Indian Health Service

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Indian Health Service Update

by

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Good morning. I am Dr. Yvette Roubideaux, Director of the Indian Health Service, and it is a real pleasure to join all of you here today at the National Indian Health Board's 29th Annual Consumer Conference.

Thank you to the National Indian Health Board for putting together a great conference. The purpose of this year's conference is to discuss "successes, challenges, opportunities, and the future of health care for American Indian and Alaska Native people."

I will be giving an update today on our progress on changing and improving the IHS. The work we have done together, IHS and Tribes, has resulted in real progress in improving the IHS in the past few years. I believe our partnership with the National Indian Health Board has also been strengthened over the last few years, and I regularly join the Board meetings in person or by phone. And while we know there is still more to do, I know that this progress can continue as a result of these partnerships we have strengthened over the last few years.

One area we have made progress in is the IHS budget. The budget is a huge factor in how we are able to improve the IHS, and tribal consultation is an important part of our budget formulation process. Thanks in large part to tribal input and support, we have made a lot of progress on increasing the IHS budget over the past four years. Overall, the IHS budget has increased 29% since fiscal year (FY) 2008. Within this increase, there have been some significant targeted increases: Contract Health Service (CHS) funding has increased 46%; Contract Support Costs (CSC) have increased 76%; and Health Care Facility Construction has increased 132%.

The increases in CHS funding have made a real difference; more patients are getting the referrals they need. In fact, at some facilities, patients are having referrals paid for beyond Priority 1(life or limb).

The text is the basis of Dr. Roubideaux's oral remarks at the National Indian Health Board Meeting on Sept. 25, 2012. It should be used with the understanding that some material may have been added or omitted during presentation.

All of these increases were achieved in partnership with Tribes and with the support of this Administration and Congress. It shows that when we all work together on a common goal, significant progress can be made.

And the FY 2013 President's budget for next year has a proposed increase of $116 million, or 2.7%, with a total budget authority of $4.42 billion. Since the overall proposed increase is less than in recent years, it was a challenge to try to fit all priorities into the budget. But we did focus on including as many tribal priorities in the budget as possible. So far, the House has actually proposed a larger increase, and the Senate was working on the budget. However, Congress just passed a 6-month Continuing Resolution. That would take us through to next March.

We are also facing sequestration in January 2013, which means automatic across-the-board budget cuts for federal programs. The only way this won't happen is if Congress acts to avoid it before January; we certainly hope they do take action. The current version of the Budget Control Act actually includes an 8.2% cut for IHS discretionary funding and a 2% cut for our mandatory program, the Special Diabetes Program for Indians. We certainly hope Congress takes action to avoid these cuts, which, at about $356 million total, would be devastating for IHS programs.

We are also in the FY 2014 budget formulation process. We have completed the Area consultation sessions and the national budget formulation session. At the Department of Health and Human Services (HHS) Tribal Budget Consultation, Tribes proposed a 22% increase. We are now in the middle of our budget formulation process and will be incorporating tribal budget priorities as in previous years. While this year is likely to be a tough budget year as well, we still have strong support from the Administration and Congress.

For FY 2015, we plan to begin the Area tribal budget formulation process soon, and instructions should go out by October 1. This is going to be a very important budget discussion with several important items to consider. I hope you make sure to participate in your Area sessions.

I would now like to provide an update on progress on our agency priorities. Tribal consultation is an important part of our first agency priority, which is to renew and strengthen our partnership with Tribes. This priority is founded on our belief at the IHS that the only way we're going to improve the health of our communities is to work in partnership with them. We have seen evidence throughout our system that we accomplish more when we work in partnership with our communities.

We have done a lot to improve consultation at the national level. We held Area listening sessions each year, either in person or by phone or videoconference. I have held listening sessions with ten IHS Areas so far in 2012. We have also held over 350 tribal delegation meetings, meet regularly with tribal workgroups and advisory groups, and attend tribal meetings and conferences.

We have been working on Area and local improvements in consultation and partnership, and Tribes are telling me they see improvements. I have also asked all Area Directors and CEOs to send updates to Tribes on our progress at least quarterly to improve communication.

Tribal consultation is a priority of President Obama, who has expressed a commitment to honoring treaty rights and making tribal consultation a priority. Last December, the President held the 3rd White House Tribal Nations Conference. The President also met with tribal leaders after the larger meeting, and Direct Service Tribes were at the table that day.

Secretary Sebelius is committed to making IHS a priority, and established the first cabinet level Secretary's Tribal Advisory Committee. I am very grateful for her support of the IHS. She has consistently made IHS a top budget priority.

We just held our 3rd Tribal Consultation Summit in Denver, Colorado, in August, which was intended as a "one-stop shop" for Tribes to learn about IHS consultation activities. The Agenda had presentations from IHS Advisory Committees on the work they are doing and workshops on current consultation topics. Plenary session speakers from the Director's Advisory Workgroup on Tribal Consultation, the Direct Service Tribes Advisory Committee, and the Tribal Self Governance Advisory Committee all gave updates. We had a great turnout of tribal leaders, tribal program staff, and technical advisors. We held several workshops on current consultation topics, such as the health care facilities construction consultation workshop. These workshops gave tribal leaders an opportunity to ask questions and provide input.

We have consulted with Tribes on many important issues in the past few years. Current and recent consultation topics include:

- Improving the tribal consultation process;
- Improving our CHS program - some significant work has been done here to improve the program;
- Priorities for the Affordable Care Act and implementation of the Indian Healthcare Improvement Act;
- Budget formulation;
- Information Technology Shares–this is important for our P.L.93-638 negotiations;
- Contract Support Costs, including evaluation of the 2007 CSC Policy and now the impact of the Ramah decision – I just sent a letter to Tribes with an update and request for further input;
- Implementation of the Federal Advisory Committee Act;
- How to improve our Indian Healthcare Improvement Fund allocation;
- The Tribal Epidemiology Centers Data Sharing Agreement;
- Long-term care;
- Behavioral health issues and suicide prevention;
- The Department of Veterans Affairs (VA)-IHS MOU; and
- The draft VA-IHS reimbursement agreement.

We discussed many of these issues at the Tribal Consultation Summit in August. While some of these have been resolved, some of these are ongoing issues and the implementation of decisions or further work is still in progress. We welcome your input at any time.

We have several new consultation topics, including:

- Health care facility construction,
- CHS prevention funding,
- Traditional medicine, and
- The draft Urban Confer Policy that was recently published in the Federal Register for comment and consultation.

New topics that were introduced at the Tribal Consultation Summit and have letters in progress include prescription drug abuse and recruitment and retention.

We developed an email address where you can send input on any of these topics – consultation@ihs.gov.

One of our improvements to the tribal consultation process has been our tribal consultation website – it includes descriptions of all our workgroups and committees, and a complete listing

of all our tribal leader letters. I encourage you to visit this site from time to time to see what we are working on with Tribes, and of course to submit input at any time at consultation@ihs.gov.

We also posted a summary table of tribal consultation activities from 2009 to August 2012. The table is sorted by topic, and the date of the letters and the status or outcomes of the consultation are briefly listed. There have been so many consultations; we hope this table helps provide a bigger picture of the status of these consultations. We know that Tribes don't just want consultation; they want to see progress and outcomes from these consultations, which you can see in this summary table.

I recently met with the Tribal Self-Governance Advisory Committee and the Direct Service Tribes Advisory Committee. These meetings are important for sharing information and listening to issues and concerns from the Tribes. Area listening sessions are also an important venue for me to hear about Area and local issues. I do try to attend these types of meetings in person, but can join by phone if needed.

Our second IHS priority is "to bring reform to the IHS." This priority has two parts – the first part includes passage of the health reform law, the Affordable Care Act (ACA), and the Indian Health Care Improvement Act (IHCIA). The second part is about internal IHS reform – how we are changing and improving the organization.

We are so grateful for the recent Supreme Court decision to uphold the ACA. As you know, the Court decided that the individual mandate was constitutional, and the entire law, including our IHCIA reauthorization, was upheld. The Medicaid expansion was also upheld with the caveat that States could choose to opt out without loss of their Medicaid funding. The implications of the decision are that we are continuing implementation of the ACA and the IHCIA. The main activities now focus on the State Exchanges and the HHS consultation on the Federally-Facilitated Exchanges and Medicaid Expansion – the third session was last month.

We know that efforts will continue in Congress to try to repeal the ACA. However, we are continuing to implement the new law and are consulting with Tribes on the various provisions.

The ACA will make quality and 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.

The benefits of the ACA for American Indians and Alaska Natives are significant. They can benefit from all the reforms, whether they have insurance now, want to purchase affordable insurance through the Exchanges, or benefit from the Medicaid expansion starting in 2014. Our elders are already benefiting from how Medicare is being strengthened.

At our recent Tribal Consultation Summit, we discussed the Health Insurance Exchanges, an important topic as implementation of the ACA moves forward.

We are also continuing our implementation of the permanent reauthorization of the IHCIA. We recently posted an update to our table that summarizes progress on implementation. The update is linked to the April 6 ACA posting on my Director's blog.

Of course there are many self-implementing provisions that are already in place. For example, health care professionals in tribal facilities are now allowed to work under a license from any State, and outside providers cannot go after patients for referral charges if the referral is authorized for payment by the CHS program. Third-party reimbursements must remain at the Service Unit where they were received. Several provisions are in progress of being implemented, and some will require funding.

We continue consultation on implementation. You can submit input at any time at consultation@ihs.gov. I also encourage you to visit www.healthcare.gov and my Director's blog on the IHS website for general information and updates on the ACA.

And of course, we are thrilled that the IHCIA, our authorizing legislation, was made permanent in the ACA. I know that some are concerned that with the ACA, the IHS will go away or the responsibility of the federal government towards Indian health care will somehow be reduced. However, I want to assure you that with the ACA, eligible American Indians and Alaska Natives can still use IHS as a health care system. IHS is not going away; it is here to stay. The IHCIA made the IHS permanent.

If our patients want additional health insurance coverage, they will have more choices, including new insurance protections, State Exchanges, Medicaid, a stronger Medicare, and options such as access to federal insurance for tribal employees.

The Act has the potential to benefit all American Indians and Alaska Natives because if more have health coverage, services can be expanded at Indian health facilities through increased reimbursements. More coverage means more services for everyone we serve.

And the delivery system reforms in the Act will shift focus to the quality of care rather than billing volume or frequency in reimbursements.

I encourage all of you to learn about how the ACA will benefit our patients and our communities. Every hospital and clinic should have a plan for how they are going to help patients with enrollment, improve their business office practices around third-party reimbursements, improve customer service and the experience of care so patients stay with us, and demonstrate better quality of care in order to maximize reimbursements.

National and Area tribal organizations have been helping with the outreach and education effort. I know that they are doing trainings in each Area on the ACA. We also have a new slide show, tailored to the American Indian and Alaska Native population, to help with outreach and education efforts in Indian communities. We recently distributed it and posted it on our website so everyone can use it. You can check my May 14 blog entry for the link to the slide show.

Our internal reform efforts are focused on improving the way we do business and how we lead and manage our staff. Overall, we have implemented many improvements.

I have set a strong tone at the top for how we will conduct business, with emphasis on customer service, ethics, professionalism, and performance management. This sets expectations for our staff and reaffirms that we are changing as an organization.

To improve the way we do business, we're working with the HHS and our Area Directors to improve how we manage and plan our budgets and improve our financial management. This past year we had our best performance as a part of the HHS Annual Audit.

We're working to make our business practices more consistent and effective throughout the system. I recently held a meeting with our 12 Area Directors and their Chief Medical Officers where we worked on some of our reform activities.

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 are using the new HHS supervisory training for our managers, and we are improving our performance management process.

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.

I recently sent an update on our corrective actions and responses to the Senate Committee on Indian Affairs investigation of the IHS Aberdeen Area to tribal leaders. The letter is available on our consultation website. The investigation is helping us improve the way we do business, and we are addressing the issues found in the investigation system-wide.

One example of improved outcomes since the investigation is pharmacy security. Several actions have been taken by the Aberdeen Area to ensure security of controlled substances at the Service Units, including security cameras, cages, secured pharmacy access, and new staff focused on accountability. These actions have resulted in improved outcomes – for example; pharmacy discrepancies decreased significantly, from a high of 3653 in November 2010 to a low of 31 in February 2012.

In relation to our third priority, to improve the quality of and access to care, we began with 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 hearing stories about some improvements. In fact, I recently awarded IHS Director's Awards for Customer Service to several outstanding individuals and groups at the IHS Director's Awards Ceremony.

We have expanded our Improving Patient Care, or IPC, initiative to 90 sites in the Indian health system. The IPC is our patient-centered medical home initiative that is designed to improve the coordination of care for patients. We are starting a new cohort of programs – IPC4 – and plan to expand this initiative throughout the entire IHS system. This program is essential for us to be able to adapt to the new delivery system changes with the ACA, and for helping us improve customer service by making our care more patient-centered.

This initiative should help us improve customer service and improve care. Many of the sites have been able to reduce waiting times and arrange the system so that patients can see the same providers each time they come to the clinic, resulting in better coordination of care.

A patient-centered medical home model is about quality improvement, team work and making changes that will result in measurable improvements in care that are focused on the needs of the patient. We have many programs that are doing really outstanding work. And the IPC team recently held a learning session for the new cohort of IPC sites – IPC4.

A few other initiatives are also helping us improve the quality of care. The SDPI is continuing its successful activities. They have shown that in partnership with our communities, we can prevent and treat diabetes in Indian country with innovative and culturally appropriate activities. The SDPI is also up for reauthorization in 2013, and I know we are all hoping this successful program is reauthorized as soon as possible. This $150 million congressional initiative funds 404 grant programs in two areas: 338 community-directed programs and 66 diabetes and healthy heart prevention initiatives.

We just recently released our 2011 SDPI Report to Congress. This report clearly shows that the SDPI programs have done an incredible job of implementing activities to prevent and treat diabetes in the communities we serve. The report includes the latest data on the grant programs.

The SDPI programs have shown that they have dramatically increased access to diabetes treatment and prevention services. For example, access to diabetes clinics has increased from 31% in 1997, when SDPI funding began, to 71% in 2010. Based on local needs and priorities, the SDPI grant programs has implemented proven interventions to address the diabetes epidemic, often where few resources existed before.

As access to diabetes services increased, diabetes health outcomes improved significantly in American Indian and Alaska Native communities. One of the most important improvements has

been a 13.7 percent decrease in the mean blood sugar level of American Indians and Alaska Natives with diagnosed diabetes, a major achievement over 15 years. The average blood sugar level decreased from 9% in 1996 to 8% in 2011 as measured by the A1C test. Decreases of this magnitude translate to an almost 40 percent reduction in diabetes-related complications.

The most important impact of sustained clinical improvements is seen in the dramatic drop in the rate of end stage renal disease (ESRD) in American Indian and Alaska Native people with diabetes when compared with other racial and ethnic groups in the U.S. Between 1995 and 2006, the incident rate of ESRD in American Indian and Alaska Native people with diabetes fell by 27.7% – a greater decline than for any other racial or ethnic group. Given that Medicare costs per year for one patient on hemodialysis were $82,285 in 2009, this reduction in new cases of ESRD means a decrease in the number of patients requiring dialysis—translating into millions of dollars in cost savings for Medicare, IHS, and other third-party payers.

Through their screening activities, patient education for individuals and groups, and focus on healthy lifestyle changes, the SDPI programs are showing that we can prevent and treat diabetes.

I was so proud of the IHS Pine Ridge Service Unit Diabetes Prevention Program that got to talk with Secretary Sebelius on our recent trip with her to South Dakota. They told us about how their program has helped individuals reduce their risk for diabetes. The program presented information on their activities, and participants in the program got to present their personal stories of how they have adopted a healthier lifestyle. I also recently got to attend the poster session for the SDPI Diabetes Prevention and Healthy Heart Initiatives.

We are also focusing on behavioral health issues, which is a top tribal priority. IHS is making progress on its recently released National Behavioral Health Strategic Plan and its National Suicide Prevention Plan. We are beginning a focus on addressing the problem of prescription drug abuse, and the evaluation data from the Methamphetamine and Suicide Prevention Initiative (MSPI) and the Domestic Violence Prevention Initiative (DVPI) are very promising.

The National Tribal Advisory Committee on Behavioral Health is helping to advise us on these efforts. They will be discussing the consultation on the distribution for MSPI and DVPI in 2013 and other issues at their meeting this week.

We have a lot of data from the MSPI and DVPI programs showing how the new trainings, programs, and services are helping people. While I don't have time to relate all of the programs accomplishments today, I wanted to mention some outcomes from the MSPI programs.

MSPI programs are engaged in a wide range of prevention activities and the percent of programs participating in them is increasing. Between 2010 and 2011, training in evidence-based practices increased from 66% to 90% among MSPI programs. In terms of outcomes, the number of reported suicidal ideation and attempts decreased from 14,242 in 2010 to 5,772 in 2011; and the number of persons trained in suicide crisis response increased from 674 in 2010 to 3,911 in 2011.

I mentioned earlier that we are working to address the growing problem of prescription drug abuse in Indian Country. A Prescription Drug Abuse Summit was held in the Bemidji Area in July, and there was a lot of interest expressed on working on this serious problem in our communities.

Prescription drug abuse includes the non-medical use of prescription-type pain relievers, sedatives, stimulants, and tranquilizers. In a 2009 national survey, 6.2% of American Indians and Alaska Natives reported engaging in current non-medical use of prescription drugs, more than twice the rate of whites and the highest rate of all races nationally. Some reservations report

prescription drug abuse at epidemic levels among their communities. We all have to work together to address this serious problem in our communities.

I understand Dr. Karol, our Chief Medical Officer, is leading a workshop on prescription drug abuse at this conference, if you want more information on this topic.

We've also launched the Healthy Weight for Life initiative to unify all our efforts to promote a healthy weight among American Indians and Alaska Natives. We now have a website with information on evidence-based, proven approaches to help fight the obesity epidemic that is threatening the health and well-being of Indian people.

And we have joined the First Lady's *Let's Move! in Indian Country* initiative, which includes our IHS Baby-Friendly Hospital initiative. We will be promoting breastfeeding in all our IHS hospitals because it has been shown that breastfeeding can reduce childhood obesity. We are working to make all IHS hospitals Baby-Friendly and to encourage all tribally-managed hospitals to join us in this effort. This is the gold standard for recognizing best practices in support of new mothers and children through breastfeeding education and counseling. And I am pleased to report that the Rosebud IHS Hospital recently became the first IHS hospital to be designated a Baby-Friendly hospital!

We are also participating in the national Million Hearts Campaign, with its goal of preventing a million heart attacks and strokes over the next 5 years. And the new Partnership for Patients that was launched by HHS will help us improve the quality of care by focusing on reducing harm and improving patient safety in our hospitals. This initiative focuses on reducing hospital-acquired conditions and hospital readmissions. The ability to demonstrate improvements in these areas will also likely help with reimbursements in the future.

And we just signed an agreement with the Centers for Medicare and Medicaid to establish a new hospital consortium to work on improving quality and meeting accreditation requirements in our hospitals. We plan to establish a system-wide business approach to accreditation.

We have accomplished a great deal as we work to meet our priorities, and this is reflected in our recent Government Performance and Results Act (GPRA) measures. You may remember that in FY 2011, for the first time ever, we met all of our clinical GPRA measurement goals. We are proud of all the IHS and tribal sites that worked so hard to make improvements in the quality of healthcare that we deliver.

The results are in for 2012 and we did great again – we met all but three indicators, and two of those had a change in clinical practice so the new baseline won't be established until next year, and the other one is being discontinued in favor of a better measure. So congratulations to all our IHS and tribal sites for a great showing again this year on GPRA.

But perhaps the biggest demonstration of progress on improving the quality of and access to care can be seen in the trends of our quality measures over the years. For instance, since 2006, the percent for depression screening has risen from 15 to nearly 62 percent. This is good news, especially since behavioral health is a top tribal priority. We have also seen significant increases in screening for alcohol use in pregnant women to prevent fetal alcohol syndrome.

We are seeing other improvements in clinical care. Tribal leaders often ask if we can do more prevention activities to avoid chronic diseases such as heart disease, diabetes, and cancer from occurring in the first place. Certainly this would help our system save resources and improve the health of our patients; prevention is a good investment for us.

So I am happy to report that we are seeing improvements in areas such as an increase in the percent of patients who receive a comprehensive cardiovascular disease assessment. Also, the percent of patients who received tobacco cessation interventions has risen from 12 to over 35

percent. And the percent for mammography screening has finally risen to above 51 percent. You may remember that in some of my first speeches as IHS Director, I pointed to the challenges in improving quality of care, and pointed out that in some important areas we needed to improve. Then, it seemed like the percent of patients receiving mammograms was stuck in the mid 40 percent range. Now we are seeing the percent finally increase. It is possible that the big increase in CHS funding over the past few years, along with some increased accountability, has helped these numbers increase.

We are also seeing some improvements in influenza immunizations; and this is your official reminder to get your flu shot this year!

We also have seen an increase in screening for colon cancer. And the number of dental sealants has increased in the past few years. We also have had improvements in recruitment of dental providers in the same period.

So we are seeing progress in our efforts to change and improve the IHS, and we actually are seeing these improvements reflected in our quality measures. More patients are getting the care they need. That's what can happen when we receive increased funding and we work to change and improve the organization.

Our fourth priority is to make all our work transparent, accountable, fair, and inclusive. We have worked hard to improve transparency and communication about the work of the agency. We have also enhanced our website with the IHS Reform page, Director's Corner, and Director's Blog, which contain important updates and information on reform activities.

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.

The Director's Blog on the IHS website is the way we post brief updates on our activities and the latest IHS news at least weekly. This is one of many efforts to be more transparent about what we're doing as an agency. I am updating the blog this week, so make sure you check frequently for updates on the latest information.

In summary, we are working hard, in partnership with Tribes, to change and improve the IHS through our reform efforts. These efforts should help us do better at the business of healthcare, to provide higher quality services, and to address the health disparities in Indian Country.

The Affordable Care Act, and the reauthorization of the Indian Health Care Improvement Act, will also help Tribes and the IHS provide better care to American Indian and Alaska Native 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 have shown over the past few years that it is possible to change and improve. However, it is clear that there is more to do.

We need and appreciate all your input and support. Tribal consultation is fundamental to our progress. I know we can continue to make improvements as we continue to work in partnership.

Thank you.