Indian Health Service

Briefing

APRIL 5, 2016

2016/2017 Strategic Goal

Continued focus on providing quality health care services, including ensuring patient safety and access to primary, emergency, and behavioral health care for AI/AN beneficiaries.

Indian Health Care System Today

IHS direct health care services

Tribally-operated health care services

- Titles I and V of the Indian Self-Determination and Education Assistance Act provide Tribes the option to assume control and management of programs.
- Today, over half of the IHS appropriation is administered by Tribes, primarily through self-determination contracts or self-governance compacts.

Urban Indian health care services and resource centers

National View: Indian Health Care System

170 IHS and Tribally-managed service units

34 Urban programs

15,370 employees

	Hospitals	Health Centers	Alaska Village Clinics	Health Stations
IHS	27	59	n/a	32
Tribal	18	284	163	79

Data as of October 2015

Indian Health Service – Appropriations

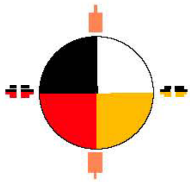
Fiscal Year 2016 Enacted:

- Discretionary: $4.8 billion
- Program: $6.1 billion

Fiscal Year 2017 Proposed:

- Discretionary: $5.1 billion
- Program: $6.6 billion

Increase of +$402 million above FY 2016: If enacted, the FY 2017 Budget would represent a 53% increase in resources for IHS since FY 2008.



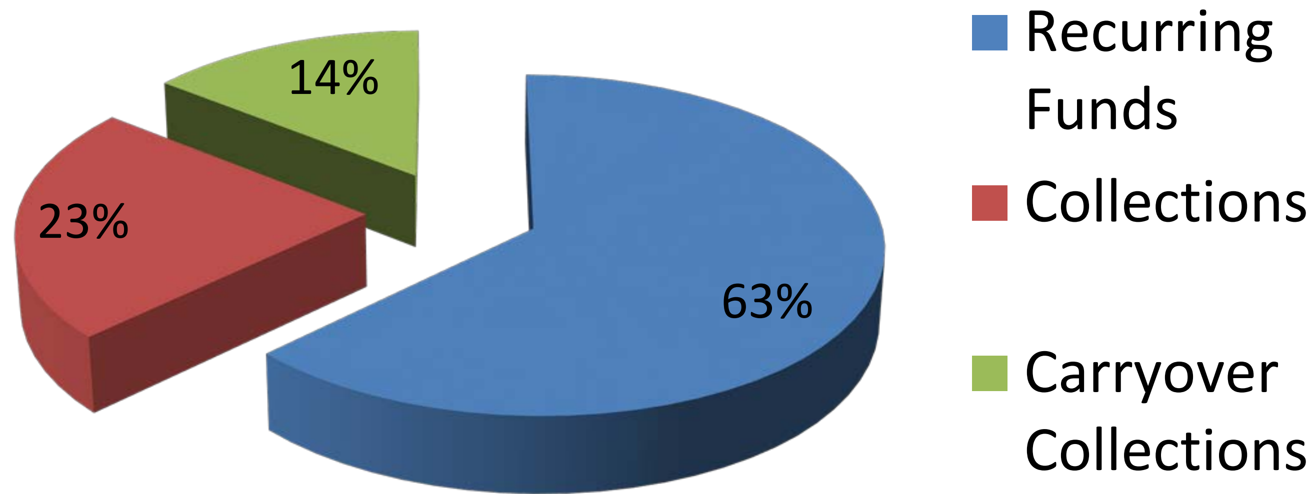
2015 IHS Expenditures Per Capita and Other Federal Health Care Expenditures Per Capita

Per Capita spending in the year for which data are available

Year	Category	Per capita spending
2014	Medicare spending per beneficiary	$12,179
2015	National health spending per capita	$8,517
2015	Veterans medical spending per patient	$8,760
2011	Medicaid spending per enrollee	$5,790
2015	FDI benchmark per user (inflated)	$5,460
2015	Actual IHS spending per user	Medical* $3,136; Other $524

Y-axis: $0, $2,000, $4,000, $6,000, $8,000, $10,000, $12,000

Great Plains Area Fiscal Year 2015 Funding



$577 million

Seven Great Plains Area Hospitals

Facility	Beds (2014)	Accreditation Status (March 2016)	Accrediting Organization *
Cheyenne River Hospital	8	Accredited	DNV
Fort Yates Hospital	12	Accredited	DNV
Pine Ridge Hospital	45	Accredited – CMS Action	DNV
Quentin N Burdick Memorial Health Facility	27	Accredited	DNV and TJC
Rapid City Hospital	9	Accredited	DNV
Rosebud Hospital	35	Accredited – CMS Action	DNV
Omaha Winnebago Hospital	29	Accredited – CMS Action	DNV

* NOTE – All IHS facilities to transition to accreditation with TJC

Great Plains Area Facilities

	Hospitals	Health Centers, Health Stations	Total
IHS	7	9	16
Tribal	0	17	17

Data as of March 2016

Great Plains Area Context

569 existing staff quarters

- 291 are over 30 years old
- 5 replacement and 234 new quarters needed

$60.2 million backlog of essential maintenance

2,789 positions

Data as of March 2016

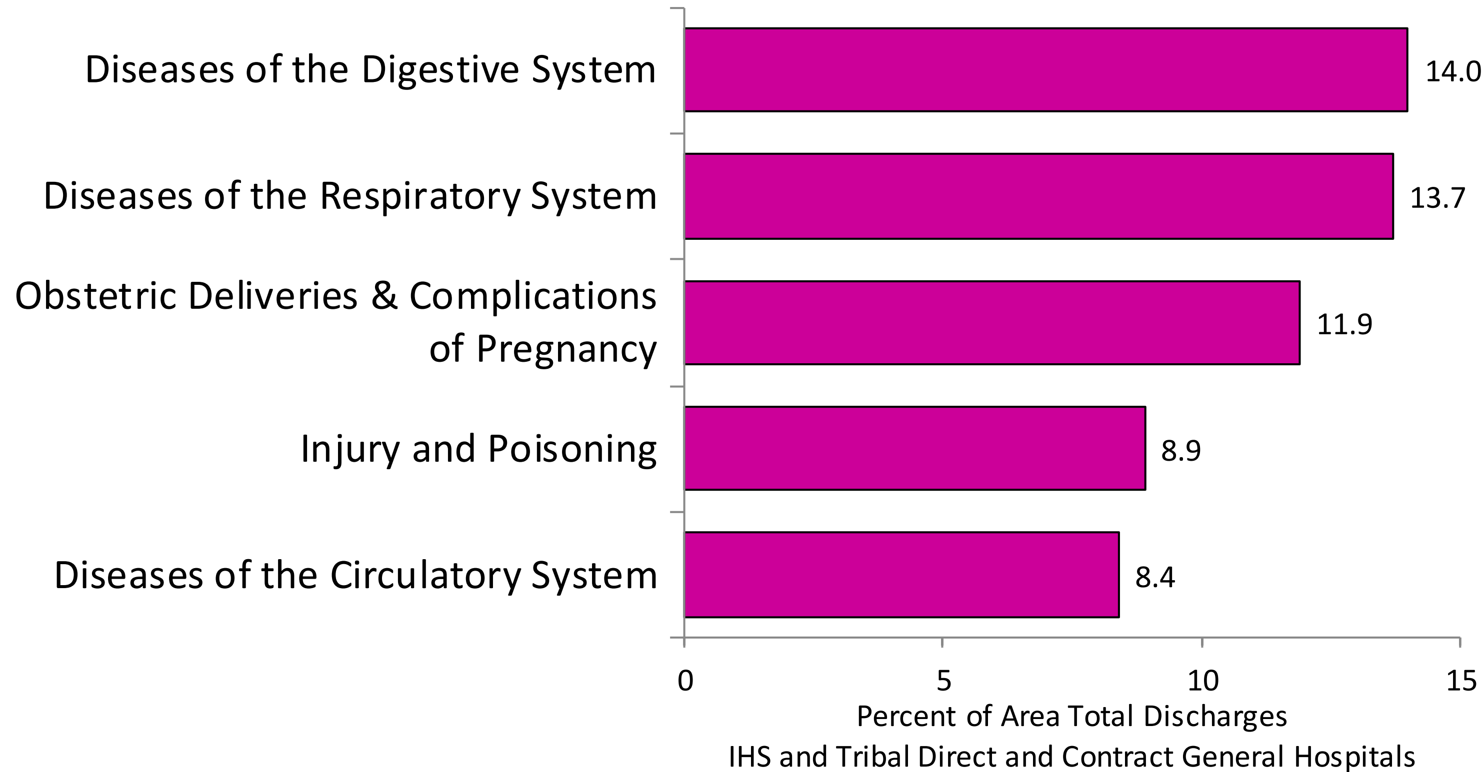
Great Plains Area Emergency Department Encounters, FY2013 - FY2015

Facility	FY 2013	FY 2014	FY 2015
Cheyenne River Hospital	13,926	14,538	15,517
Fort Yates Hospital	7,582	6,642	6,311
Pine Ridge Hospital	22,138	21,941	21,135
Quentin N Burdick Memorial Health Facility	13,448	12,836	13,053
Rapid City Hospital	15,779	14,481	14,064
Rosebud Hospital	17,529	17,196	14,584
Omaha Winnebago Hospital	10,379	10,496	9,564

Great Plains Area
Average Daily Patient Load

Facility	2012		2013		2014	
	Beds	ADPL	Beds	ADPL	Beds	ADPL
Cheyenne River Hospital	13	1.2	8	2.0	8	2.1
Fort Yates Hospital	N/A	1.2	12	2.0	12	0.3
Pine Ridge Hospital	45	10.3	45	9.8	45	10.6
Quentin N Burdick Memorial Health Facility	27	7.8	27	6	27	6.6
Rapid City Hospital	28	0.4	9	0.9	9	0.4
Rosebud Hospital	35	5.8	35	7	35	6.4
Omaha Winnebago Hospital	28	2.1	29	7.9	29	9.2

Great Plains Area Leading Causes of Hospitalization



Data as of January 2016

Great Plains Area Inpatient Diagnoses for Purchased and Referred Care (2013-2014)

Diagnosis	2013		2014	
	# Admissions	Rank	# Admissions	Rank
Diabetes Mellitus	163	1	125	1
Septicemia	148	2	166	2
Episodic Mood Disorder	103	3	108	3
Acute Myocardial Infarction	85	4	92	4
Cellulitis and Abscess	74	5 (tie)	87	5
Alcohol Induced Mental Disorder	74	5 (tie)	67	6
TOTAL PRC ADMISSIONS	**3105**		**2896**	

Challenges Across Health Care Sector

- Competitive labor market (clinical, 3rd party billing staff)
- Training challenges – complex regs, maintain staff certifications
- State Medicaid expansion choices
- Disparities in health status
- Rural health care – limited options for transportation
- Rising costs/medical inflation

IHS Great Plains Area – Challenges

- Long standing deficiencies cited by CMS
- Long term solutions need support and resources from outside GPA
- Recruiting/retention complicated by salary and living quarters limitations
- Aging facilities and outdated equipment
- Geographic isolation hampers recruitment, drives low volume, limits training opportunities, and limits potential for efficiency in resource acquisition and use
- Patient education about benefits of 3rd party coverage and payment

IHS and HHS Response

- Consultation with Tribes
- Deployment of needed staff from other IHS Areas and HHS operating divisions
- HHS Executive Council on Quality
- Recruitment of clinical staff: new hires
- Central monitoring systems and equipment
- Changes for long-term recruitment and retention of clinical staff: pay exception for ED physicians
- IHS Quality Consortium and creation of agency wide quality office
- Training for personnel
- Systems Improvement Agreement negotiation

Tribal Suggestions Received To Date

- Involve Tribes in facility governing body decisions
- Examine employment policies/processes that retain poor performers
- Improve internal reporting of potential mismanagement and protections
- Provide immediate access to third-party reports on surveys, etc
- Ensure transparency and better communication between Tribes/Tribal organizations and IHS, all levels

Tribal Suggestions Received To Date

- Facilitate self-governance when requested by Tribe
- Seek authorities for increased physician pay
- Increase PRC resources so that fewer referrals are denied
- Enhance consultation with Tribes on leadership and services

Short-Term Strategies

- Rosebud Systems Improvement Agreement for recertification
- Engage Tribal Leadership in support of meeting the health care service needs of their communities
- Immediately deploy clinical staff to hospitals that are in immediate threat/ loss of CMS billing certification
- Procure temporary living quarters

More Short-Term Strategies

- Identify individuals eligible for Medicaid or private insurance
- Complete master contract at IHS HQ for field ER operation
- Resolve hiring and compensation barriers
- Expand behavioral health facilities and staff

Breakout Sessions

- Service Delivery
- Behavioral Health
- Telemedicine
- Quarters for Health Professional Staff
- Staffing
- Governing Board & Quality

Breakout Session: Service Delivery

1. In hospitals with small inpatient workloads, what other models of care delivery could be considered?

2. What are your thoughts on care provided by staff who are contractors of IHS? By IHS employees? Should we consider expanding contracts for medical services operations and management beyond Emergency Department, subject to funds availability?

   There are a number of individual service units with individual specialty service contracts in existence. Should we explore more Area-wide contracts for lab, cardiology, orthopedics, endocrinology, etc?

3. How can the Great Plains Area Office best support quality health care?

Breakout Session: Behavioral Health

1. What strategic partnerships need to be developed to improve access to behavioral health services?
2. What are the top three solutions to recruit and retain highly qualified behavioral health providers?
3. What types of behavioral health care providers are needed most in the Great Plains Area? Could this care be provided by Licensed Marriage and Family Therapists and Licensed Professional Counselors? Should we bring on more of these providers?
4. How could expanding the function of CHRs be helpful to improving access to behavioral health services (for example, peer specialist certification for CHRs, mental health first aid training)?
5. How can we capitalize on behavioral health integration with primary care to improve access to behavioral health services? What are the current challenges? What resources do we need to have in place?

Breakout Session: Telemedicine

1. How can we work together to use telemedicine optimally to support quality health care in your community?
2. How can telemedicine services best be used to expand services for your community? In what types of care interactions are you in favor of expanded telemedicine?
3. What telemedicine services are being considered and how will they impact current services?
4. What will be the impact of telemedicine services on current hired staff at IHS facilities and jobs for local community members?

Breakout Session: Quarters for Health Professional Staff

1. What priority is given to health care provider occupancy in the IHS federal quarters and what should prioritization look like going forward?
2. What land and infrastructure are available for additional quarters near health facilities? Are Tribes willing to provide land and infrastructure for addition of quarters on, or near, the local health campus?
3. What ideas do you have about how to provide desirable living quarters for health professions staff?

Breakout Session: Staffing

1. How can we better work together to attract and retain high quality health care staff? What has worked in the past and how can we replicate?
2. What are your thoughts about the possibility directing additional service unit funding resources to salary and incentive options?
3. What are your thoughts about the possibility of Tribal waiver of Indian Preference in particular situations? Is this an option we should pursue together?
4. What is most attractive about your community for health providers and how can we build that into our recruitment efforts?

Breakout Session: Governing Board & Quality

1. How should tribal leaders be involved in hospital governance?
2. What ideas do you have for assuring that there is ample opportunity to relay your community's needs to the IHS facility (or facilities) that serve your community?
3. What is your definition of quality care, and what are some key indicators of quality from your perspective?
4. What changes would you like to see made to hospitals in your community to know that the care is of the highest possible quality?

Next Steps

- Tribal consultation and feedback on improving access to care
- Ensure sustainability of changes
- Evaluation

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