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Subcommittee on Indian and Alaska Native Affairs Oversight Hearing
on the President's FY 2013 Budget Request for the Indian Health Service
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STATEMENT OF THE INDIAN HEALTH SERVICE

Mr. Chairman and Members of the Subcommittee:

Good morning. I am Dr. Yvette Roubideaux, Director of the Indian Health Service. I am accompanied today by Mr. Randy Grinnell, Deputy Director. I am pleased to have the opportunity to testify on the President's FY 2013 budget request for the Indian Health Service (IHS).

INDIAN HEALTH SYSTEM – ACCOMPLISHMENTS AND PROGRESS

First I would like to review what the IHS has accomplished with the funding the Congress appropriated over the past few years. Since FY 2008, the IHS budget has increased 29 percent and this funding has helped IHS make significant progress in our efforts to change and improve the organization, as well as in addressing the four priorities that guide our work. These priorities are: 1) to renew and strengthen our partnership with Tribes; 2) to reform the IHS; 3) to improve the quality of and access to care; and 4) to make all our work transparent, accountable, fair, and inclusive.

Our partnership with Tribes is fundamental to improving the health of our communities, and in partnership, we have consulted with Tribes in various formats and have made improvements based on their priority recommendations. We have improved consultation at the national level, consulted on a variety of Tribal priorities, held over 350 Tribal delegation meetings and held Tribal listening sessions by phone, videoconference or in person with all 12 IHS Areas each year. We regularly meet with Tribal advisory groups and workgroups, attend Tribal meetings and conferences and have established a website where we post letters sent to Tribes. We have also been working on Area and local improvements in consultation and partnership, and Tribes are mentioning that they see improvements. Tribal consultation is fundamental to our budget formulation process and each year we incorporate Tribal priorities into our budget requests.

We are also making progress on reforming the IHS with an emphasis on improving the way we do business and how we lead and manage our staff. Setting a strong tone at the top that we must change and improve has been important to our progress. We have improved fiscal controls and have found more efficient and effective ways to conduct our business matters and provide quality health care. We have worked with our Area Directors to make our business practices more consistent and effective, and have implemented better management controls throughout the system. Performance management and accountability, starting with our Senior leadership, has brought about needed changes at all levels of the agency.

Another very important area where we have made significant improvements is in how we manage and monitor our budgets. By requiring IHS Area Offices and service units to implement more financial controls, return third-party collections to the IHS facility of origin, regularly monitor performance targets, and make improvements in the use of the Unified Financial Management System, our accounting system, IHS was able to demonstrate its best performance ever as a part of the HHS CFO audit. And even though we have improved, we continue to focus on using resources efficiently and effectively; for example, since 2010, we have reduced agency-wide travel by 24 percent.

We have continued our work to address the issues that were raised in the Senate Committee on Indian Affairs Investigation of the Aberdeen Area and the corrective actions that were implemented are resulting in improvements. Pre-employment suitability assessments and background checks are being conducted, providers are required to be credentialed and privileged to provide care, the use of administrative leave has decreased, pharmacy security has improved and financial management has improved. In addition to improvements in the Aberdeen Area, we are conducting reviews of all twelve IHS Areas to ensure these problems are not occurring elsewhere. So far, we have completed reviews in seven Areas: Albuquerque, Billings, Navajo, Oklahoma City, Phoenix, Aberdeen, and Tucson Areas. Overall, we are finding that we have appropriate policies in place, and we are making improvements to ensure consistent implementation of those policies across the system.

To improve how we lead and manage staff, we have made the hiring process more efficient and less time-consuming. And we have made progress by reducing our average hiring time from 140 days to 81 days! We are focused on implementing standard Position Descriptions, with the goal of more timely and effective advertisement that results in the right candidates. We have also been working on improving pay disparities in selected healthcare provider positions. These steps should help greatly with our recruitment and retention efforts.

The Contract Health Services program has demonstrated accomplishments in IHS reform through improved business practices and improving access to care. The CHS budget has increased 46 percent since 2008; as a result some CHS programs are able to pay for more than priority-one referrals and services. While the overall need is still significant, the increases are making a difference. With this 46 percent increase in funding, an additional

7,400 inpatient admissions, 278,000 outpatient visits and 10,000 one-way transportations have been purchased.

Regarding business practices, IHS has negotiated lower rates with the Fiscal Intermediary (FI) that pays the claims for health services provided in the private sector programs. By reducing the rates from \$30.31 to \$28.00 per claim, the IHS estimates it will save almost \$1 million based on the estimated 468,000 claims processed in FY 2011. The IHS Director's Workgroup for Improving CHS has recommended specific activities to improve the business of the CHS Program, to better estimate the need, and to provide better education about the program to staff, Tribes, patients and our outside providers. We are also notifying outside providers that the recent reauthorization of the Indian Health Care Improvement Act contains a provision that prevents providers from holding patients responsible for medical bills when the referral was approved by IHS for payment. We are working with outside providers to ensure better coordination of referrals and their payment.

We have also made significant progress in improving quality and access to health care. We have focused on improvements in customer service with many new activities throughout our Areas. The IHS Improving Patient Care (IPC) initiative is an important part of that progress. The IPC initiative is our patient-centered medical home initiative that is focused on improving how we deliver care that is centered on what our patients want and need. It also is about working better as a team in the care of the patient. We have expanded the IPC initiative to 90 sites in the Indian health system and plan to expand this initiative throughout our system.

The Special Diabetes Program for Indians (SDPI) continues its successful activities to prevent and treat diabetes. The grantees have shown that in partnership with our communities, we can reduce diabetes and cardiovascular disease risk factors in Indian country with innovative and culturally appropriate activities. For example, the Diabetes Prevention Program, designed as a demonstration project to translate research findings into real world settings, achieved the same level of weight loss as the original Diabetes Prevention Program Research study funded by the National Institutes of Health. The SDPI is authorized through 2013.

Our Methamphetamine and Suicide Prevention Initiative is also reporting some impressive accomplishments for 2011. During the first year of this congressionally funded initiative:

- 4,370 individuals were identified with a methamphetamine addiction;
- 1,240 people entered a methamphetamine treatment program;
- Over 4,000 people participated in suicide prevention activities;
- 42,895 youth participated in prevention or intervention programs; and
- 647 people were trained in suicide crisis response.

And in 2011 our Domestic Violence Prevention Initiative:

- Developed 21 interdisciplinary Sexual Assault Response Teams;
- Served over 2,100 victims of domestic violence and/or sexual assault;

- Screened over 9,100 patients for domestic violence;
- Made over 3,300 referrals for mostly domestic violence services;
- Reached nearly 9,500 community members through community and educational events; and
- Provided 37 trainings events for approximately 442 participants on domestic violence, mandated reporting for abuse, child maltreatment, dating violence, and bullying.

Quality of care is being improved through the use of health information technology in our system. With the help of Recovery Act funds, IHS was the first large federal healthcare system to have a certified electronic health record (EHR). And we are working hard to implement the meaningful use of electronic health records in the Indian health system. This is an important first step in the process for IHS, Tribal, and urban Indian health sites that use our Resource and Patient Management System (RPMS) to qualify for and receive the new EHR Incentive Payments from Medicare and Medicaid. This could help bring valuable new resources to the Indian health care system. It is also important for Tribes that do not use RPMS, because they can still qualify for incentive payments by using a certified electronic health record.

Performance improvement through GPRA measures indicates that the Indian health system is making progress in addressing health disparities. In FY 2011, for the first time ever, we met all of our clinical GPRA measurement goals. Several GPRA measures have demonstrated significant increases from 2008 to 2011, as follows:

- 12,606 additional diabetic patients received nephropathy assessments for a relative 26% increase.
- Dental sealants placed have increased by 35,686 for a relative 15% increase.
- 24,860 additional patients were screened for colorectal cancer for a 57% relative increase.
- 23,585 additional smokers received tobacco cessation intervention for a relative increase of 54%.
- 32,161 additional patients were screened for depression for a relative increase of 66%.

The GPRA measure for cardiovascular disease (CVD) is a comprehensive assessment for five CVD-related risk factors (blood pressure, LDL, tobacco use, BMI, and lifestyle counseling).

- 4,767 additional patients were screened for a 48% relative increase.
- Additional 5,269 women received mammography screening for a relative 23% increase.

The IHS Health Care Facilities Construction (HCFC) Program has contributed to IHS increasing access to care and improving its partnership with Tribes. HCFC funding has increased by more than \$45 million since FY 2008 and is helping us complete the hospital in Barrow, Alaska, and continue construction in Kayenta and San Carlos, AZ, and begin the design of the Southern California Youth Regional Treatment Center.

Recovery Act funds have helped complete the health care facilities in Eagle Butte, South Dakota last year and Nome, Alaska this year.

Collaborations with other agencies also are important in our efforts to improve the quality of and access to care. We are implementing our Memorandum of Understanding with the Department of Veterans Affairs (VA) and working with Tribes at the Area and local levels to help improve coordination of care for Native veterans who are eligible for the VA and the IHS.

In addition, our collaboration with the Health Resources and Services Administration has resulted in designations of all IHS, Tribal, and urban Indian health sites as eligible for the National Health Service Corps loan repayment and scholarship programs. This will have a positive impact on our workforce development goals as more physicians, dentists and behavioral health providers will now be eligible to work in our underserved communities. So far, 490 IHS, Tribal, and urban Indian health program sites are approved for provider placement and 221 additional providers have signed on to work in Indian health sites through this program.

The principles of transparency, accountability, fairness and inclusiveness guide our work and decision-making. The decisions that we make need to benefit all the patients we serve, whether they are served by our direct service, Tribally-managed or urban Indian health programs. We understand that in order to get the support we need, we have to demonstrate that our activities result in improved outcomes – for local programs and for the system as a whole. We are working to communicate more about our activities and reform efforts and their outcomes.

INDIAN HEALTH SYSTEM – CHALLENGES REMAIN

When I was first appointed the IHS Director, I heard input from Tribes, patients and staff that we needed to change and improve the IHS in many ways. Although we have made significant progress in addressing the agency priorities, much work remains to be done. The population we serve continues to grow, and the challenges of providing health care in rural settings are ever present. The rise in chronic diseases such as diabetes, cancer and heart disease require more coordinated approaches to care over the lifetime of a patient. Along with the rest of the country, we face challenges in recruiting and retaining primary care providers. As reforms in the nation's health care system are implemented, our system needs to adapt to many changes, including delivery system and payment reforms. Our data continue to show the incredible need for services by the patients we serve, and we continue to struggle to meet our mission with available resources. Tribal consultation continues to identify areas for improvement and areas of need. The increases in IHS funding over the past few years have helped us make progress, but we still have much to do.

For example, the estimated need for the CHS program, defined as denied and deferred services, remains high. Reduced increases for inflation and population growth in recent appropriations results in less buying power. While vacancy rates have improved for

dentists, pharmacists, and optometrists, physician and nurse vacancies continue to be high at 21 percent and 15 percent, respectively. After this year, implementation of the Electronic Dental Record is still needed in 118 sites. The Backlog of Essential Maintenance Alterations and Repair for Indian health facilities is currently \$427 million. The total Sanitation Deficiency System need is approximately \$3 billion. And the amount of funding needed to complete all facilities on our current priority construction list is \$2.2 billion. We are grateful for the funding we have received in the past few years because it has helped us make progress in the face of these significant needs and challenges.

FY 2013 BUDGET REQUEST – WHERE WE WANT TO GO

The FY 2013 President's Budget request for IHS will help the agency address these challenges and make progress on our agency priorities through targeted investments to increase access to care, improve the quality of care, support our oversight and accountability functions, and address Tribal management support costs. The budget request is \$4.422 billion, an increase of \$115.9 million over the FY 2012 enacted level. The request includes funds to support activities identified by the Tribes as budget priorities, including the following:

Current Services

The request includes \$2.4 million in increases for pay costs for federal Commissioned Corps personnel and \$34 million for inflation costs to cover the rising costs of contract health care, which is spent on purchasing health care from private sector providers outside the Indian health system. These increases impact access to care through supporting retention of health care providers and enabling IHS and Tribal programs to maintain the level of services purchased through the CHS program. An increase of \$49 million is included to staff and operate newly constructed health facilities, including facilities completely constructed by Tribes under the Joint Venture Construction Program. The success of the Joint Venture program reflects the effectiveness of our partnership with Tribes in reducing the \$2.2 billion backlog of health facility construction projects and staffing needs.

Funding Increases to Continue Improving Quality of and Access to Care

The IHS proposed budget includes a \$30.3 million increase for programs that will increase access to care and strengthen the capacity of the Indian health system to provide clinical and preventive care. The budget request includes a program increase of \$20 million for the CHS program, the top Tribal priority for program increases. This increase will expand the number of referrals for medical services in the private sector that IHS and Tribal CHS programs are able to fund. A \$5 million increase is included for Contract Support Costs for Tribes that have assumed the management of health programs previously managed by the Federal government. A \$1 million increase in Direct Operations will help the agency continue its reforms and to provide accountability and oversight in key administrative areas.

In this budget request we also target an important funding increase to the Agency's HIT systems, which are an increasingly critical and necessary component for the delivery of patient care services at the numerous IHS and Tribal hospitals and ambulatory clinics, and Urban Indian Health Programs. The HIT systems capture patient and performance data for statistical reporting and decision-making, and comprise the billing and collection system for third party reimbursements. The \$6 million HIT increase will support mandatory ICD-10 (International Classification of Diseases) implementation and provide \$1 million in support for the Electronic Dental Record (EDR) program.

For the Facilities appropriation, the overall request is \$443.5 million. Within this increase, the total Health Care Facilities Construction budget is \$81.5 million to continue construction of the San Carlos Health Center in Arizona, and the Kayenta Health Center on the Navajo Reservation. An increase of \$1.7 million will help address routine maintenance and improvement needs of our aging facilities.

CLOSING

The IHS is a predominantly rural, highly decentralized federal, Tribal, and Urban Indian health system that provides health care services under a variety of challenges. However, IHS has proven its ability to improve the health status of American Indians and Alaska Natives and to improve the way it does business with the resources we receive. IHS has shown notable progress, accomplishments, and outcomes over the past few years. We will continue to move forward in partnerships with Tribes to make needed improvements and to improve the quality of and access to care for the American Indian and Alaska Native people we serve. The President's budget request will help us make progress in changing and improving the IHS.

Thank you for this opportunity to present the President's FY 2013 budget request for the Indian Health Service.