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Chapter 1 : Indian Health Service - Wikipedia

The IHS is the principal federal health care provider and health advocate for Indian people, and provides a comprehensive health service delivery system for American Indians and Alaska Natives. The IHS Mission is to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level.

Disabled children are included in the aged, blind and disabled category. Centers for Medicare and Medicaid Services, a. Some states 3 Unless otherwise indicated, data in this section are based on Department of Health and Human Services, Page 35 Share Cite Suggested Citation: The National Academies Press. SCHIP operates as a block grant program to the states. States have the option of creating SCHIP programs as Medicaid expansions, as separate programs, or as combined programs i. Most states rely on managed care arrangements as their primary mechanism of service delivery for both healthy children and those with special health care needs. Eligibility is triaged according to the available budget; those with compensable, service-connected disabilities are assigned the highest priority Veterans Administration, a. VHA serves as a payer of last resort for treatment not related to service-connected disabilities that is provided through VHA facilities. Each VISN contains 7 to 10 hospitals, 25 to 30 ambulatory care clinics, 4 to 7 nursing homes, and other care delivery units Kizer, Most clinical and administrative staff are employees of VHA. Generally, the VHA population is older, low-income, and characterized by high rates of chronic illness see Table Approximately 19 percent of the total VHA population sought inpatient and outpatient mental health services including those related to substance abuse in Van Diepen, a. At the core of the program is a direct care system of military treatment facilities MTFs , which provide most of the care delivered to active-duty personnel and over half of that provided to TRICARE beneficiaries overall. There is an MTF located at most major military facilities in the United States and abroad, each operated by one of the military services. TRICARE also has regional contracts with private-sector health plans to provide active-duty personnel with certain services not available through MTFs and to serve other beneficiaries. Nonâ€"active-duty beneficiaries may choose from among three program options: Lastly, since the Gulf War, a great deal of attention has been focused on early detection of risks associated with the activities and settings of deployment e. In addition to force health protection, the service needs of other TRICARE beneficiaries, mostly active-duty dependents, are sometimes described as basically babies and bones Jennings, IHS currently provides health services to approximately 1. The provision of these health services is based on treaties, judicial determinations, and acts of Congress that result in a unique government-to-government relationship between the tribes and the federal government. IHS, the principal health care provider, is organized as 12 area offices located throughout the United States. These 12 areas contain health care delivery facilities operated by IHS and tribes, including: Poverty and low education levels strongly affect the health status of the Indian people. Approximately 26 percent of American Indians and Alaska Natives live below the poverty level, and more than one-third of Indians over age 25 who reside in reservation areas have not graduated from high school. Common inpatient diagnoses include diabetes, unintentional injuries, alcoholism, and substance abuse. This section highlights two important trends: Chronic Care Needs Trends in the epidemiology of health and disease and in medical science and technology have profound implications for health care delivery. Chronic conditions defined as never resolved conditions, with continuing impairments that reduce the functioning of individuals are now the leading cause of illness, disability, and death in the United States and affect almost half the U. Most older people have at least one chronic condition, and many have more than one Administration on Aging, Fully 30 percent of those aged 65â€"74, and over 50 percent of those aged 75 and older report a limitation caused by a chronic condition Administration on Aging, Thus, the majority of U. This trend is strongly reflected in the government health care programs. In the Medicare and VHA programs, most of the beneficiaries have multiple chronic conditions. Diseases such as asthma, diabetes, hypertension, cancer, congestive heart failure, and mental health and cognitive disorders are important clinical concerns for all or nearly all of the programs. The increasing prevalence of chronic illness challenges systems of care designed for episodic contact on an acute basis Wagner et al. Hospitals and ambulatory settings are generally designed to provide acute care services,

with limited communication among providers, and communication between providers and patients is often limited to periodic visits or hospitalizations for acute episodes. Serious chronic conditions, however, require ongoing and active medical management, with emphasis on secondary and tertiary prevention. The same patient may receive care in multiple settings, so that there is frequently a need to coordinate services across a variety of venues, including home, outpatient office or clinic setting, hospital, skilled nursing facility, and when appropriate, hospice. There is mounting evidence that care for chronic conditions is seriously deficient. Fewer than half of U. Health care is typically delivered by a mix of providers having separate, unrelated management systems, information systems, payment structures, financial incentives, and quality oversight for each segment of care, with disincentives for proactive, continuous care interventions Bringewatt, For individuals with multiple chronic conditions, coordination of care and communication among providers are major problems that require immediate attention. There are many efforts under way to develop new models of care capable of meeting the needs of the chronically ill. For example, Healthy Future Partnership for Quality, an initiative in Maine now in its fifth year, enrolls insured individuals from leading health plans and the state Medicaid program and uninsured individuals covered by a 10 percent surcharge on the fee for each insured participant and paid by insurance companies with chronic illness in an intensive care management program that provides patient education, improved access to primary care and preventive services, and disease management Healthy Futures Partnership Page 39 Share Cite Suggested Citation: It involves 1, patients, half of whom participate in home monitoring using devices that read blood sugar, take pictures of skin and feet, and check blood pressure , intensive education on diabetes, and reminders and instructions on how to manage their disease. The changing clinical needs of patients have important implications for government quality enhancement processes. These processes and the health care providers they monitor should be capable of assessing how well patients with chronic conditions are being managed across settings and time. This capability necessitates consolidation of all clinical and service use information for a patient across providers and sites, a most challenging task in a health care system that is highly decentralized and relies largely on paper medical records. Patient-Centered Care Patient-centered care is respectful of and responsive to individual patient preferences, needs, and values and ensures that patient values and circumstances guide all clinical decisions Institute of Medicine, Informed patients participating actively in decisions about their own care appear to have better outcomes, lower costs, and higher functional status than those who take more passive roles Gifford et al. Most patients want to be involved in treatment decisions and to know about available alternatives Guadagnoli and Ward, ; Deber et al. Yet many physicians underestimate the extent to which patients want information about their care Strull et al. Patient-centered care is not a new concept, rather one that has been shaping the clinician and patient relationship for several decades. Authoritarian models of care have gradually been replaced by approaches that encourage greater patient access to information and input into decision making Emanuel and Emanuel, , though only to the extent that the patient desires such a role. Some patients may choose to delegate decision making to clinicians, while patients with cognitive impairments may not be capable of participating in decision making and may be without a close family member to serve as a proxy. Patients may also confront serious constraints in terms of covered benefits, copayments, and ability to pay discussed below under benefits and copayments The recently released physician charter by the American Board of Internal Medicine ABIM Foundation, the American College of Physicians- Page 40 Share Cite Suggested Citation: Principle of Patient Autonomy. Physicians must have respect for patient autonomy. Physicians must be honest with their patients and empower them to make informed decisions about their treatment. The current focus on making the health care system more patient-centered stems at least in part from the growth in chronic care needs discussed above. Effective care of a person with a chronic condition is a collaborative process, involving extensive communication between the patient and the multidisciplinary team Wagner et al. Patients and their families or other lay caregivers deliver much if not most of the care. Patients must have the confidence and skills to manage their condition, and they must understand their care plan e. For many chronic diseases, such as asthma, diabetes, obesity, heart disease, and arthritis, effective ongoing management involves changes in diet, increased exercise, stress reduction, smoking cessation, and other aspects of lifestyle Fox and Gruman, ; Lorig et al. Pressures to make the care

system more respectful of and responsive to the needs, preferences, and values of individual patients also stem from the increasing ethnic and cultural diversity that characterizes much of the United States. Although minority populations constitute less than 30 percent of the national population, in some states, such as California, they already constitute about 50 percent of the population Institute for the Future, A culturally diverse population poses challenges that go beyond simple language competency and include the need to understand the effects of lifestyle and cultural differences on health status and health-related behaviors; the need to adapt treatment plans and modes of delivery to different lifestyles and familial patterns; the implications of a diverse genetic endowment among the population; and the prominence of nontraditional providers as well as family caregivers. Although there has been a virtual explosion in Web-based health and health care information that might help patients and clinicians make more informed decisions, the information provided is of highly variable quality Berland et al. Some sites provide valid and reliable information. There are also notable efforts to provide consumers with comparative quality information on providers and health plans. These efforts are discussed further in Chapter 5. There is little doubt, however, that we are embarking on a long journey to determine how best to make valid and reliable information available to diverse audiences with different cultural and linguistic capabilities Foote and Etheredge, In general, communication with consumers is enhanced through the use of common terminology, standardized performance measures, and reporting formats that follow common conventions. At the program level, the predilection of each government program to design and operate its health care quality enhancement processes independently is a serious problem. Just as the quality enhancement processes of the government programs are being assessed in this report, these other aspects of program design must be evaluated in the future for alignment with the objectives of those processes. Benefits and Copayments Health insurance was established in the United States in the s and s as a way to help the average person cope with the high costs of hospital care Stevens, Today hospital care, although still very expensive, consumes about one-third of the health care dollar, and other facets of health care, such as prescription medications 9 percent with a growth rate of Increased demand for these other facets of care reflects the growth in chronic care needs discussed earlier as well as new treatment options stemming from the extraordinary advances made in medical knowledge and technology, including minimally invasive surgery. Page 42 Share Cite Suggested Citation:

Chapter 2 : Indian Health Service | NBCC

Indian Health Program. T he mission of the Indian Health Program (IHP) is to improve the health status of American Indians living in urban, rural, and reservation or rancheria communities throughout California.

This relationship, established in , is based on Article I, Section 8 of the Constitution , and has been given form and substance by numerous treaties, laws, Supreme Court decisions, and Executive Orders. Health services for the needs of American Indian and Alaska Natives in the United States were first provided through the Department of War from the early s until the Office of Indian affairs came into creation and took over the mission. This law requires the agency to give preference to qualified Indian applicants before considering non-Indian candidates for employment, although exceptions apply. Public Health Service Commissioned Corps. This is a non-armed service branch of the uniformed services of the United States. Professional categories of IHS Commissioned corps officers include physicians, physician assistants, nurses, dentists, pharmacists, engineers, environmental health officers, and dietitians. In , most IHS job openings were on the Navajo reservation. This authority was expanded in with the Indian Sanitation and Facilities Act , which also authorized construction and maintenance of sanitation facilities for Native American homes, communities, and lands. All federally recognized Native American and Alaska Natives are entitled to health care. This health care is provided by the Indian Health Service, either through IHS-run hospitals and clinics or tribal contracts to provide healthcare services. This policy makes it difficult for an Indian who leaves their tribal home for education or employment to receive health care services to which they are legally entitled. An IHS fact sheet clarifies that Indians are also eligible to apply for low-income health care coverage provided by state and local governments, such as Medicaid. A contributor to Indianz. Others have concerns that the restrictions of the Indian-preference policy do not allow for the hiring of the most highly qualified health professionals and administration staff, so quality of care and efficiency of administration suffer. Participants are paid according to the GS pay-grade system, which is beneficial for college students. Their GS level is determined according to credit-hours acquired from an accredited college. Engineering Extern participants generally practice field work as needed and office work. The IHS was able to build and renovate medical facilities and focus on the construction of safe drinking water and sanitary disposal facilities. The IHS now contracts with urban Indian health organizations in various US cities in order to expand outreach, referral services, and comprehensive healthcare services. The current acting director is Rear Admiral Michael D. Twelve regional area offices each coordinate infrastructure and programs in a section of the United States. IHS areas[edit] A network of twelve regional offices oversee clinical operations for individual facilities and funds. As of , the federally operated sites included twenty-eight hospitals and eighty-nine outpatient facilities. Director, Leonard Thomas, M. Navajo [20] Bemidji Area: Director, Keith Longie, M. Director, Dorothy Dupree, M. Director, Beverly Miller, C. Cherokee [21] Great Plains Area: The name of this area was changed in from the "Aberdeen" area. A Cherokee [23] [24] Navajo Area:

Chapter 3 : United States Indian Health Service Program Statistics Team [WorldCat Identities]

AGENCY/PROGRAM: Indian Health Service, Office of Public Health, Office of Program Support, Division of Program Statistics DESCRIPTION: The purpose of this database is to provide a data source for the analysis of American Indian and Alaska Native (AI/AN) deaths.

Chapter 4 : American Indian Health Program

American Indian Health Program (AIHP) (Health Plan ID #) American Indians and Alaska Natives (AI/AN) enrolled in AHCCCS or Children's Health Insurance Program (KidsCare) may choose to receive their coverage through the AHCCCS American Indian Health Program (AIHP) or one of the AHCCCS-contracted managed health plans.

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Chapter 5 : What Is the Indian Health Service? - Brigham and Women's Hospital

The Indian Health Program (IHP) administers the AIIHI program, which provides extensive home visiting/case management services to high-risk Indian families. The AIIHI is modeled after the "Healthy Families America" program, which offers home visitation to provide basic health care information for high-risk or potentially at-risk families with.

Chapter 6 : Indian Health Service, U.S. Department of Health and Human Services - IHS - calendrierdelasc

Indian Health Service / Tribal Health Program (IHS/THP) Reimbursement Agreements Program. The VHA Office of Community Care, the Office of Tribal Government Relations, and VA medical centers work together to implement the Tribal Reimbursement Agreements Program.

Chapter 7 : Indian Health Program

Indian Health Service/Tribal Health Program $72,, Program Total Disbursed Total Unique Veterans Total Disbursement - Out of System Retropayments (only).