Indian Health Service

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Priorities for Reforming the Indian Health Service

by

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Good morning. It is an honor and a privilege to speak with you today as the Director of the Indian Health Service (IHS). I am grateful to have the opportunity to return and spend time with all of you here at the Native Investigator Program. A year ago, I could not have predicted that I would have transitioned to such a different role in American Indian and Alaska Native health!

Today, I will review my priorities for the Indian Health Service, and I will also discuss how research will play a role in informing our work over the next few years.

As the Director of the Indian Health Service, I run a business, and that business is health care. To briefly give an overview of our agency: the IHS is a comprehensive health care system that serves 1.9 million American Indians and Alaska Natives (AI/ANs). Our mission is to raise the physical, mental, social and spiritual health of AI/ANs to the highest level. The IHS fiscal year 2010 budget is approximately $4.05 billion, and IHS has a total of approximately 15,700 employees. Our work is done in partnership with tribes – approximately half of the IHS budget is managed by tribes under contracts and compacts.

The IHS has served to improve the health status of AI/ANs over time – this is best seen in the decrease in mortality rates since 1973, ranging from 14% for suicide to 84% for tuberculosis. This accomplishment is clearly due to providing access to care that otherwise would not be available in our communities.

However, the IHS continues to experience challenges as it works to achieve its mission. Health disparities continue to persist for American Indians and Alaska Natives compared to other populations; for example, mortality from diabetes and injuries for AI/ANs are nearly three times that of the U.S. All Races rates, and suicide rates are nearly twice the general population rate. Also, the average life expectancy for American Indians and Alaska Natives is still nearly 5 years less than that for the U.S. general population. Of course, you are all familiar with these statistics.

The text is the basis of Dr. Roubideaux's oral remarks at the University of Colorado's Native Investigator Development Program on January 12, 2010. It should be used with the understanding that some material may have been added or omitted during presentation.

The challenges we face in the Indian health care system are driven by a host of medical, cultural, geographic, and socio-economic factors, including:

- Population growth – that results in an increased demand for services
- Rising costs/medical inflation – especially in rural areas
- Increased rates of chronic diseases – such as diabetes and cancer
- Difficulty recruiting and retaining medical providers in our remote sites
- Challenges of providing rural health care
- Old facilities, equipment
- Lack of sufficient resources to meet demand for services
- And in the face of all these challenges, trying to balance the needs of patients served in IHS, tribal, and urban Indian health programs.

It is clear that a lack of adequate resources is a huge barrier to fully meeting the mission of the IHS. For example, per capita expenditures for IHS are much lower than those for other federal health care sources, such as Medicare, Medicaid, Veterans Affairs, etc. And even though the IHS budget has shown some small increases over the years, its buying power has actually decreased, due to inflation and escalating medical costs.

All of these challenges impact programs funded by the IHS, including tribally-managed programs, IHS Direct Service programs, and urban Indian health programs. Tribes often have to use their own resources to make up for the shortfalls in funding. IHS Direct Service programs are concerned about whether the IHS will continue to be able to meet their needs as more tribes apply to contract or compact their health programs. And urban Indian health programs face numerous challenges trying to serve the growing urban Indian population.

Because of these challenges, it wasn't a surprise to hear a great call for change as I did during my work on the Transition Team. In listening sessions with tribes, they indicated the need for both new funding and change and improvement of the IHS. President Obama has stated his goal of quality and accessible care for First Americans. He voted for increased funding and co-sponsored the Indian Healthcare Improvement Act reauthorization while he was a Senator. His administration is all about change. During my congressional visits for my confirmation hearing, I found great support for increased funding and improvements for the IHS. And I see evidence of hope and change already:

- The President's 2010 budget for the IHS includes a 13% increase – the largest in 20 years.
- The American Recovery and Reinvestment Act funding provided $590 million to the IHS for facilities and sanitation projects, maintenance and improvement, medical equipment, and health information technology.
- President Obama recently held the White House Tribal Nations Conference and told tribal leaders that "you will not be forgotten as long as I'm in this White House," which reaffirms his commitment to AI/ANs.

One of the most hopeful signs I see is the appointment of several Native people to critical positions in the new administration. With so many of us in the new administration, we can work together in new and innovative ways on a variety of issues of importance to our communities.

As the new Director of the Indian Health Service, I plan to focus on four priorities for our work over the next few years:

- To renew and strengthen our partnership with tribes
- In the context of national health reform, to bring reform to IHS
- To improve the quality and access to care for patients who are served by IHS; and
- To have everything we do be as transparent, accountable, fair, and inclusive as possible.

One of my top priorities as IHS Director is to renew and strengthen our partnership with tribes. I believe that the only way we can improve the health of our communities is to work in partnership with them. This partnership is based on the government-to-government relationship between the federal government and the tribes. It is also based on the federal trust responsibility to provide health care.

Tribes are important partners to IHS; they currently manage over half of the IHS budget. I am now consulting with tribes on our tribal consultation process to see how we can improve the process of how we work in partnership and make consultation more meaningful at all levels. In November 2009, President Obama issued a Presidential Memorandum that requires all Departments to consult with tribes on a plan to outline how they will work with tribes in this new administration; those plans were due in 90 days – which means they are due in February 2010.

My second priority distinguishes between the internal reform we need to bring to IHS over the coming months and years and the broader health insurance reform currently under consideration in Congress. I am sure you are all aware of the debate in Congress over national health insurance reform. While the House and Senate conference on a final version, we are all watching the Indian specific provisions in health reform and the Indian Healthcare Improvement Act, which is included in current health reform legislation in both the House and the Senate.

My priority to bring internal reform to IHS means taking a look at what we are doing, in partnership with tribes and with all of our staff, and identify what we are doing well and where we need to improve. It is clear that in order to get the support we so dearly need, we have to demonstrate that we can change and improve within IHS also.

I have started by gathering a wide range of input from tribes and staff on priorities for internal IHS reform – because the challenges are so great and we cannot do everything at once. The results have been very interesting and helpful as we start our reform activities.

You can track our progress on www.ihs.gov/reforms. On that website, you can review input received from tribes, through a formal tribal consultation, and from IHS and tribal staff. The leading priorities identified by IHS staff have included comments about how we lead and manage people and how we do business. While there were comments about how we deliver care, it is clear that there are significant challenges in how we operate as a business, and that impacts how we deliver care. The leading priorities from tribes were different and focused on more broad issues, such as funding, contract health care, and tribal consultation. We are beginning work on the top priorities.

My third priority is to improve the quality of and access to care for the patients we serve. We are reviewing input we received through the internal IHS reform process and also through gathering best practices ideas. We will also seek input more formally from tribes, providers, and patients served by our system. Customer service is a priority area.

My fourth priority is to make all of our work more transparent, accountable, fair, and inclusive. Transparency and accountability are priorities of the Obama administration. This will involve better communication and information about our activities, such as the reforms website and my Director's Corner on the IHS website. The Director's Corner will now serve as a one-stop place for getting updates on various initiatives and information, and will include a Director's Blog. I am focusing on media and communication strategies to help with our reform efforts.

We also have to make sure that any changes or improvements that we make to the Indian health system benefit all of our patients, whether they are served by IHS, tribal, or urban Indian health programs.

The IHS is not actually a research organization, and research is not one of our primary activities – we are a health care system. However, research, data, and evaluation impact what we do in the IHS. And they will likely play an important role as we move forward with my priorities for our work in the IHS.

We need to strengthen our partnership with tribes related to research data and evaluation – we need to partner better to ensure that we can continue to share data and monitor the health of our communities. We need to consider, as a part of our efforts to reform and improve the IHS, how to ensure we are doing the best we can for our patients. We want to ensure that we have the best quality of care (evidenced-based care according to standards), that we are evaluating our quality improvement efforts, and of course, that we are evaluating what we do as an agency.

We also need to improve the transparency and accountability of what we do – and demonstrate that we are performing well, providing quality care, and meeting the expectations of patients. Congress is increasingly demanding that we evaluate our efforts and show that we are improving outcomes and using our resources wisely.

In summary, it is clear that we need more resources to meet our mission, and that we must demonstrate willingness to change and improve. I know we all agree on the outcomes of these efforts: we need to improve the quality of and access to care for our patients, and we need to improve the health status of our people and eliminate health disparities in our communities.

The work ahead is daunting and the challenges are enormous. But when in our history have we had this opportunity – a supportive President, bipartisan support in Congress, a new and supportive administration, and the call for change from our communities and our patients?

It's clear to me that research, data, and evaluation will play very important roles as we change and improve the IHS. I believe that we have before us an extraordinary opportunity to make significant strides in improving the health of our people. I hope you all can join us in this critical work over the next few years.

Thank you.