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"Self-Governance in Challenging Times:
Maintaining Focus on Our Mission and Advancing Tribal Control"
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"Success in Meeting Health Challenges"

by

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It is an honor to be invited to speak to you today on behalf of the Secretary of Health and Human Services, Tommy Thompson, and on behalf of the Indian Health Service. As the theme of this conference has stated, these are indeed challenging times. But challenges are nothing new to tribal leaders, sovereign nations, or Indian health programs. Just as we have overcome obstacles and met challenges in the past, we will overcome the main health challenge we currently face – the scourge of chronic disease that challenges our capacity to meet the health needs of Indian country and challenges our ability to maximize our available resources.

I believe this Administration and this Secretary are up to meeting the challenges we face in providing quality health services and honoring treaty rights. They brought with them a new perspective on the role of the federal government and federal programs and the people we all serve. That perspective is a shared responsibility for the programs we administer, programs that demonstrate their effectiveness will continue to be funded, and that partnerships can make programs more effective and maximize resources. They are particularly focused on expanding community based partnerships and opportunities.

We who are involved in providing health services realize how long it takes to show results in health data. Changes in health status do not occur overnight or even within a few years. And that is the same with some of the goals and initiatives of the President's Management Agenda and the Secretary's management initiatives. When the Secretary was first confirmed, he immediately set about establishing the management model of "One Department." Some aspects of this initiative overshadowed other aspects – for example, initial attention was focused on the consolidation of human resource programs from 40 to 4, and the transfer of the HR staffs of the Operating Divisions to the Department. But there were also ongoing "One Department" initiatives to link the efforts of individual Operating Divisions so that all HHS programs shared responsibility for American Indian and Alaska Native health issues, and so that programs would effectively coordinate the delivery of services as well as expand access to health care resources and funding. As a

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result, HHS programs have an increased focus on benefiting Indian people, and there has been additional investment in programs that have demonstrated their benefit for raising the health status of Indian people. For example, the Special Diabetes Program for Indians received a $50 million increase, for a total of $150 million each year, and the authorities for that were extended until 2008. The Department also requested $20 million more for the Agency Sanitation and Facilities Construction program of the IHS because the Secretary and his leadership have been out in Indian country, they have seen the problems that many our communities have – they don't have safe water and sanitation facilities. Through this personal intervention of the Secretary and his high level staff– who saw the negative impact it would have on tribal and IHS programs – the Tribes and the IHS were excluded from implementing the Medicare Outpatient Prospective Payment System, which saved us $30 million in implementation costs and would have cost us $17 million each year thereafter. The Secretary, CMS leadership, Indian Health Service leadership, tribal workgroups and organizations all worked together to see that that issue was addressed and in a way that was favorable to Indian country. The Centers for Medicare/Medicaid Services has also made additional decisions that would affect our programs, including just recently forming a Tribal Technical Advisory Group. This group will provide advice and expertise on issues affecting the delivery of health care for American Indians and Alaska Natives served by Medicare, Medicaid, and the State Child Health Insurance Program–much like the role the Tribal Self-Governance Advisory Committee provides the IHS.

Last March the Secretary sent the Title VI Self-Governance feasibility study to the Congress. In that report he recommended that Self-Governance be expanded within HHS beyond the IHS to 11other HHS programs within 3 other Agencies: SAMHSA, ACF and AoA. The report also recommended that the Secretary retain the discretion to expand the Demonstration project to six other programs. On Wednesday, Oct. 1st, Senators Campbell and Inouye introduced S. 1696, a bill based on the HHS feasibility study, to amend the Indian Self-Determination and Education Assistance Act to provide for a demonstration program – not to exceed 5 years to allow further self-governance by Indian Tribes. The Senate Committee on Indian Affairs has scheduled a hearing on this bill for October 29, 2003. The Department is expected to present the views of the bill at that time.

The Secretary supports the government-to-government relationship with Tribes and has always been an advocate on behalf of American Indians and Alaska Natives, and we did not get lost in his "One Department" initiative. For example, as consolidation moved forward, the Secretary directed major refinements to the Indian Health Service in recognition of our unique government-to-government status as well as our unique hands-on health services delivery program. And he listened to our concerns expressed during the regional consultation meetings, which are another initiative of the Secretary's, and during other meetings, such as those regarding the consolidation of the human resources function. The refinements resulting from those meetings will allow our former IHS Human Resource employees to remain in place, and they will continue to provide services to us as before. And, when their position becomes vacant, Indian Preference will continue to apply to those positions. Recently, proposed appropriation language also appears to offer similar relief to that already provided by the Department – and the Department has initiated actions to participate with the Congress to address additional issues and concerns, and as a result, has temporarily delayed consolidation activities until their work with the Congress is completed.

The Secretary also revitalized the Intradepartmental Council on Native American Affairs. This has been a huge effort within the Department to elevate the health and social service issues of Indian country with the leadership in the Department. It has eliminated many of the barriers that might have previously existed within the Department of Health and Human Services programs and funding. The Council undertook a Grants Access Study to inventory HHS programs and determine how many of those programs were being accessed by Tribes. The study indicated that HHS has 315 programs that offer grant funding. Of the 315 programs, Tribes are eligible for 125, or about 40% of grants offered by the Department. Of the 125 programs, Tribes are only accessing 85 of them. In 2004, the Council will begin to look at why Tribes are not accessing the other 40 grant programs. If the challenges to accessing these grant programs are internal to HHS, we are going to eliminate that barrier.

The Secretary made clear his expectation that HHS programs expand access to American Indians and Alaska Natives, and I want to acknowledge the Centers for Disease Control and Prevention that has made a universal change in their grant announcements by including a specific mention that American Indian tribal governments are eligible to apply. The Secretary has also emphasized that all HHS programs have a responsibility to address the needs of our people within the scope of their respective missions. The fact that I share time on your agenda today with Charlie Curie, the Administrator from SAMHSA, which has played a significant role in Indian country with grants for substance abuse and mental health services, and Edwin Walker, Deputy Assistant Secretary from the Administration on Aging, which will have great influence on the immerging issue in Indian country of long-term care and elder health care, reflects the commitment of the

Secretary and the Department to make a difference in the health status of American Indian and Alaska Native people across the country. Rick Weaver from the Administration for Children and Families out of San Francisco, also have a large number of programs that affect Indian country. I would like to thank my colleagues for joining us here today. I would also mention that Administrator Curie, and Commissioner of the Administration for Native Americans, Quanah Crossland-Stamps, were also in St. Paul last week at the National Indian Health Board meeting. The presence of senior leadership from HHS agencies at national American Indian and Alaska Native meetings is a demonstration of our collective resolve to work as a team to look for solutions to the issues that confront us. It is an honor to serve with them on the Secretary's team.

The Secretary and his staff are extremely interested in consulting with Tribes on the budget request of the entire Department. In response to your requests for advance notice of the HHS-Tribal budget consultation meeting so that you have adequate time to prepare and to obtain technical assistance from HHS staff, the budget consultation meeting on the fiscal year 2006 budget will take place on May 12 and 13 of 2004, in Washington, D.C.

Yes, there are challenges. And there are opportunities. As I mentioned at the beginning, this Administration arrived 3 years ago with a different idea on the role of government in people's lives. President Bush said, "Government likes to begin things . . . but good beginnings are not the measure of success. What matters in the end is completion. Performance. Results." That is the standard he set for this Administration. To measure success we need to measure our performance and our outcomes.

The diabetes program is an excellent example of facing a challenge and succeeding. Not only was it a challenge of how can we become more effective in treating and preventing diabetes in Indian Country – but the challenge of demonstrating to the Congress and the Administration that their investment of additional funds toward diabetes prevention and treatment services, which started out as $30 million a year in 1998, was a good investment. From the beginning, the national diabetes program set out to measure the impact an investment of $30 million a year can make – programs were initiated, funds were distributed, and results started to be monitored. The result – 318 programs for diabetes prevention and treatment – 81 percent are tribally run, 73 percent offer prevention programs for children and youth, 86 percent offer prevention services for elders, and 87 percent offer fitness programs targeting the entire community.

These are just some of the measures which supported further investment into diabetes prevention, treatment, and control. In 2001 the investment increased to $100 million a year and extended to 2003. Then in 2002 the special funding was increased to $150 million per year and extended through 2008. And the investment wasn't just in funds; it was also in decisions that benefit our diabetes programs. For example, CMS authorized the IHS Diabetes Program to train and certify Diabetes Educators, something they had only authorized the American Diabetes Association to do, and that allows all of our Diabetes Educators to seek reimbursement for their services. I believe the more we continue to demonstrate that tribal and IHS diabetes programs are working in Indian Country, the more special funding will continue to be appropriated and will continue to increase and maintain as part of our budget.

In addition to increasing the health and quality of life for our people, there is also an eventual economic benefit from the investment into diabetes programs. The health care expenditures for people with diabetes are approximately $13,243 per person, compared with $2,650 per person for people without diabetes. This is why it is so important for us to figure out how to prevent diabetes, and I have allocated $27 million of the new $50 million for a competitive grant program starting in 2004 to figure out how to do just that in American Indian and Alaska Native communities. I think the true measure of our success will be down the road when we show that we can actually prevent this very expensive and devastating disease.

Another example of successful solutions for challenges is the Native American Research Centers for Health – the NARCH program. What began as a $1.5 million partnership between the IHS and NIH/National Institute of General Medical Sciences grew to a $4.5 million annual grant program in FY 2002, funded by additional NIH institutes and also other Operating Divisions of the Department, such as the Agency for Healthcare Research and Quality, which is going to contribute $250,000 beginning in fiscal year 2005. The benefits of this partnership are also obvious. Health research that is tribally determined and sanctioned is sorely needed to identify health issues and develop effective treatment programs. This partnership allows for the establishment of tribally-led research programs, and the additional benefit of meeting the goal of involving American Indian and Alaska Native researchers, scientists, interns, and staff in setting research goals and protocol, so that there is an Indian perspective in determining research focus and agendas for the nation.

But conducting Indian-focused research is not happening just through the NARCH program and NIH. Just recently the Montana-Wyoming Tribal Leaders Council was awarded a grant from the Agency for Healthcare Research and Quality to support the development of a research infrastructure that will provide

the foundation for ongoing sustainable research and development of effective strategies for addressing the significant health issues of American Indians in Montana and Wyoming. This is projected to be a 5-year grant in the amount of $870,000 and will be accomplished by the Tribal Leaders Council, the Black Hills State University, and the Black Hills Center for American Indian Health.

Grant awards such as these further validate the Department's commitment to meeting the health needs of Indian people through the efforts of "One Department." These grants and other funding initiatives represent additional resources outside of the IHS appropriation that are being used to build upon our success.

In three short years, this Administration and this Department have strengthened the value of performance-based budgets. The health services and outcomes of the Indian Health Service and the Tribes and urban Indian health programs can be measured. The investment we have made in software programs that can extract the information needed to measure outcomes will pay dividends many times over because we will be able to demonstrate that our programs work. And it will also allow us to identify where our programs are not working and make improvements if necessary or stop the program and approach the issue from another perspective.

As we have moved to a performance-based model for evaluating the effectiveness of our programs, we have been able to hold ourselves more accountable for outcomes. I believe we can demonstrate that these kinds of investments in Indian health is good business because we will have the data to support such a request. The diabetes program has earned additional investment because it is showing success. The NARCH program is gaining additional investors because it is showing success. The Sanitation Facilities Construction program received a large budget request because it is a success. Those are just a sample of the many successes we have out there. The more we continue to show that , the more will be able to tap in on some of the other funds in HHS and other partners across the government.

Speaking of health data, I want to take the opportunity to thank tribal programs for participating in submitting data through the RPMS system so that it can be aggregated with all the other health data that comes in. It strengthens our ability, and yours, to advocate for Indian programs and to justify budget requests. The health status trends, diagnosis, treatment, billing, services, and all the other data provide a picture of health and health infrastructure for Indian Country, and validation for continued investment in our programs. Your participation is voluntary and it is greatly appreciated because it makes an enormous difference. Just this past year we would not have achieved one of our performance goals if it weren't for the Tribes submitting their health data. When it comes to justifying our annual budget request to the Department and to the Congress, we are truly partners, working in unison to meet health objectives by sharing health data that supports our request. I want to thank self-governance tribes for their voluntary effort, I truly appreciate it. This data also improves our ability to seek Medicaid reimbursement – because the IHS and CMS interagency agreement, which is 2 years old, continues to enhance the IHS Medicaid data through the linkage with the Medicaid Data Systems of selected States.

I mentioned that the fiscal year 2006 budget tribal consultation will be next May in Washington, D.C. Yes, time to think of 2006 already, when we don't even have a 2004 fiscal year budget yet. The President signed a continuing resolution to keep the government operating though the end of October. At this time I do not have any information to share regarding the 2004 or 2005 budget appropriation – we are all waiting. As soon as there is information that can be released, we will release it to you.

Since I last spoke to the Self-Governance Tribes last November, I have been confirmed and sworn in as the seventh director of the Indian Health Service. I want to thank you for your endorsement and support during the nomination and hearing process. It is a privilege to serve the Indian people of this nation as the Director of IHS. And it will be an honor to help the agency celebrate its 50th anniversary as an organization in 2005. Over that time span there have been significant health challenges that have been overcome. Mortality rates have decreased in almost all categories, including maternal deaths, gastrointestinal disease, tuberculosis, infant deaths, unintentional injuries, pneumonia, influenza, homicide, alcoholism, and suicide.

And the lifespan of Indian people has increased from 51 years in 1940 to 71 years today, but that is still 6 years below the average life span of other Americans. And over this time frame our illness and disease challenges have transitioned away from infectious disease control to challenges of chronic disease and the consequences of behavioral and lifestyle choices.

Throughout the past 23 years the Department and the Indian Health Service has gone through challenging times – some would say every year is a challenging time, and we continue to serve Indian people today because of tribal leadership and the recognition of the Congress and the Administration of their treaty responsibilities.

Thank you again for inviting me to this conference. And thank you for sharing our goal to protect and improve the health of American Indian and Alaska Native people across this nation.

Thank you.

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