National Institutes of Health Academy
October 12, 2010

Indian Health Service Overview: Addressing American Indian and Alaska Native Health Disparities

by

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Good afternoon. It is a pleasure to be here with you today to share information on how the Indian Health Service (IHS) is addressing health disparities in the American Indian and Alaska Native (AI/AN) population.

Today I will be giving you a brief overview of the IHS and will then discuss our priorities for reforming the IHS in order to improve our ability to address those health disparities. I will also comment on how my perspective as a former researcher impacts my decision-making as we move forward with IHS reform.

For those of you who are not familiar with the IHS, I will begin with some brief background information.

Let me begin by stating the IHS mission: *The IHS mission, in partnership with American Indian and Alaska Native people, is to raise their physical, mental, social, and spiritual health to the highest level*.

The IHS provides services for approximately 1.9 million AI/ANs through a comprehensive primary care network of over 600 hospitals, clinics, and health stations on or near Indian reservations. Our facilities are managed by IHS, tribal, and urban Indian health programs. We provide a wide range of clinical, public health, and community services to members of 564 federally recognized Tribes. The IHS fiscal year (FY) 2010 appropriation is approximately $4.05 billion. We have a total of about 15,700 employees, and the IHS clinical staff consists of approximately 2,700 nurses, 900 physicians, 400 engineers, 600 pharmacists, 300 dentists, and 300 sanitarians.

The IHS nation-wide system consists of 12 Area, or regional, offices, which are further divided down into 161 Service Units that provide care at the local level. The IHS is predominantly a rural primary care system, although we do have some urban locations.

The IHS has made significant progress in improving the health status of AI/AN people since it was established in 1955. There have been significant decreases in mortality rates; for example, since 1973, mortality rates have decreased about 89 percent for tuberculosis, 79 percent for cervical cancer, 38 percent for maternal deaths, 56 percent for accidental deaths, and 66 percent for infant deaths.

IHS has also achieved accomplishments in improving the quality of care over time. For example, the percent of patients with diabetes with ideal A1C (or glycemic) control has increased from 25% in FY 2002 to 32% in FY 2008. These types of improvements have been shown to result in reduced complications of diabetes.

However, the IHS continues to faces significant challenges as we work to fulfill our mission. Health disparities continue to persist for AI/ANs compared to other populations. For instance, diabetes mortality rates are still nearly three times higher for AI/ANs than for the general U.S. population, and suicide rates are nearly twice as great.

Addressing these disparities is complicated. In addition to the challenges of delivering health care in a primarily rural location, the Indian health care system also faces a number of other challenges that are driven by a host of medical, cultural, and socio-economic factors, including:

- Population growth, which results in an increased demand for services;
- Medical Inflation, with the rising costs of delivering services – especially in rural areas;
- Difficulty recruiting and retaining medical providers, especially in our remote sites;
- Increased rates of chronic diseases – such as diabetes and cancer, which are more complicated to address;
- Old facilities and equipment;
- Lack of sufficient resources to meet demand for services; and
- Balancing the needs of patients served in our diverse network of IHS, tribal, rural, and urban Indian health programs.

A lack of adequate resources is also a huge barrier to fully meeting the mission of the IHS and reducing health disparities. Per capita expenditures for IHS are much lower than those for other federal healthcare programs, such as Medicare, Veterans health, Medicaid, etc.

In order to improve the ability of the IHS to address health disparities among AI/ANs, I have set four priorities to guide our work over the next few years:

- The first priority is to renew and strengthen our partnership with Tribes;
- Our second priority is, in the context of national health insurance reform, to bring internal reform to IHS;
- The third priority is to improve the quality of and access to care for patients who are served by IHS; and
- The fourth priority is to have everything we do be as transparent, accountable, fair, and inclusive as possible.

We are making some progress on these priorities; however, much of this work involves fundamental changes in how we do business in the organization, so the change will take some time.

Our first priority is to renew and strengthen our partnership with Tribes. I truly believe that the only way we're going to improve the health of our communities is to work in partnership with them. The IHS cannot do its work in isolation – we have evidence throughout our system that we work better in partnership with our communities.

My public health training has helped me understand that the solutions to our communities' health problems will not be solved with efforts that just focus on our clinics or hospitals. Look at some of the biggest problems we face – suicide, domestic violence, obesity, cancer, mental health issues – all are influenced by factors in our communities such as education, unemployment, law enforcement, housing, etc. IHS cannot solve these problems alone.

Our Tribes, as sovereign nations, are responsible for the health and well-being of their members, and we can accomplish so much more if we work in partnership with them. So I am grateful that with this new administration, tribal consultation is a priority.

President Obama signed the Executive Order on Tribal Consultation at the first-ever White House Tribal Nations conference in November 2009. This historic event set the foundation for this new administration's partnership with Tribes as we move forward.

Secretary Sebelius has also demonstrated her commitment to tribal consultation and partnership by meeting with Tribes on several occasions so far, including an historic moment where the Secretary held a private meeting with tribal leaders in her office on March 3, 2010. This was one more sign of this administration's dedication to tribal consultation.

In the past year, the IHS has consulted with Tribes on improving the tribal consultation process, improving the Contract Health Services (CHS) program, priorities for health reform, implementation of the Indian Healthcare Improvement Act, and the FY 2012 budget. We are beginning to implement some of the recommendations from these consultations.

I plan to formally consult on other topics this year, such as health facilities construction and improving the quality of and access to care, which is my third priority.

I have also held extensive listening sessions with Tribes, have conducted more than 270 Tribal Delegation Meetings since being sworn in over a year ago, and have visited 11 of the 12 IHS Areas so far. I have found these visits to be very helpful in understanding broad themes as well as specific Area and tribal needs. Because not all Tribes can afford to travel to Washington, D.C., these Area visits are critical to ensuring that all voices are heard.

During my Area Listening Sessions, I meet with all the Tribes in the morning session and discuss issues impacting the Area in general. In addition to meeting with the entire group during the Area listening sessions, I also met individually with tribal leaders to hear about their priority issues and recommendations from a local perspective.

I am grateful that these busy tribal leaders are taking the time to meet with me on health issues. It helps us see how we can move forward in partnership. We all want the same things – better health care for our patients and our communities.

It's important that we strengthen our partnership and that Tribes help create the vision for IHS reform. For every decision I make, I always consider the input I have received from Tribes.

My second priority is "in the context of national health insurance reform, to bring reform to IHS." This priority has two parts. The first part includes passage of the health reform law, the Affordable Care Act, and the Indian Health Care Improvement Act (IHCIA).

We are grateful for passage of the Affordable Care Act because it will make quality, affordable healthcare accessible to all Americans, including our First Americans. It is designed to increase access to health insurance, help those who have insurance, and reduce healthcare costs. It also contains the permanent reauthorization of the IHCIA, which provides new and expanded authorities for a variety of healthcare services.

Both laws have the potential to positively impact AI/AN individuals and Tribes, and IHS, tribal, and urban Indian health programs. We will be consulting with Tribes on an ongoing basis on the implementation of these new laws. We are working quickly to implement tribal priorities among the many provisions in these laws.

And the IHCIA was included in the Affordable Care Act – which is great for Indian Country because this law is the main legislation that authorizes Congress to fund health care services for AI/ANs. And it ***permanently*** reauthorizes the IHCIA.

The IHCIA updates and modernizes the IHS. The provisions are numerous but many of them give IHS new authorities. Some examples of what is in the new law include:

- Authorities for the provision of long-term care services;
- New and expanded authorities for behavioral health prevention and treatment services;
- New and expanded authorities for urban Indian health programs;
- Authorities for various demonstration projects, including innovative health care facility construction and health professional shortages*;*
- The authority for provision of dialysis services;
- Authorities to improve the CHS program;
- And authorities to improve facilitation of care between IHS and the Department of Veterans Affairs (VA).

The second part of this priority is about bringing internal reform to the IHS. In order to get the support we dearly need, the IHS must demonstrate a willingness to change and improve. It is clear that Tribes, staff, and our patients want change.

By internal IHS reform, I mean we need to look at what we do well, and be honest about where we need to improve. We requested and received input last year on tribal and staff priorities for how to change and improve the IHS. Tribal priorities for internal reform included:

- More funding for IHS, including a review of how we allocate funding;
- Improvements in the CHS program; and
- Improvements in the tribal consultation process.

We're working on these priorities, as I have already described.

We're also making progress on the top staff priorities for internal IHS reform. Overall, staff emphasized improving the way we do business and how we lead and manage our staff. I can understand this – as a clinician, I just wanted to see and help patients, but the way we were doing business was getting in the way.

To improve the way we do business, we're working with the Department of Health and Human Services (HHS) and our Area Directors to improve how we manage and plan our budgets and improve our financial management. We're working to make our business practices more consistent and effective throughout the system.

To improve how we lead and manage staff, we're working on specific activities to improve and streamline the hiring process by making it more efficient and proactive, and less time-consuming. We're also working on improvements in pay systems and strategies to improve recruitment and retention. It has been historically difficult for the IHS to recruit and retain healthcare providers, due to remote locations and noncompetitive salaries. We need to make sure the way we do business is not causing us to lose the opportunity to hire and keep good staff.
I have also sent messages to IHS staff on improving our business and management practices – such as the importance of customer service, ethics, performance management, and professionalism. Many of our staff members want improvements in these areas, and our work starts with a strong message from the top that these are important areas for all of us.

Nothing is more frustrating than working with or being taken care of by someone who is unprofessional, or who does not treat patients or staff well. Our patients – and staff – deserve to be treated with respect and kindness at all times.

Overall, we need to improve how we do business as an agency – yes, we are a "service" organization with a great mission, but we also have to function as an efficient and effective business to survive, given the challenges we face. And as an American Indian physician who has worked in IHS clinics, I will make sure we don't forget that our ultimate focus is on the patient.

In relation to our third priority, to improve the quality of and access to care, I started by identifying the importance of customer service – how we treat our patients and how we treat each other. I am now starting to see activities to improve customer service throughout the system and am starting to hear stories about some improvements. However, we still have a lot of work to do to improve our customer service.

We also plan to expand the Improving Patient Care (IPC) initiative to 100 more sites over the next 3 years. This is our "medical home" initiative that puts the focus of our healthcare team on serving the patient. We're now beginning phase 3 of the IPC.

And I began collecting best practices in providing quality care last year – we need to avoid reinventing the wheel by doing a better job of sharing what we're doing well and disseminating that information more effectively. We know our programs and facilities are doing some great things, especially in the provision of culturally competent care.

Other ways we are working to improve quality care include collaborations with other departments and agencies. Given that we have limited resources in Indian health, we have to leverage all resources to improve care for our patients.

For instance, we have been meeting with the Department of Interior on health issues in our communities – I met with Assistant Secretary of Indian Affairs Larry Echohawk, and he understands how we must work together to address some of the most difficult health problems we are facing in tribal communities.

I also met with Secretary Shinseki from the Department of Veterans Affairs (VA). We are working to collaborate on several activities, including coordination of care for veterans who are eligible for both IHS and the VA. We just signed an updated VA-IHS Memorandum of Agreement to help improve how we coordinate care for our veterans.

I also am working with other operating division heads in HHS to expand availability of resources and services for AI/ANs. I have worked with Mary Wakefield, Administrator of the

Health Resources and Services Administration, and Pam Hyde, Administrator of the Substance Abuse and Mental Health Services Administration, on suicide and behavioral health efforts. And we are working with the Surgeon General on improving the United States Public Health Service Commissioned Corps organization in HHS – IHS employs the largest number of commissioned officers in HHS. And we are working more with the HHS Regional Directors to address tribal issues.

The signing of the Tribal Law and Order Act is an example of a collaborative effort that will help us improve health in our communities by addressing the serious problem of violence against women. Many federal agencies are collaborating on implementation of this law, and we are involved in those activities. Violence against Indian women is unacceptable, and we all need to work to eliminate it in our communities.

My fourth priority is to make all our work transparent, accountable, fair, and inclusive. Since I began my tenure as the Director of IHS, I have worked hard to improve our transparency and communication about the work of the agency. This includes working with the media, sending more email messages and *Dear Tribal Leader* letters, holding regular internal meetings, and giving presentations at meetings like this.

We have also enhanced our website with the IHS Reform page, Director's Corner, and Director's Blog, which contain important updates and information about reform activities.

And we're looking at ways to improve IHS-wide communication among Areas, Service Units, and Headquarters.

We're also emphasizing accountability and fairness in the way we do business – by evaluating our programs and focusing on areas of greatest benefit, and by always considering fairness when dealing with staff and making programmatic decisions.

Inclusiveness is a part of these priorities because as the IHS Director, I have to ensure that all my decisions consider the impact on all our patients, whether they are served in an IHS, tribal, or urban Indian health facility. Balancing the needs of the various parts of our healthcare system is a challenge, but inclusiveness is very important as we work to improve the IHS.

So what are our accomplishments so far? Well, we are making progress on IHS reform, but a lot of the work is internal to the organization right now and much of the work to improve the way we do business is in progress. Certainly the most visible progress to date for this new administration is the increases in funding for the IHS:

- The FY 2010 budget with its 13 percent increase has the largest percent increase in over 20 years for IHS. We're now just feeling the impact of this increase. For example, there was a $100 million increase in CHS funding – this meant an increase in the range of 14-30 percent in each IHS Area, which will result in more referrals being paid.
- And this increase included a substantial increase in our Catastrophic Health Emergency Fund, which pays for high cost cases. This year, we may be able to make it to the end of the year and not run out in June, as has been the past experience.
- The FY 2011 President's budget proposed an almost 9 percent increase, and we're waiting to see if Congress decides to keep that increase in the budget.
- The Recovery Act funding provided $590 million for health facilities construction, sanitation facilities construction, maintenance and improvement, equipment, and health IT. Some of you may be seeing this funding benefiting your communities now. For instance, hospital constructions in Eagle Butte, South Dakota, and Nome, Alaska, are making progress.

So what about the role of research in IHS? Well, research, data, and evaluation play an important role in the work of the IHS, although the IHS is not a research organization and does not fund research. However, we work with various partners on research related efforts, including public health surveillance. One of my goals is to make program evaluation and accountability a larger part of the discussion about reforming the IHS.

We have an Institutional Review Board that helps protect data, especially from Tribes, who are very concerned about how their data is shared. And we fund Tribal Epidemiology Centers in each IHS Area, which assist Tribes. Our Native American Research Centers for Health Program is a collaboration with the National Institutes of Health that funds research and training activities. There is also an HHS AI/AN Health Research Advisory Council.

So research, data, and evaluation are an important part of what we do at IHS, even if we don't actually fund research directly.

In summary – the IHS provides healthcare to AI/ANs under challenging circumstances. However, we are working to change and improve the IHS through our reform efforts. These efforts should help us do better at the business of healthcare and provide better quality services. The Affordable Care Act, and the reauthorization of the IHCIA, will also help Tribes and the IHS provide better care to AI/AN people.

Overall, we are beginning to make progress on our priorities and are moving forward on the challenging work to change and improve the IHS. We must continue to make progress to get the support we need. It's clear to me that as we move forward, research, data, and evaluation will play a very important role as we change and improve the IHS

While changing and improving the IHS may seem like a daunting and challenging task, I still believe we're in a unique time in history, with a supportive President and administration, lots of support at HHS, and bipartisan support in Congress for reform. We must all take advantage of this opportunity to change and improve the IHS.

Thank you.