throughout the system and am starting to hear stories about some improvements. However, we still have a lot of work to do to improve our customer service.

We also plan to expand the Improving Patient Care (IPC) initiative to 100 more sites over the next 3 years. This is our "medical home" initiative that puts the focus of our healthcare team on serving the patient. We're now beginning phase 3 of the IPC, and 67 sites have been selected to join the current sites.

We recently released information on the results of the IHS Special Diabetes Program for Indians Diabetes Prevention and Healthy Heart Demonstration Projects. They achieved successful results and showed that in partnership with our communities, we can reduce diabetes and cardiovascular disease risk factors in Indian country with innovative and culturally appropriate activities.

We are working on a number of other initiatives to help improve quality. I am grateful to your colleague, Dr. Tom Sequist and his colleagues, who are helping us with data and research related to quality in our system.

We are also collaborating with other federal partners, such as the VA, and with other HHS agencies. For instance, we have been meeting with the Department of Interior (DOI) on health

issues in our communities. Assistant Secretary of Indian Affairs Larry Echohawk understands how we must work together to address some of the difficult health problems we are facing in tribal communities, such as youth suicide.

We recently announced a series of listening sessions on suicide prevention in coordination with the Bureau of Indian affairs/DOI and the Substance Abuse and Mental Health Services Administration. And we have heard from Tribes that they want more coordination by federal agencies on this important issue.

I am also working with other Operating Division heads in HHS to expand availability of resources and services for AI/ANs. For instance, I have worked with Mary Wakefield, the Administrator of the Health Resources and Services Administration, on workforce issues, including trying to get more healthcare professionals through the National Health Service Corp to work in Indian country. This requires collaboration to make sure tribal sites are eligible. American Recovery and Reinvestment Act funding is making more of these resources available.

You may know that we have a scholarship program in IHS to recruit AI/AN students into the health professions. We also have a loan repayment program similar to the National Health Service Corp – salary plus loan repayment and interest – it's a great way to get rid of significant medical school debt. I encourage you to consider working for us and getting your loans repaid!

I also met with Secretary Shinseki from the VA last May. We are working on several collaborations, including coordination of care for veterans who are eligible for both IHS and the VA. We just signed an updated VA-IHS Memorandum of Understanding – updated from the one we signed in 2003 – to help improve how we coordinate care for our veterans. We will be consulting with Tribes on implementation shortly.

Our fourth priority is to make all our work transparent, accountable, fair, and inclusive. Since I began as the Director of the IHS, I have worked hard to improve transparency and communication about the work of the agency. This is an important component of changing our organization. It includes working with the media, sending more email messages and letters to tribal leaders, holding regular internal meetings, and giving presentations at meetings like this. We have also enhanced our website with the IHS Reform page, Director's Corner, and Director's Blog, which contain important updates and information about reform activities. And we're looking at ways to improve IHS-wide communication among Areas, Service Units, and Headquarters.

We're also emphasizing accountability and fairness in the way we do business – by evaluating our programs and focusing on areas of greatest benefit, and by always considering fairness when dealing with staff and making programmatic decisions.

Inclusiveness is a part of these priorities because as the IHS Director, I have to ensure that all my decisions consider the impact on all our patients, whether they are served in an IHS, tribal, or urban Indian health facility. Balancing the needs of the various parts of our healthcare system is a challenge, but inclusiveness is very important as we work to improve the IHS.

As I just mentioned, we are enhancing our IHS website. One addition is my "Director's Corner," which is linked to the IHS home page. There you can get information on presentations, Dear Tribal Leader letters, updates on internal IHS reform, and other messages. There is also a link to our tribal consultation website there.

You will also see an orange "Director's Blog" button that you can click on that will take you to my blog. I use the Director's Blog to post brief updates on our activities and the latest IHS news at least weekly. This is one of many efforts to be more transparent about what we're doing as an agency.

I think it's important for the public to know that meeting with Tribes is important to the agency, and putting updates and pictures on the blog helps.

In summary – the IHS provides healthcare to American Indians and Alaska Natives under challenging circumstances. However, we are working to change and improve the IHS through our reform efforts. These efforts should help us do better at the business of healthcare and provide better quality services.

The Affordable Care Act and the reauthorization of the IHCIA will also help Tribes and the IHS provide better care to American Indian and Alaska Native people.

Overall, we are beginning to make progress on our priorities and are moving forward on the challenging work to change and improve the IHS. While changing and improving the IHS may seem like a daunting and challenging task, I still believe we're in a unique time in history, where we have a supportive President and administration, including lots of support at HHS, and bipartisan support in Congress for reform. We must take advantage of this opportunity to change and improve the IHS.

Thank you for giving me the opportunity to share information about my current job. Again, I am very grateful to the Brigham faculty for all their support and encouragement.

Thank you.