California Area Indian Health Service
Annual Tribal Leaders Consultation Conference
"Expanding Partnerships"

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"Priorities and Partnership"

by

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When I received the invitation to meet with the California tribal leaders, our country was preparing for war. Six days ago that war began. Just as 9-11 changed the priorities of the nation on that day, the missiles the evening of March 19th also started a new chapter in our country's history. Although the nation's priorities have changed, the health priorities of the Indian Health Service, tribal governments, and urban Indian health programs have not. We remain committed to the shared goal of increasing the health status of Indian people to the highest level possible. Meeting our priorities during a time of war is a challenge we have faced in the past. We are capable of supporting the war effort so that our warriors who are over in Iraq, like our ancestors and relatives who fought in the other wars of this country, have what they need to defend our country. I know that there are sons and daughters from the California Tribes who are performing with distinction and honor. Among the many freedoms they are defending, they need to know that the health needs of their families and communities will continue to be met.

To support the war effort, and to respond to any completed threats at home, the Department of Health and Human Services has placed all the U.S. Public Health Service Commissioned Corp on alert status for possible deployment. Almost 36 percent of the PHS Commissioned Corps is assigned to the Indian Health Service. Almost 95 percent of IHS dentists, pharmacists, sanitarians, optometrists, physical therapists, podiatrists, and engineers are commissioned officers. And 45 percent of our physicians are in the Commissioned Corps.

If mobilized, a large part of our health workforce could be affected. Will that have an affect on our ability to provide health services? Yes. How will we be able to meet the health needs of our people? – through partnerships.

The IHS is a $3.6 billion health corporation. And we all acknowledge we can't do it all. This is not to mean we don't do an awful lot! The dedicated, hardworking, and outstanding employees of the Indian Health Service, tribal, and urban Indian health programs are the foundation for everything we do and are able to achieve. They build the reputation of the IHS-Tribal-and urban Indian health system – and it is that reputation which opens many doors for partnerships. The Indian health system is an enormous system that moves forward and makes a difference in the lives of American Indians and Alaska Natives wherever they live because we are all focused on the same goal – improving the health of our people.

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I believe we are in a new era of strengthened and expanding partnerships within the Department of Health and Human Services. The Secretary, Deputy Secretary, and senior members of their staff are committed to improving the health of all Americans by putting the resources of the entire department into achieving that goal. It is more than just an IHS partnership with other operating divisions or programs within the Department – it is also partnerships directly between tribal and urban Indian health programs and the programs of the Department. In the past the entry to the Department for Tribes seemed to be through the Indian Health Service. But this Secretary has strengthened the government-to-government relationship by re-emphasizing the role of the Inter-Governmental Affairs Office within the Office of the Secretary. That is the entry point for Tribes and urban Indian representatives who wish to arrange consultation meetings or initiate program contacts. That is also the office within which the Secretary's Regional Directors are located. And the partnerships between the Regional Directors and Tribes, urban Indian programs, and the IHS Area Director's are being strengthened and becoming more effective.

As an example, next week there will be a joint meeting in Washington, D.C., between the IHS Area Directors and the HHS Regional Directors. The agenda includes topics such as tribal consultation, Area Director and Regional Director responsibilities, emergency preparedness and communications with Indian Country, and also discussions around opportunities for future collaborations.

Attending this conference today is someone who will also be attending the meeting next week, and whom many of you know, Dr. Josh Valdez, the Secretary's Representative for Region IX. Dr. Valdez is based out of San Francisco. There is no one I consider more qualified for understanding the diversity of the California Tribes and their health needs than Dr. Valdez. His work with under-served, uninsured, and minority communities and his experiences working in a variety of health care delivery systems gives him a perspective on the value of partnerships, and consultation, which will serve Indian Country well. I look forward to hearing his remarks this morning.

A further demonstration of the Secretary's commitment to partnerships was the personal interest he took to re-energize the Intradepartmental Council on Native American Affairs. I co-chair that Council, along with Quanah Crossland Stamps, the Commissioner of the Administration for Native Americans. And the members of the Council are the Directors of the other Operating Divisions and programs of the Department. Not their Deputy, not a representative, but the Director of the agency. The Intradepartmental Council is expected to coordinate the resources and programs of the Department to ensure that the health disparities and health interests of American Indians, Alaska Natives, and Native Hawaiians benefit from the more than 315 programs of the Department. Another goal we have is to increase the number of programs being accessed by tribal and urban Indian health programs from approximately 85 to at least the estimated 125 that are specifically targeted for Indian people. For example, we are working closely with the Health Resources and Services Administration to identify opportunities for tribal and urban programs to benefit from the Community Health Centers program – and what changes to the criteria, within the Department's authority to change, could be considered to broaden the opportunity for urban Indian programs to participate. Another example is the Substance Abuse and Mental Health Services Agency and their Alcohol and Substance Abuse funding. Over the next 3 years, it has been proposed for SAMHSA to receive $600 million to help addicted Americans find treatment. There may be opportunities within that program to possibly fund some of the IHS, tribal, and urban Indian alcohol and substance abuse programs, as well as for faith-based and traditional health programs in Indian country and urban areas.

The IHS is located within a truly remarkable and diverse Department. Through the combined resources of the Department we can support the troops overseas and their families at home, protect our country within our borders, and strive to meet the health needs of Indian people.

Our health needs can also be met through partnerships external to the Department. Health status is not just an access to care issue. American Indian and Alaska Native people must have the same opportunities afforded to all Americans—the opportunity to receive an education, to have meaningful employment, to share in the economic development of a community, to benefit from the advantages of a technological society, and to enjoy a safe community. Our greatest disparities in our health status with the rest of the Country are in those diseases and illnesses that are the consequence of behavior and lifestyle choices. Health access, education opportunities, effective employment, environmental health and safety, all help form the choices that people make. Partnering with others gives us an opportunity to remove despair from influencing the choices that are made.

I am committed, as many of you are, to raising the health status of American Indians and Alaska Natives. All these things I mentioned, and many more, are interdependent. One aspect of well-being builds on another. I am always encouraged to attend meetings such

as these because of what I learn from you, and because it underscores the combined strength that we have to make a positive difference.

Another way we will meet the health needs of our people is by contracting with others for the services that we cannot offer. Now that an appropriation for 2003 has been passed, I will shortly release my decision regarding the distribution of Contract Health Service Funds. In general, three formula options were presented for my consideration – maintain the current formula, change to a new formula, or blend the current and the new formulas. Whatever decision I announce regarding the formula, my final decision will include a provision for distribution of funds on a recurring basis. Because of the critical need for Contract Health Service care, my decision will also include a "hold harmless" clause so that no Tribe will receive less funding than they currently receive.

I will also soon announce my decision regarding the distribution of the Alcohol and Substance Abuse funding. What I can say now is that each of the four distribution methodologies submitted for my consideration contained a 5% set-aside for urban Indian health programs of the funds available for distribution.

My decisions have been reached through consultation with Tribes. The recommendations I considered were from the Tribes. That is what I consider effective Tribal consultation. The decisions reached as a result of consultation are worth the time and effort.

One of my management priorities is to restructure the agency headquarters so that we have a cadre of agency representatives with the authority and responsibility to make decisions. I consider that talking to anyone in the IHS is the same as talking to me. I expect, and I receive, feedback informally and formally. I hope you do not feel that I have to be in the room for you to be sure I am getting your message, but if you feel that way – my door is open so that we can see what we can do to continue moving this agency and the health care programs for American Indians and Alaska Natives forward.

One cannot move forward without looking at the past. And look how far we have already come. In 2 years we will mark 50 years of service to American Indian and Alaska Native people as part of the Department of Health and Human Services. But we have a history of greater than 50 years for providing health services to Indian people through programs that ultimately evolved, from the first treaty agreements with the Federal Government in 1784, into the Indian Health Service, an organization that is the primary agency responsible for carrying out the federal government's obligation to provide health services to members of tribal governments.

Continuing this legacy of health care is important because we all have an obligation to honor our ancestors by ensuring that the agreements for health services and meaningful tribal consultation are honored. I believe our President and his Administration, including the Secretary, and indeed all of HHS, are committed to this goal.

Helping one another, I believe, will be critical in the future. The country faces many challenges causing shifts in priorities, realignment of resources, and restructuring of the economy and the government. These challenges will likely require sacrifices that will affect the future for our families, cultures, and traditions. Partnerships and alliances must be developed and strengthened – because they produce results.

Earlier this month I testified before the Senate Committee on Indian Affairs regarding the President's fiscal year 2004 budget proposal for the agency. I mentioned some of the highlights of his proposal. I also recognized the Committee for raising the 2003 budget appropriation to 3.3% above the 2002 enacted level. In this era of war and economic challenges, there are austere budgets for many government programs, and any increase is viewed as a success. The performance of the Indian health system of IHS, tribal, and urban Indian health programs is well understood and documented, and increases can be attributed to that factor in the budget decision-making process.

I also mentioned that the Indian Health Service appropriation is only **part** of what it takes to address the health disparities between American Indians and Alaska Natives and the rest of the population. The other part is the importance of our alliances – not just at budget time but throughout the year.

Collaborations between the Indian Health Service and tribal and urban Indian health programs should also not be overlooked as an avenue for conserving funds and maximizing business practices. For example, to continue to be eligible to collect third-party payments from Federal programs such as Medicare and Medicaid, covered health care providers must comply with the Transaction Rule of the Health Insurance Portability and Accountability Act. The Indian Health Service has expended significant workforce time and effort to meet compliance implementation dates. These compliant items are available from the IHS website for tribal and urban Indian health programs to use and modify, if needed. Not only does this sort of collaboration conserve the funds and workforce efforts of Tribes and urban Indian health program staff – it also ensures that we all can continue to bill and collect from Medicare and Medicaid, which, for the IHS, accounts for nearly half-a-billion-dollars a year in additional resources and for the urban program accounts for nearly $10 million.

I believe there are many organizations and individuals who want to become actively involved, or

expand their involvement, in helping meet the health needs of American Indians and Alaska Natives. Another type of partnership we are actively trying to form is an Indian health foundation. To that end I am initiating the process to have legislation introduced in the Congress that will establish an Indian Health Service Foundation. Senators Campbell and Inouye recently introduced Senate Bill S.555 to establish the Native American Health and Wellness Foundation. There will be a hearing on April 9, 2003. The Foundation would connect ideas with individual, philanthropic, and corporate donors to significantly promote Indian health, expand health services, and develop new initiatives to encourage solutions for conditions affecting American Indian and Alaska Native people and communities – wherever they may live.

Lastly and most importantly, let me speak about the status of health of our people. It is totally unacceptable to me, both as an American Indian and the Interim Director of the Indian Health Service, that in our prosperous nation, Indian people continue to experience health disparities and death rates that are significantly higher than the rest of the U.S. general population:

- Alcoholism - 770% higher
- Diabetes - 420% higher
- Accidents - 280% higher
- Suicide - 190% higher
- Homicide - 210% higher

Those statistics are startling, yet they are so often repeated that some view them as insurmountable facts. But every one of them is influenced by behavior choices and lifestyle. Making significant reductions in health disparity rates, and even eliminating them, can be achieved by implementing best practices, using traditional community values, and building the local capacity to address these health issues and promote healthy choices.

A heartbreaking aspect of the health disparity for American Indians and Alaska Natives is the portion that burdens Indian children and adolescents. I consider no greater example of effective partnership than that of the California Area Tribal Advisory Committee that have joined state and federally recognized tribal leadership, urban Indian health programs, and the California IHS Area Office staff to address the issue of alcohol and substance abuse among our youth. In addition to developing a network of residential- and community-based rehabilitation and follow-up services they have also agreed to submit a request to develop and construct two 35-bed Youth Regional Treatment Centers in California. And the facility is being planed to also provide lodging for families involved in family therapy. I understand that the cost of this facility is being incorporated into the California fiscal year 2005 budget formulation process. I applaud your initiative on this proposal and offer the assistance of my headquarters staff to ensure this request moves forward.

There are significant leadership challenges confronting each of us in our various roles. We are operating within a dynamic and ever-changing set of factors that will influence decisions affecting Indian health programs now and for years to come. We must act to ensure that we maintain the valuable and necessary infrastructure that we now have and at the same time look for future opportunities to strengthen our programs and partnerships. Our people are counting on us.

Thank you, once again, for inviting me to join you here today

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