



5 OCT 2016

Dear Tribal Leader:

At the request of Tribal Leaders, the Indian Health Service (IHS) will host a joint meeting with our Tribal Advisory Committees – Direct Service & Contract Tribes Advisory Committee (DSTAC) and Tribal Self-Governance Advisory Committee (TSGAC). Please make your plans to join us for a Joint Tribal Advisory meeting on October 9 from 9:00 a.m. – 5:00 p.m., in Room 106A at the Phoenix Convention Center, located at 100 North 3rd Street, Phoenix, Arizona. We have also extended a special invitation to the members of the Secretary’s Tribal Advisory Committee (STAC).

The purpose of the meeting is two-fold. First, this meeting seeks to generate concrete ideas to establish a framework for transformative change that can be implemented immediately. Our objective is to address both medical and non-medical leadership challenges within the IHS in the short-term, and in the longer term, create a plan of action. Secondly, this meeting will provide a forum to host a discussion among advisory committee members to share the goals, objectives, and strategic plans of the DSTAC and TSGAC.

The IHS will utilize a *World Café* model to address workforce ideas. The *World Café* model fosters conversations by focusing on exploring themes, rather than on problem-solving. To learn more about the *World Café* model, please visit the following links: <http://www.theworldcafe.com/> or <http://www.artofhosting.org/>.

At the end of this meeting, we will have an action plan to address both short- and long-term workforce issues that can then be incorporated or adopted into the respective advisory committee plans.

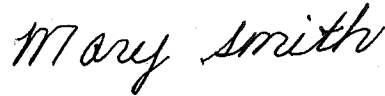
For your reference and preparation for this meeting, please find enclosed the following documents:

1. Meeting Agenda
2. IHS Summary Sheet – IHS Workforce Challenges
3. Crosswalk of DSTAC and TSGAC Common Priorities

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Thank you for your partnership and engagement as we continue addressing IHS workforce challenges and strengthening access to quality health care services. I look forward to your participation in this meeting.

Sincerely,

A handwritten signature in cursive script that reads "Mary Smith". The letters are dark and fluid, with a clear loop for the 'M' and a trailing flourish at the end.

Mary Smith
Principal Deputy Director

Enclosures

Indian Health Service Meeting (IHS) with Tribal Advisory Committees

Strategy Session and World Café: The Road Ahead and Improving Leadership & How Will You Lead It?

Sunday, October 9, 2016 – 9:00 a.m. – 5:00 p.m. - Phoenix, Arizona

Purpose: To generate concrete ideas to establish a framework for transformative change in the Indian Health Service (IHS) that can be implemented immediately. Our objective is to address both medical and non-medical leadership challenges within the IHS in the short-term, and in the longer term, resulting in the creation of a plan of action and communication.

AGENDA

Phoenix Convention Center – Room 106A

- 9:00 a.m. Invocation
- 9:10 a.m. Welcome & Introductions
- Overview of agenda, meeting structure, and introductions of Tribal Moderators and IHS Key Leaders
- *Mary Smith, Principal Deputy Director, IHS*
 - *Chief Lynn Malerba, Chair, Tribal Self-Governance Advisory Committee, IHS*
 - *Nicolas Barton, Chair, Direct Service Tribes Advisory Committee, IHS*
 - *Chairman Aaron Payment, Secretary's Tribal Advisory Committee, HHS*
- 9:30 a.m. IHS Briefing for Tribal Leaders - Challenges Facing IHS
- *Elizabeth Fowler, Deputy Director for Management Operations, IHS*
 - *Lisa Gyorda, Acting Director, Office of Human Resources, IHS*
- 10:30 a.m. Presentation, Crosswalk and Discussion of Advisory Committee Strategic Goals, Objectives, and Plans
- *Chief Lynn Malerba, Chair, Tribal Self-Governance Advisory Committee, IHS*
 - *Nicolas Barton, Chair, Chair, Direct Service Tribes Advisory Committee, IHS*
 - *Chairman Aaron Payment, Secretary's Tribal Advisory Committee, HHS*
- 11:30 a.m. Tribal Advisory Committee Member Discussion on Morning Topics
- 12:00 p.m. Lunch (on your own)

WORLD CAFÉ MODEL

- 1:30 p.m. Welcome to the World Café on Leadership and Community Change
- *Mary Smith, Principal Deputy Director, IHS*
- 1:40 p.m. Setting the Leadership Framework
- *Chief Lynn Malerba, Chair, Tribal Self-Governance Advisory Committee, IHS*
- *Nicolas Barton, Chair, Direct Service Tribes Advisory Committee, IHS*
- *RADM Kevin Meeks, Acting Deputy Director for Field Operations, IHS*
- 1:50 p.m. Overview of Question 1: Recruiting Strong Health Care Leaders
- *Mary Smith, Principal Deputy Director, IHS*

Question No. 1: What is the one transformative change in your community that would make the most immediate difference in recruiting strong leaders in providing health care in the short term? What is the one change that IHS can do in the short-term to recruit strong leaderships at IHS?

- 1:55 p.m. 20-minute Table Discussion on Question No. 1
- 2:15 p.m. Report Out and Discussion
- 2:40 p.m. Tribal Example and Best Practice –Cheyenne and Arapaho Tribal Communities
- *Nicolas Barton, Chair, Direct Service Tribes Advisory Committee, IHS*
- 3:00 p.m. Introduction of Question 2: Building a Pipeline of Strong Health Care Leaders
- *Mary Smith, Principal Deputy Director, IHS*

Question No. 2: What can you do to lead your community to immediately build a pipeline of strong leaders in medical professionals and management positions, over the longer term? And, what do you need IHS to do to make it happen?

- 3:05 p.m. 20-minute Table Discussion on Question No. 2
- 3:25 p.m. Report Out and Discussion
- 4:00 p.m. Session Wrap Up – Next Steps and Communication Plan for 1) Short- and Long-Term Action Plan for Addressing IHS Workforce Challenges and 2) Strategic Ideas Generated from the World Café
- *Mary Smith, Principal Deputy Director, IHS*
- *Chief Lynn Malerba, Chair, Tribal Self-Governance Advisory Committee, IHS*
- *Nicolas Barton, Chair, Direct Service Tribes Advisory Committee, IHS*
- *Chairman Aaron Payment, Secretary's Tribal Advisory Committee, HHS*
- 4:45 p.m. Final Questions and Comments

Indian Health Service Summary of Recruitment and Retention Challenges

Over two-thirds of the over 15,000 IHS employees provide direct patient care or clinical support services at IHS service units. Additional service unit staff provide administrative support in areas such as administration, procurement and personnel. When possible, IHS hires American Indian and Alaska Native people, many from the local communities we serve, to provide culturally competent health care to Indian communities. Currently 69 percent of IHS employees are American Indian or Alaska Native. The IHS, like many rural health systems, faces difficulties finding qualified applicants willing to serve in rural locations, especially health care providers. Specifically, IHS has identified the following challenges that impact the recruitment and retention of health care providers.

Recruitment and Retention Challenges

Rural Locations -- Attracting health professionals to rural and remote locations is an ongoing challenge. While there are some rural health residencies and training programs, most health professionals receive their education and training in urban locations. Once they have completed their education/training, few choose to relocate to rural or remote areas unless they are from a rural or remote area or they receive significant incentives to relocate (e.g., repayment of educational loans).

Housing/Schools/Basic Amenities -- Many rural and remote areas often lack amenities families consider essential. These include grocery stores, theaters, restaurants, and organized activities for children, such as sports leagues or civic organizations. Lack of housing options are often a barrier due to a lack of federal employee housing or rental units on reservations. In some cases, providers must commute in excess of 60 miles one-way to find adequate housing. Also, many locations have limited choices for high achieving schools for employee's children. Highly trained medical professionals are often hesitant or unwilling to relocate to locations that lack adequate educational opportunities and often demand access to exceptional schools for their children.

Spousal Employment Opportunities -- Employees often have difficulty finding employment for spouses or family members. This is particularly true for physicians who, at ever increasing numbers, are married to other professionals, e.g. attorney, systems analysts, CEO's and other physicians. Indian Preference requirements can impede a spouse from being considered for a job.

Compensation Limitations, including limited Title 38 Authorities -- Title 38 Part V, Chapter 74 of the United States Code governs all aspects of personnel administration for the Department of Veterans' Affairs (DVA) unless expressly overridden by another law or regulation. In many areas of personnel administration, the DVA is exempt from Title 5 laws and regulations by virtue of Title 38. The U.S. Office of Personnel Management (OPM), under the authority of sections 1104 and 5371 of Title 5 of the United States Code, has authorized HHS to use the Title 38 provisions pertaining to pay rates and systems, premium pay, classification, and hours of work. If HHS Operating Divisions, including IHS, use the delegated Title 38 provisions, the comparable authority under Title 5 is waived. However, 5 U.S.C. § 5371 does not provide

Indian Health Service Summary of Recruitment and Retention Challenges

authority to apply all personnel provisions of Title 38 in lieu of comparable Title 5 provisions.

The ability to use Title 38 for pay purposes is beneficial because IHS can offer market pay to physicians and dentists, and special salary rates to individuals in other health care occupations. However, IHS's use of these compensation authorities is not adequate by itself to compete with other public sector agencies and private sector organizations, including tribal health care facilities and programs.

IHS faces specific private and public sector competition in the area of annual leave accrual. Many private organizations offer more lucrative leave for doctors and nurses – even for those new to the profession. In addition, the DVA provides 8 hours of annual leave accrual per biweekly pay period to all new nurses, doctors, dentists, podiatrists, optometrists, and chiropractors – regardless of their years of experience. Due to the limited scope of 5 U.S.C. § 5371, IHS does not have this authority as it is covered by 38 U.S.C. § 7421, “Personnel administration: in general”. Thus, when a candidate with just a few years of experience is choosing between IHS and the DVA, he or she will likely choose the organization offering 8 hours of annual leave accrual per pay period, as opposed to 4 hours of annual leave accrual per pay period. Supervisors report anecdotally that IHS has lost many candidates due to this difference in accrual rates.

In addition to the 8 hours of annual leave, Title 38 allows for the hiring of non-citizens, two-year probationary periods and proficiency ratings system for assessing performance for certain medical professionals. Title 38 provides the DVA the flexibility to compete with both the public and private sector and to create the best possible human resources program.

Indian Preference -- In certain cases Indian Preference has been a barrier in recruitment efforts. The Indian Preference applies to all appointments to vacancies within the IHS, with only Indian Preference eligible candidates who are at least minimally qualified receiving consideration in the hiring process even where there is a strong candidate who is not eligible for Indian Preference. Indian Preference does not have any of the flexibilities of Veterans Preference (for example, the pass-over process). There is no waiver available (unless all the affected tribes grant a waiver) and it applies to transfers and reassignments.

Limited Leadership Pool -- IHS faces challenges with recruitment of highly qualified individuals for leadership positions and are not sufficiently staffed to develop a ready pool of management-trained professionals awaiting opportunities for promotion into leadership positions.

- We have come to rely on the expertise and professionalism of current staff until they can receive training while in temporary management or leadership positions pending permanent hires.
- IHS relies heavily on just-in-time development of leadership competencies from the internal pool of candidates who are busily occupied with patient care duties leading up to their new leadership assignment or must accept minimally qualified candidates due to the absence of highly qualified candidates resulting from recruitment challenges related to

Indian Health Service
Summary of Recruitment and Retention Challenges

remote locations, insufficient pay (by comparison to the private sector or Veterans Administration), and community issues.

- Additionally, due to the remote and rural location of many of our facilities, we hire from within the communities which can limit the pool of qualified candidates.

Personnel Security and Background Investigations -- IHS requires that all hires, including contractors and volunteers, receive a pre-clearance for personnel security requirements before they may begin work. This process includes a fingerprint check and submission of background information. The timely receipt and review of the information may cause delays in hiring and may also result in new hires not being found suitable for employment, and therefore requires the agency to re-advertise the position if there are no other candidates available.

IHS Scholarship and Loan Repayment Program -- There are disparities in how the IHS Scholarship and Loan Repayment programs have been managed in relation to the stated goal of placing health care professionals within medically underserved Indian health programs throughout the United States. Current program data indicates low application success rates, significant administrative challenges for applicants and program staff, and an overly burdensome system for reviewers and verifying officials in the field largely due to a poorly designed and technologically deficient application system. Program data also support significant disparities in approvals with disproportionate representation of scholarship recipients in a limited number of geographic locations.

Loan Repayment: Historically, IHS has chosen to offer more employees lesser amounts rather than identifying the highest need occupations with larger annual loan repayment amounts as authorized by law. This approach results in minimal progress in addressing significant disparities and is not helping address the critical needs in the hard to fill locations. IHS is examining the possibility of offering higher loan repayment awards for sites with higher site scores, similar to what is done by the National Health Service Corps. This would encourage applicants to consider higher priority sites. Additionally, we are examining limiting the number of approved occupations and identifying overlap between loan repayment programs to maximize usage. IHS is also examining the occupations currently receiving loan repayment and will be looking at re-allocating funds to cover the most critical, hard to fill health professions with the highest average debt burden where increased loan repayment awards could serve to recruit and retain healthcare providers.

Scholarship Program: Management is currently evaluating the IHS Scholarship program to ensure our systems and process will allow maximum consideration from all eligible applicants across all service areas. Currently, initial disqualification rates stand at or above 50% largely due to the manual processing of applications and lack of technology throughout. We are also evaluating the scope of approved disciplines which have expanded to ensure the highest consideration is provided to critical need direct healthcare occupations.

Indian Health Service Summary of Recruitment and Retention Challenges

Half-time Service Obligation: IHS has requested legislative authority for half-time service for the Loan Repayment and Scholarship programs. Allow IHS loan repayment/scholarship recipients to fulfill service obligations through half-time clinical practice, under authority similar to that now available to the National Health Service Corps Loan Repayment Program and Scholarship Program.

Tax Exemption: IHS has requested legislative authority to make IHS Scholarship and Loan Repayment programs tax exempt. IRS has determined that IHS loan repayment/scholarship awards are taxable, reducing their value. IHS is seeking a tax exemption for these awards similar to that of the National Health Service Corps.

Placement of IHS Nurse Scholars -- IHS vacancy announcements specify that a minimum amount of experience is required which makes it impossible for a new graduate nurse to qualify. Additionally, the IHS does not have a nurse residency program to assist new nurses in gaining experience. OHR is proposing renewed training efforts to scholarship coordinators and recruitment staff to identify scholarship recipients and ensure minimal delays in placement once open positions have been identified.

Lack of Residency Programs – IHS does not have a residency program, however IHS facilities do provide rotations to numerous medical students and residents annually. The challenge is how IHS can track these residents for future hiring. The IHS is looking at how local sites can improve communication with these students throughout their training and early career.

Shrinking Physician Pool -- Fewer physicians graduating in primary care disciplines (Only 32% of ALL physicians go into primary care) and only 9% of physicians seek to practice in rural areas.

Licensure issues -- 50-75% of physicians contacting IHS recruiters have licensure or conduct issues making them unsuitable for federal employment.

Flexible Work Schedules -- Flexible work schedules are more often found at larger health care facilities. Most IHS facilities are too small to provide great flexibility for providers as finding colleagues to cover shifts can be difficult. These same providers may have great distances to travel for shopping, activities, traveling for vacation, etc. so this lack of flexibility is impactful. Although a schedule of two weeks on/two weeks off is possible, it is rarely feasible at an IHS facility.

**INDIAN HEALTH SERVICE
JOINT TRIBAL ADVISORY COMMITTEE - COMMON
PRIORITIES**

- Transparency
- Accountability
- Quality and Innovation

Short Term	Long Term
<ul style="list-style-type: none"> • Revise IHS CSC Policy • Include P/RC in VA-IHS reimbursement agreements • IHS & Area Consultation • Recruitment and Retention • Traditional Medicine • Make CSC funding Mandatory • Evaluate Indian-specific provisions of the ACA • Telemedicine • Evaluation of Medical Equipement 	<ul style="list-style-type: none"> • Increase IHS Appropriations and Move IHS funding to Mandatory funding • Enact Advanced Appropriations • Facilitates and Staffing • Expand Tribal Self-Determination to other HHS agencies • Permanently reauthorize SDPI • Restore Cuts and Exempt Tribal Programs from Sequestration • Institute a Tribal Advisory Committee for OMB

NOTE: This draft document was prepared by IHS has a handout of the October 9, 2016 IHS meeting with Tribal Advisory Committees. It includes a compilation of shared priorities of the IHS Direct Service Tribes Advisory Committee (DSTAC) and Tribal Self-Governance Advisory Committee (TSGAC). The information sources include: DSTAC meeting minutes, DSTAC Budget Priorities, TSGAC meeting minutes and the 2015-2017 National Tribal Self-Governance Strategic Plan & Priorities (2015).