

Ask The Experts: American Indian Health September 27, 2004

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JILL BRADEN-BALDERAS: Good day and thanks for tuning to Ask the Experts. I'm Jill Braden-Balderas with kaisernetnetwork.org. On our web cast today we will address the health and health care issues facing American Indians and Alaska Natives. We're joined by a distinguished panel of guests who will take your questions, but before I introduce you to them we're going to do something a little different for Ask the Experts. Today's show comes on the heel of the opening of the newest Smithsonian Institution museum here in Washington, D.C., the National Museum of the American Indian. Kaisernetnetwork.org would like to offer you a glimpse both inside and out of this stunning structure established by an act of Congress in 1989; the Smithsonian's 18th museum celebrates the history, culture and future of Native people throughout the Western Hemisphere. An array of colors, feathers and beaded garments dazzled onlookers as nearly 20,000 people danced, drummed and sang in the Native Nation's procession all to celebrate the opening of the Smithsonian's National Museum of the American Indian.

MALE SPEAKER: Today Native America takes its rightful place on the National Mall in the very shadow of the nation's Capitol Building itself. That Act establishes a powerful, physical, cultural, and spiritual marker for the ages in recognition of the first citizens of the Americas.

JILL BRADEN-BALDERAS: This museum has filled the last

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open spot on the National Mall, at the same time filling Native American's with pride and excitement. People came from as close as Virginia and from as far away as Peru.

FEMALE SPEAKER: I think that the Indigenous people of the Americas that were represented just simply by the nations that are here is a phenomenal response to the museum.

JILL BRADEN-BALDERAS: With a perspective as unique as the building that holds them the stories told in these exhibits are completely from a Native vantage point. Inside visitors find a mix of multimedia and ancient pottery representing the rich diversity of indigenous peoples who live in both rural and urban settings. One of the nation's most prominent American Indians said he knew eventually this day would come.

MALE SPEAKER: The Hopi prophecy told to me 40 years ago by Thomas Benyocka, spiritual leader of the Hopi nation about the reemergence of the Red people of the land after going through decades of poverty and despair. That reemergence of the Native people has come true.

JILL BRADEN-BALDERAS: While the museum primarily showcases the deep cultural roots of Indians across the western hemisphere, some suggest it may also be a catalyst to address the struggles, like poverty and health that many Native Americans face.

MALE SPEAKER: Part of a healthy body is a healthy mind as well and part of the health of a community is really in the

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strength of its character and its cultural history and its spirituality. And so we look at all those different elements.

JILL BRADEN-BALDERAS: The museum stands in honor of ancestors past and is a landmark for future generations to remember their rich heritage. For more information you can log onto the museum's web site at www.nmai.si.edu.

According to the 2002 U.S. Census, 2.5 million identified themselves as solely American Indian or Alaska Native. When compared with all other races in the United States, Native Americans face lower life expectancies and higher mortality rates of alcoholism, tuberculosis, diabetes, and suicide. And more than 1/3 of American Indians and Alaska Natives are uninsured. Based on what's known as a "Trust Responsibility" the Federal Government must provide health care to members of federally recognized tribes and the Indian Health Service is the vehicle to supply that care. Since its inception in 1955, the IHS has helped improve health outcomes and access to care in the Native American population, but few would argue their task is complete. We want you, our viewers, to ask our experts here in the studio via e-mail or a phone any questions you may have, so please e-mail us at ask@kaisernetwork.org. That's ask@kaisernetwork.org or phone us toll free with your questions to 1-888-kaiser8. That's 1-888-524-7378.

Joining us are IHS Director, Dr. Charles Grim, Mr. Jim Crouch, Executive Director of the California Rural Indian

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Health Board, and Dr. Yvette Roubideaux, Clinical Assistant Professor at the University of Arizona's College of Public Health and their College of Medicine. So you can read more about their accomplishments and research, we've posted their biographies on the Ask the Experts web site.

First of all, all of you, thanks so much for joining us today. We really appreciate it. I'd like to start with you, Dr. Grim. A speech that you made to the Association of American Indian Physicians last year, in it you had a quote, which is this, "At no time during the history of the United States has the overall health status of the Indian people ever equalled that of the rest of the population for most diseases and conditions." We could actually probably spend the entire show talking about this one question and the history behind it and the current issues faced in this population today, but could you just tell us what you think are the most pressing issues that are actually causing this major disparity in health and health care?

CHARLES GRIM, DDS: Well, in the early days of the Indian Health Service we made huge improvements and we have made huge improvements in various aspects of health care for American Indians and Alaska Natives. And a lot of the improvements that we made in the early years were due to diseases that were infectious in nature that we could take care of through immunizations. We could take our mental health and

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engineering services, we have a very comprehensive safe water and sanitation facilities program that brought safe water and sanitation facilities to reservations, and then with the advent of antibiotics for a lot of the infectious diseases that we faced. Today we have diseases that are more chronic lifestyle, behavioral types of diseases that much of the rest of the population is facing, like cardiovascular diseases, diabetes, cancer, all of which are rates higher in our population than in the U.S. general population. But to say that it's a health care system problem alone is not accurate. Just because you have a hospital or clinic located in your community and you have access to health care does not make an individual or a community healthy. There are a lot of issues beyond that. There are a lot of poverty on many of our reservations, high rates of unemployment, lack of adequate educational opportunities, lack of adequate housing, and as I said earlier, sanitation facilities and safe water in those houses. There are many Indian homes today, an earlier percentage that I'd used that our staff has told me has gone up lately and I haven't had updated lately for any hearings, but you're 7 times more likely if you live in an Indian home to not have safe water and sanitation facilities, and that all leads to increased diseases. So it's very, very intertwined with all these socioeconomic factors in communities the health of an individual.

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JILL BRADEN-BALDERAS: As we saw with the opening of the museum of the American Indian, this population is incredibly diverse. Mr. Crouch, could you just kind of give us an overview of this population of American Indians and Alaska Natives? How many live in rural areas? How many live in urban areas? And kind of the makeup of the population?

JIM CROUCH, MPH: There's a lot of diversity in the American Indian community that creates part of the difficulty in providing care to that community. The Indian Health Service itself provides care to about 1.6 million Indian people nationwide. That's from Alaska to the tip of Florida. There are 560 or so federally recognized tribes that are represented and each one of them, of course, is likely to be a cultural group and a language group unto itself. And they're divided between those that live in rural areas, primarily on reservations, although in California there's almost, where I work, there's almost no federal Indian trust land. The Indian community is divided in general between urban and rural people. The Census numbers provide us with 3 million or so, better than that American Indians depending on how you define them, but in actual fact only 1.6 find their way to an IHS funded facility and are able to receive care in those sites.

JILL BRADEN-BALDERAS: And what is the percentage of urban Native Americans in rural?

JIM CROUCH, MPH: My memory is 60% of the Native

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American community live in urban sites and centers and of course there's this huge disparity between the resources in the IHS directed towards that community versus those that are in reservation and rural settings. We like to talk about what we call the ITU system, I for the Indian Health Service, T for Tribally Operated Programs like the one that I work for, and U for Urban Programs. And only about 1% of the resources go to urban programs, although the disparity in funding even inside of the program that was run by tribes and by the IHS is also an issue we need to confront.

JILL BRADEN-BALDERAS: You know Dr. Roubideaux, you just released some new research on this ITU system that Mr. Crouch just explained to us and while you discussed many different issues, one of the things that you covered in the research was this movement towards self-determination and the fact now that most IHS money is actually managed by tribes. So can you talk about this movement toward self-determination and tribal management of money and some of the plusses and minuses of that system you found in your research?

YVETTE ROUBIDEAUX, MD: Yes, it's an extraordinary time in Indian health where tribes are starting to assert their sovereignty and have decided while we realize that the Indian health system has its limitations in terms of funding and while they continue to advocate to Congress for more funding, many tribes have decided that they need to take a primary role in

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insuring the health of their communities. So since Public Law 93638, the Indian Self Determination Educational Assistance Act was passed in 1976, many tribes have decided to take over the management of their health care programs from the Federal Government and to try to use their extra resources in their community to augment and improve services. They also believe that by doing this they can make the services more culturally appropriate and more specific to their own community needs, and also to build capacity within their tribes. In terms of whether this movement is improving health care, there's lots of anecdotal evidence that it is. I was involved in a survey by the National Indian Health Board of Tribal Leaders about 6 years ago and on average tribes that have taken over the management of their health care programs were able to increase the number of services in health programs and facilities more than programs that were still managed, tribes that had programs that were still managed by the Indian Health Service. That's the advantage if the tribe has a viable economic resource in its community. It is able to add to programs and also to help improve services. So I think it's a very exciting time in Indian health. We do need more data, however, to sort of evaluate what is the quality of care in this entire system that is changing so dramatically. More tribal programs, downsizing and reduced size of the IHS, but still an important role and also what about urban Indian health programs that are so

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severely underfunded? So my report that was published by the Commonwealth Fund, the bottom line was there have been improvements in the quality of care, but much more data and information is needed and many more efforts are needed to improve quality.

JILL BRADEN-BALDERAS: What about data on actual health outcomes?

YVETTE ROUBIDEAUX, MD: Well the only data we really have on health outcomes are the overall indicators of health status that the IHS gathers. To my knowledge there are no actual specific studies that look at tribal management leads to these outcomes. It's very difficult to do that in a research sense because each tribal program is different, serves a different population, has different needs, has different levels of services. I know that the department can be the committee that looked at what were some of the issues needed to measure the quality of care in tribally managed programs and the impact on the system and their conclusions were the same. It's very difficult. But even though it's difficult, we have to get in there and start measuring quality of care and look at health outcomes for both tribally managed and Indian health programs.

JILL BRADEN-BALDERAS: Dr. Grim, can you give us an idea and your take on why you think that many tribes are actually opting now to move toward self determination and actually control IH funds themselves? And then actually what

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kind of an impact that has on the IHS?

CHARLES GRIM, DDS: Well I think a lot of it is what Yvette said, there's been an interest in a lot of tribes to have local control of their programs. The Indian Health Services, they manage the hospitals and clinics for a given set of tribes out there and roughly 48% of the monies that come through the IHS are still managed federally. We try to work very, very closely with health advisory boards that give guidance and advice to our local management there, but the ultimate responsibility then for the management of that program still rests with the Federal Government, the federal officials that are there are the ones held accountable. When a tribe takes over the management of their program, then they are the ones held accountable by their people as to the types of services, the availability of the services, the accessibility and there tends to be a lot more involvement of the community as a whole at that point, I think, when a tribe takes over their program. All of our facilities, tribal as well as federal are accredited by the Joint Commission on the Accreditation of Health Care Organizations, JCAHO. Some of the facilities use an ambulatory health accrediting organization, AAAHC, so from that measure of quality all of our facilities are delivering a high level of quality of care and JCAHO and others have tried to implement more outcome based measures in a lot of those accreditation visits. We have some of the highest average

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scores in the nation when it comes to those type visits, so I agree with Yvette. I think the quality is there. We see it being delivered. We measure it the way many private sector organizations do, but there isn't enough research out there to really look at specific quality measures in certain types of programs. We have a lot that we measure around some of the high levels of diseases that we have that have high prevalence, such as diabetes. For years we've collected lots of clinical data on our diabetic patients. Congress has given us additional funds over the last 6 years. They've asked for an interim report and then a final report at the expiration of the next 5 years of the funding. And actually they've asked for us to do some more rigorous type research on the monies that we give out, so we're going to be giving some competitive grants out actually starting toward the end of this month, about 27 million dollar's worth and there will be a little bit more rigorous component of research to that and that will be around the primary prevention of diabetes and then cardiovascular risk reductions. So we're starting to take a look at and Congress is starting to take a greater interest in some of those issues.

JILL BRADEN-BALDERAS: Now, Dr. Grim talked about how tribes are held accountable when they actually oversee this money. You have great experience in this area. What are some of the issues that tribes face when they actually take control of this money?

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JIM CROUCH, MPH: California Rural Indian Health Board has been operating tribally controlled health systems for over 35 years in California. Actually it was a precursor to the Indian Self-Determination Act. I think there are a number of real take home messages and some of them have really important implications for the future of health care for the Indian community. One, as both Yvette and Dr. Grim have mentioned, is this issue of community control and identification with the service that comes from that change. I think that just like we have to have individuals take more responsibility for their health behaviors until the community takes more responsibility for the health care system, we can't really trigger that. You don't have the closing of the feedback loop somehow that you need in order to foster a lot of community and health improvement kind of activities. Part of the problem you have in running a tribal health care system that's even more pronounced than the IHS I think, is the issue of recruitment and retention of providers and particularly of system managers, really competent management staff. The best possible situation, of course, is to grow people from the community into those positions but that takes time. People that really know how to run ambulatory care aren't that easy to find, or even hospital care. And it's also true and one of the things that I don't think the audience really probably appreciates so much is that the nature of what's appropriate care changes over time and so

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that there's a need to stay updated. And of course that's more difficult in small, isolated sites, even when they're networked in a way like California Rural Indian Health Board.

JILL BRADEN-BALDERAS: We'd like to go ahead and go to some e-mails. We actually have had a number of e-mails on the Indian Health Care Improvement Act, which I understand that there was some movement on Capitol Hill last week with this bill. So I'd just like to get an update. And we also, 2 of our viewers actually e-mailed in and wanted to know if there was any sort of provision for long term care in this bill. So, Dr. Grim, if I could start with you and then actually get all of you to comment on the bill.

CHARLES GRIM, DDS: Okay. I know that each of them will have some comments to make. It's been a bill that's been a long time in the working. It was first passed in 1976, but in 1999, the IHS went on a very extensive consultation process with tribes. We held area level meetings, the IHS is broken into 12 various regions. We operate in 35 different states and those 35 states are broken into 12 regions. We then had what might be called "multi regional" meetings and then national meetings where we consulted very heavily on the bill itself. We took the old bill and tribal leaders, tribal attorneys, tribal experts like you have here sitting beside me, all had a hand in helping to draft probably what was one of the most sweeping changes in revisions to that bill since it was enacted. It sat

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through a couple of Congresses. Our Secretary, Tommy Thompson testified not too long ago, just a couple of months ago before the Senate Committee on Indian Affairs. And there have been a number of hearings that I've testified at. And finally, on Wednesday, September the 22nd, both the House Resources Committee and the Senate Committee on Indian Affairs marked that bill up and passed it out of their committees. That's the most movement we've seen on it in 4 years and there's been a strong interest in the Administration to try to get that bill passed this year. It is the cornerstone Act that authorizes the IHS and all its programs, many of those we've talked about so far and many that we haven't, such as our facilities program, our behavioral health program, our scholarship and loan repayment programs, all of our health service programs. And so it's a very, very sweeping bill. The urban program that was mentioned earlier when you asked about urban versus rural statistics. So it's a huge bill. It's over 300 pages long, a lot of provisions that have been controversial to one group or another either inside the government or out or to tribal leadership themselves, and it's come a long ways. There's been a lot of work on it in the last 4 years and I'm cautiously optimistic that it might pass before this session of Congress is over.

JIM CROUCH, MPH: You know, the IHS doesn't really have a defined benefit package, so when you ask about long term

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care, does the IHS provide it or do they not provide it? And in actual historical context they don't provide long-term care. There is provision in the Indian Health Care Improvement Act that might survive that would more clearly authorize the agency to support tribally operated, long-term care facilities. Of course those are generally supported through the Medicaid program and in order to make the bill more passable, a lot of the Medicaid provisions are being stripped from the bill in order to get it through Congress. So whether that will survive or not is hard to tell at this point.

JILL BRADEN-BALDERAS: Anything else you'd like to add, Dr. Roubideaux?

YVETTE ROUBIDEAUX, MD: Yes. I think that the Indian Health Care Improvement Act is very important. It's important because it's an authorization bill that acknowledges that there is still need to increase the services for Indian health care. It's very well known, well documented and clear that the IHS underfunded. Some estimates put it, it's funded at less than 40% of the need. The current budget for the IHS is 2.9 billion dollars. Tribal estimates have been that the budget should really be 18 billion dollars. Senator Daschle has introduced for 3 or 4 years in a row bills to try to increase appropriations for the IHS to 4 billion or more. It's very clear the IHS is underfunded. When I practiced as a doctor in the IHS, I was constantly frustrated that the lack of equipment

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and staff and how overworked I had to be to try to provide even the best care that I possibly could, but it's definitely underfunded. The Indian Health Care Improvement Act, all 300 pages of it is an acknowledgment by the Federal Government that this is what the IHS needs to provide good quality care and it's important that Congress fund this program as much as it can to help improve the quality of care for American Indians. Once this bill is authorized, which I hope happens during this session of Congress, then I hope Congress can then move on to appropriate adequate funding to help meet what the IHCA promises.

JILL BRADEN-BALDERAS: How many of the issues, Dr. Grim, would you say that the IHS faces are actually do to inadequate funding?

CHARLES GRIM, DDS: Gosh, that's a tough one to quantify, especially on the spot. If I had my statisticians here they could probably relay that to you, but I guess one of the things that I might add to your previous question too before I answer that, is that long term care is a term that I think is misunderstood by many people. A lot of people think of it as nursing home care only. Whenever I really look at it and I think many people in health care now, they look at it as a spectrum of care that starts with can a person be taken care of in their own home either by visiting a facility periodically or having some sort of health care home worker come out to their

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home periodically? All the way through full time care at home to assisted living to nursing homes to hospice care and things like that. So it's really a broad spectrum and I think the IHS for some time does have certain health type workers that have been performing those sorts of services. We have community health representatives, public health nurses and others that do go out into the communities to provide certain types of what might be called "long-term" care. The IHS does not run nursing homes and has not and in this new reauthorization if it were to pass then we do have in one of the versions there was authorization to potentially get us into the nursing home business, which is starting to be a great need in Indian communities, both assisted living homes, nursing homes, and a lot of home health care workers. So we've been looking into that a lot. On our web site, which I know you all have linked into yours, www.ihs.gov, the Indian Health Service with the Administration on Aging and the National Indian Council on Aging not too long ago had a roundtable on long term care and I would encourage people to look at that. It's a very difficult subject. Very complex. We are as has been mentioned when you look at us compared to other sorts of statistics or other sorts of health care programs, we do have an underfunding issue. One of our most recent studies called the Federal Disparities Index looked at the IHS funding versus a Blue Cross/ Blue Shield Federal Employee's health benefit package, something that a

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Congressman or federal health care workers could purchase for their own families. And so it was something that the people that we worked with felt like might resonate with Congressional leaders to understand how Indian country is funded compared to a package they would buy for their own families. And that particular study found that we were about 60% funded level compared to that package. And you can take a look at other statistics on the average Medicaid or Medicare enrollee and those statistics are out there. I think, as I said earlier and as has been alluded to, underfunding is one issue. It does prevent access to care I would say. It does keep the access to care down. It prevents some types of services from being provided that we'd like to provide. We do ensure that the services we provide are of high quality, but when you have an access problem that can be looked at as a quality problem too. But I don't want to downplay some of those issues I mentioned earlier on in your question about the health of a community. If we had all the money we needed to fund all the health care issues in every single community out there, I think if we still had poverty problems, lack of educational opportunities, lack of adequate housing, lack of adequate economic opportunities on reservations that we would still have health disparity problems in our population.

JIM CROUCH, MPH: I'd like to add a comment to the funding issue, because it's not just a question of the IHS

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global funding level, but the distribution of those resources across all of the operating units. In that distribution because there's been no systematic process over the years, there is a random distribution of resources, so that a tribal health program located in one part of the United States might have 90% of all the funds they need to operate appropriately, and one on another part of the United States or maybe just in 2 or 3 counties over might have 30% of the funds they need. And that disparity is also part of the problem. So it's not just a question of globally funding the IHS. It's a question of having administrative processes in place that would distribute those funds in a rational and equitable and defensible way. And of course to do that it takes a lot more research like Dr. Roubideaux does and greater coordination, actually, with other federal agencies than just the IHS. Probably 30 cents of every dollar comes from non-IHS sources, such as Medicare and Medicaid. And as we move increasingly toward joint funding from those agencies or billing to those agencies, the lack of data on how much money's coming in from those sources increasingly makes it difficult for Dr. Grim and his people to meet that level of rational and defensible distribution of the IHS resource.

JILL BRADEN-BALDERAS: And I'd actually like to get Dr. Roubideaux to comment on what kind of role Medicaid and Medicare and SCHIP apply to in this situation, but I actually

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just want to remind our viewers that they can call in. And our number to call in and ask questions of our guest panel is 1-888-kaiser8. That's 1-888-524-7378. So can you just talk a little bit about your research in this arena and obviously Native Americans, if they qualify under their state programs can tap into Medicaid resources and SCHIP resources. What are some of the issues that are surrounding their actually getting into those programs?

YVETTE ROUBIDEAUX, MD: Right. One of the things a lot of people don't realize is American Indians and Alaska Natives are citizens of the United States and so they also qualify for other health and public programs. They can buy their own health insurance if they have a job. They can qualify for Medicare if they meet eligibility such as being over the age of 65 and having worked. They can qualify for Medicaid if they meet poverty levels within their state. And they also can use other sources of health care, such as traditional medicine and community health centers. These sources of health care play a very important role in situation of dealing with access to care issues. If an American Indian grew up getting health care in the IHS on the reservation and then moves to an urban area where there is not an urban Indian health clinic, they're lost because they don't have health care. So they have to learn about these other sources of health care. Medicare and Medicaid are important sources of funding for Indian health programs.

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Indian health programs can bill the government for services that they provide in their facilities, and in some cases it provides over half of the entire facility's operating budget. So it's very important. The problem is a lot of American Indians are not aware of these other potential sources of health care and you can see that in statistics. Through Kaiser Family Foundation we published a recent article in the American Journal of Public Health that showed that despite the availability of all these sources of health care American Indians still have less employer coverage, much more public coverage, and are much more uninsured than the rest of the population. So there needs to be a lot of education about these other sources. I know the IHS does that. Whenever you walk in a clinic you get sent to the business office to see what you're eligible for and they encourage you to apply. But still there is a problem that not a lot of people are getting access to these other sources of health care.

JIM CROUCH, MPH: There's structural problems in that outreach in enrollment that need to be overcome. For starters, a lot of the Indian elders who had employment before when they were at working age worked in professions that simply weren't covered by the Social Security Act, so they don't have the 40 quarters of employment that goes for getting free access to ambulatory care or Medicare. The Medicaid programs have refused to allow tribal organizations, tribes in some places, but

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tribal organizations to participate in what's known as the Medicaid Administrative Match Program, which would help fund the cost of CHR's and business office people to help enroll and educate the Indian community about the availability of those coverage's. So again there are lots of little technical fixes that we're working and in part they're addressed through the Indian Health Care Improvement Act, that's the kind of thing that bill does. And in part they have to be done state by state because each Medicaid program is different. And so we have to advocate on a state-by-state basis to improve Indian participation in those programs.

CHARLES GRIM, DDS: Those monies have become very important to the operation of not only the Indian Health Service, but the tribal and the urban managed programs as well. We don't have accurate figures on all tribal programs because once they take them over they don't have to report in to us on their third party collections, but right now as we prepare for Congressional budget justifications and things like that our appropriated budget is approximately 2.9 approaching 3 billion dollars. Over half a billion dollars now comes from third party resources, and depending on the location, so that ups our budget to about 3.5 billion dollars. And depending on the location and as Dr. Roubideaux said, some of our facilities now find that over half of their operating budget now comes from third party resources instead of appropriated resources from

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the Federal Government. I agree with what both of them said that there are probably many more people out there that could have access to those resources that don't. and there are many, many reasons from local structural issues within a facility to philosophical issues with individual patients who say, the Federal Government from treaty and trust responsibilities owes us health care and I don't need to apply for Medicare and Medicaid or what other programs that there might be out there. And so we are constantly educating them that the money that we collect in our federal facilities, 100% of that goes back to that local facility to buy more providers, buy more pharmaceuticals for their patients, and it really helps expand the level of care in the programs that are out there. So our abilities to do that have been very, very beneficial to our programs.

JILL BRADEN-BALDERAS: We actually have our first caller on the line. From Spokane, Washington, caller you're on the air. Go ahead with your question.

FEMALE SPEAKER: Thank you. And this is a question for all of you, but especially to Dr. Grim. And my question addresses the major gaps between what we know scientifically, and what we do in the delivery of health care to all people. And we know that overweight and obesity is at epidemic levels, and it's really at the root of many preventable diseases in all races and ethnic groups. Yet the National Institutes on Health

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came out with the evidence based guidelines on identification, evaluation, treatment of overweight and obesity in adults. And the 2000 Centers for Disease Control and Prevention came out with the evidence based guidelines on BMI for age and growth charts. All are available to be downloaded. Education, I've worked with [Inaudible] and asked for things, educational materials. Doctors could hand out as we developed our Spokane BMI initiative here in Spokane, Washington. And they developed, many of them, they are there at the web site and can be downloaded and used in all these ethnic groups and people could learn for themselves. But there is no system in place to get these guidelines into our health care system. It seems to be the failure of coding at the various levels of the intervention. That is the biggest barrier. So my question is, what can you do to remove the barriers and get these guidelines? Promote institutionalization of these guidelines into all of health care for Native Americans, Alaskan, all of health care, all across our country?

JILL BRADEN-BALDERAS: Thank you for your question.

FEMALE SPEAKER: American Medical Association has approved these.

CHARLES GRIM, DDS: And you're very knowledgeable about a lot of the most recent data that's come out and one of the things that we are trying to do is, both the President has a Healthier U.S. Initiative, the Secretary of our department,

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the Department of Health and Human Services has an initiative called "Steps to a Healthier U.S.", and then the IHS has in the last couple of years really redoubled our efforts on health promotion and disease prevention. As a matter of fact we began this segment with a very historic event for Indian country, one that was attended by thousands and thousands of American Indians and Alaska Natives across the U.S. and across this Northern Hemisphere, really. And one of the things that we did that was of historical significance this week was we brought members from various communities across the country together and tried to partner them with both academia, with medical centers, with outside organizations that are both for profit and not-for-profit, with groups that want to work with Indian country. We have a heavy focus now on obesity, on nutritional and physical activity, and we realize that many, many of the diseases that we're facing are really, if you could get rid of obesity in our population that you would be able to deal with that. The Secretary of our department has held two health summits I believe now, two prevention health summits and in the very first one he got two other Cabinet level Secretaries to come and speak about policy level issues within the Federal Government, the Department of Agriculture and the Department of Education, talking about some of the foods that we serve and also talking about physical education activities in schools and things like that. And then there's also the issue, you talked

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about it a little bit, these things are available now, but the technology transfer from research into practice takes years and years. I'm trying to remember the last study that I saw, but it's in the teens. Maybe Yvette or Jim could through that in. Seventeen years, I believe, from research to get that technology transferred into day-to-day practice of all of our community for it to become a standard of practice within the health care professions. And so I think this is one that hopefully will not take that long. We're seeing huge rise in chronic diseases of all sorts and many of them have at the root obesity, sedentary lifestyles, et cetera, so we're doing all we can internally. We started a big push and again, like I said, the President and the Secretary have too and they're looking at many, many issues at the policy level to try to do this. And they're pulling lots of professional organizations together. I attended a meeting last year with the Secretary where he had the executive directors or presidents of many of the national professional organizations to say, how can we work together to do something about this epidemic of obesity and chronic diseases in our country? So as a government they are trying to take a policy level lead at the Cabinet level to try to do things like that.

JILL BRADEN-BALDERAS: We actually have another caller. Caller go ahead with your question and can you please tell us where you're from?

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FEMALE SPEAKER: Washington, D.C. I have been studying the Indian health care services and I notice that they distinguish between direct and contract health care services. I'm struggling to understand the alternate resources rule and was wondering if any of you could comment on that?

CHARLES GRIM, DDS: We could probably all three comment on that and I'll take a first crack at it since our agency is the one that helped set up the rules, and then if Jim or Yvette have anything they'd like to say. But there are two types of, we've talked about federal, tribal, and urban, but there are two other sorts of breakdowns of care in our system. Direct health care services where you walk into the door of one of our hospitals or clinics and receive the cares that are available there. Then there are contract health services. Any American Indian and Alaska Native of a federally recognized tribe is eligible to seek direct health care services in any of our facilities across the nation. And as you heard me say earlier, we have those in 35 different states. Contract health services have different sets of eligibility requirements and in some states are a little bit more confusing than in others. That particular line item of our budget is approximately half a billion dollars now, and it's the money that we use to buy care in the private sector that we cannot provide in our own health care facilities. Most of our health care facilities, with the exception of a few that are higher level medical centers are

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basically rural based, primary health care and ambulatory health care facilities that do provide a broad array of ambulatory care sorts of services and then we use this other bit of money to purchase health care in the private sector. And that money in most locations, not all, but is limited to the people that are located on or near a reservation and so that is the general rule. There are a few states across the nation where an entire state is considered a contract health service delivery area and if you live in that state you can be covered by that fund, but it's really subject to a lot of criteria from that local site and that's where people need to learn the most about it.

JIM CROUCH, MPH: I think your question is mostly about the two tiers of eligibility and it is obviously more restrictive for contract health care. But I'd like for you to think about what that money does. That's the money used to provide the rest of the continuum of care that isn't immediately available through a direct access, whether it's tribally operated or urban or IHS operated. So for example, in California we have no hospitals in the entire state and we have very few out of 27 operating units, we have 7, I think, licensed pharmacies. So CHS money in California is used for essentially inpatient care up and down the state and pharmaceuticals up and down the state. So the use of that care, CHS funding varies again from site to site and the rules are

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essentially designed to restrict access. Each tribal health program, each IHS operating unit is trying to make a door through which their patients can access care that fit the available funding. And it is absolutely an example of rationed health care in America that is very problematic for the Indian community. And to make, again, matters worse, the distribution of those funds really isn't based on the availability of the continuum of care. It's based historically on the number of people to which you've denied service. In other words, if you had a system of providing some care and you're starting to deny people, it shows more need than in those areas that simply have no availability. So it's CHS and those eligibility criteria are definitely part of what's always under discussion in the Indian health world.

YVETTE ROUBIDEAUX, MD: Contract health services are the most confusing thing for the American Indian and Alaska Native people because they hear that the Federal Government is supposed to provide them health care and then they go to the clinic and then they realize that there's a number of rules that they have to follow about calling to make sure if they get services, getting referrals approved, priorities, levels, paperwork, things that need to be done. It's an unfortunate situation. I know the IHS is trying to do the best it can in this circumstance of having a fixed amount of funding and much more need that is out there that the funding can take care of.

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And it is, it's similar to managed care where limited amount of money you have to ration care and you have to have protocols and priorities in place. I think we need to do a lot more to help educate American Indian and Alaska Native people on what the rules are, but then again, if the Indian Health Care Improvement Act could pass and we could get more funding, we wouldn't have this problem.

JILL BRADEN-BALDERAS: I'd like to change topics a little bit and go back to an e-mail that we actually received from several viewers wanting to know about providing culturally competent care. We had several e-mails, one from North Carolina and one from Arizona with practical questions. One like, would it be offensive to American Indians and Alaska Natives to display a skeleton in a health care, a place where you're providing health care? So are there places where people can go to find out what could be offensive, what could not be offensive and basically find out how they can deliver culturally competent care? Dr. Roubideaux I'd like you to address that as a practitioner.

YVETTE ROUBIDEAUX, MD: Yes, the challenge of delivering care to this population is it's incredibly diverse with 562 tribes and over 300 distinct cultures and languages. It's very complicated for health care providers to understand how to provide the best care to people with different language, a different belief system, those sorts of things. And it's also

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very difficult for patients to interact with people who come from places that they've never been or they're not familiar. I think there are two excellent sources for people who are interested in learning more about what is culturally appropriate. The first place is your local Indian health facility. Going and talking to the health care providers there about what they know, their knowledge and experience with the community. But the other important source is the tribe themselves. Talking with the health director, talking with people who are in the tribe and asking them, because it's very challenging. I am Rosebud Sioux by my tribal membership. When I went and worked on San Carlos Apache Indian reservation, just because I'm American Indian didn't mean I automatically knew what to do. I had to take some time, learn the local customs, learn the local traditions, and learn to adapt my approach to health care to make sure that it was appropriate for that community.

JILL BRADEN-BALDERAS: We actually have several callers who are holding to ask questions. So the next caller, you are on the air and if you could tell us where you're calling from? Caller are you there?

MALE SPEAKER: Yeah, this may be me. I'm from Cleveland, Ohio.

JILL BRADEN-BALDERAS: Go ahead with your question.

MALE SPEAKER: Dr. Grim has recently implemented a new

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program under a special endorsement for the Medicare Discount Drug Card that's going to extend some additional funding to IHS services across the country and I wondered if he might comment on that and the upcoming training sessions?

CHARLES GRIM, DDS: Sure. There has just recently passed, as most of America knows, a Medicare Modernization Act and in that there were a number of Indian specific provisions for our Indian Health Service tribal and urban facilities, but the drug card has a benefit that's eligible to all Americans. Our organization has been working very, very closely with the Centers for Medicare and Medicaid Services. I just sent out a memorandum to all of our regions that's going to talk about some training and the types of people that should be at those trainings. We're going to try to get everyone up to speed on what they need to do to educate our patient population about enrollment, to make sure that our providers know, both our pharmacy providers, our primary care providers, and others to be able to answer questions of their patients about this benefit because it has been confusing to a lot of people. The Centers for Medicare and Medicaid Services have done an outstanding job, I think, in an incredibly short period of time trying to implement this. They're working very, very closely with us trying to do that. The IHS has signed agreements with two companies right now that will see our patients or allow us to be network pharmacies with them. The tribal and urban

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programs can sign with these two cards or they're eligible to sign with other card companies across the nation too, but these two have agreed to sort of what might be looked at as our restrictive eligibility standards that you have to see. our facilities see American Indian and Alaska Native patients only so we've had two cards that are very specific, very willing to work with us on that limited population group. So we're very, very excited about it. There are a lot of other provisions in that bill that are going to help the IHS and as you heard I believe it was Jim that said earlier that a lot of the Indian Health Care Improvement Act was what gave us the ability to bill Medicare and Medicaid and private insurance for services provided through the IHS tribal and urban facilities, and because of the recent passage of the Medicare Modernization Act, because Medicaid is a state based sort of program, sort of shared state and federal, a lot of the specifics that were in the Indian Health Care Improvement Act reauthorization have been removed just because of all the changes that have been made recently to those two programs, Medicare and Medicaid. A lot of what was in the IHICIA, many of those things got implemented through Medicare Modernization. So we're very excited. Not only are there some very specific Indian provisions, but many of the things that are in there for rural communities, rural EMS programs, rural hospitals, those with disproportionate share and things like that are going to accrue

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to our facilities as well. We've not been able to analyze what sort of an economic impact that will have yet because many regulations have yet to be written, but we're very, very excited that all of our pharmacies are going to be included in that drug card.

JIM CROUCH, MPH: Let me make a quick comment, I have the privilege of sitting on the Tribal Technical Advisor Group to the Center for Medicare and Medicaid Services, and I would urge all our listeners in the Indian health world to attend those area based trainings on this transitional assistance opportunity, but I would also, and I also would agree that the people at CMS have been working very hard to meet a lot of short time frames, and there's certainly an amount of shortfall in that, but it's still a lot of hard work we should recognize. But this is a classic example of trying to fit an individual entitlement into a trust responsibility direct and contracted delivery system. It's going to make a difference. There are these 2 special providers for that drug card's service. It's going to make a difference how fast we get people signed up, whether we capture fully the \$1,200 of extra resource that comes with that drug card for our tribal programs or not. It's going to make a difference in how we purchase pharmaceuticals. It's really interesting one of the most important things about the transitional assistance is that we're left with the ability to buy our pharmaceuticals from the federal supply sources,

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which are simply better than are going to be available in the general market. So yes, those trainings are happening. People should participate in them and it's going to be a lot of work rolling out the interface between the Indian health delivery system and this new important pharmaceutical benefit over the next several years.

JILL BRADEN-BALDERAS: We actually have another caller on the line from Arizona. Caller go ahead with your question.

MALE SPEAKER: Yes, good afternoon. My name is Carl [Inaudible]. I have a question for Dr. Yvette Roubideaux. Dr. Roubideaux, you conclude in your commonwealth fund report that significant pits in American Indian and Alaska Native health care have been demonstrated, although there have still been significant disparities evident in the quality of care and health outcomes. You concluded and recommended that data is needed both in the changing structure of the Indian health care system and on measuring the quality of health care and services in urban Indian health programs. Talk upon how you suggest this data collection to occur.

YVETTE ROUBIDEAUX, MD: I think this approach to data collection needs to be very comprehensive. I think that I applaud the efforts of the IHS to establish indicators of quality as they have and their continued efforts with Joint Commission on Health Care Organizations. I encourage not only the IHS to continue gathering data, but for that function to be

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preserved in all the process of transitioning to tribal management that public health surveillance and quality data efforts need to continue to be sort of a national public health and central function. I also encourage more tribes and more health providers to get involved in measuring the quality of care. I think that what I would like to see is more people thinking about disparities in equality of health care and trying to figure out how to quantify them, how to explain them, and how to reduce and eliminate them. I think there needs to be a lot more research done in this area, but research by those types of researchers who are willing to understand the important technical and cultural aspects of doing research related to this population and the importance of respecting tribes and their sovereign rights when conducting research. And overall I hope to see a lot more partners at the table looking at data in quality in Indian health.

JILL BRADEN-BALDERAS: We actually just have a few minutes left. The hour always goes by very quickly. But I have a few more e-mails that I would like to get to. So we actually have an e-mail from someone in Massachusetts asking to comment on the pipeline problem for Native American health professionals and what should be done about it. I imagine that all of you could actually comment on that, so Dr. Roubideaux I'd like to start with you.

YVETTE ROUBIDEAUX, MD: There's a serious shortage of

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American Indian health professionals. We're the most underrepresented when you look at the statistics. We not only need more health care providers, such as physicians, nurses, and other health program people, we also need more people who are doing policy, who are in leadership positions in the tribe who can impact health and help provide more community based efforts. I think that we need to encourage students when they go away from school, support them, help them get through school, and then also to have much more education on Indian health issues so that they can understand what their specific role will be in this huge effort to try to improve care. The Kaiser Family Foundation has a program called the Barbara Jordan Health Policy Scholars program, which I'm on the national board for, and it recruits students who are college seniors or recent graduates to spend a summer in Congress learning about health issues and health policy. And many of those students have gone back to take leadership roles in their communities. So I think it's very important to not only support students who want to get that sort of education, but also to do a lot more education on Indian health issues so they can understand their important unique role in helping us improve health care for Indian people.

JILL BRADEN-BALDERAS: And Dr. Grim, IHS also has its own program, correct?

CHARLES GRIM, DDS: Yes we do. We have approximately

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30 million dollars of our budget that goes into either scholarships, loan repayment for professionals coming out of school, or specific agreements with certain universities across the nation to try to recruit more Indian health care professionals into the different professions. We've worked very, very hard on that because we do have a pipeline problem and we do have a problem with vacancies in our system right now. And the physician, nurses, dentist, and pharmacy ranks we have some levels that are above the national average that we'd like to see reduced, and the best way I think is to be able to train local community members and they're more apt to stay there. I don't want to mention any university in particular because I know I'll miss some of our good partners, but we are working very, very closely right now with a number of universities trying to work on some new methods of training health care professionals. We've always had people that come out to our facilities and do rotations or residencies and things like that at various locations, but we're looking at some new concepts of getting people out in teams to try to work with us and things like that. So there's a lot of interest from a lot of universities in wanting to work with us to get more Indian health care professionals out there and we're doing everything we can to partner with them and play our role in that.

JILL BRADEN-BALDERAS: Mr. Crouch, I'd like to direct

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this e-mail to you. This is about group plan purchasing and this is someone from Falls Church, Virginia. Are there currently any state or federal programs that allow tribes to purchase health insurance as a group to increase bargaining power and therefore lowering costs? Do you think this is a fair idea given the level of poverty affecting many tribes? And the increasing call for small businesses to be able to enter into these purchasing pools. Is this something that you've seen happen? And then I'd also like to give you the opportunity to comment on the Turtle Health program that's going on in California as well, because we haven't touched on that yet. So if you could maybe just address this e-mail's questions and then go.

JIM CROUCH, MPH: Sure. There are a number of situations where the ability of tribes or tribal health programs to purchase services for all of their client population in the same way that small businesses purchase services from the market would be advantageous. We've seen some of the gaming tribes take this approach very effectively, in fact a law passed in California requiring the state regulated insurance entities to allow the tribes to approach them as groups or as employers. The functions are very similar. You know who your workers are. You know who your tribal members are. You've got less. You've got a way to reduce, take the funding and write a single check to the insurer. It makes good

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sense. It is illegal for you to use your federal funds to buy indemnity coverage on an individual basis, but it is appropriate and possible to buy managed care coverage using your federal funds. In California we are trying to establish an Indian controlled tribal health program that would be a state licensed managed care structure that would contract first with the government agencies and then later offer private coverage for tribes and their members and also their employees. Managed care has some things in common with what IHS has been practicing for 30 years and there's a lot of congruity there that I think makes that an interesting avenue for some groups and some locations.

CHARLES GRIM, DDS: I might just play off on that on the some locations part. There are a lot of places that we serve in Indian country across the nation where there are not that accessibility of private programs for you to go to. If you're hours from the nearest city where the hospital is located and a lot of the tertiary care medical center services. it's not practical necessarily for a tribal that's in a situation like that to purchase a plan where their members have to travel 3 hours just to access care. So there are many parts of the country and Jim said it toward the end, but I just wanted to highlight that, that I think it would work well in many parts of Indian country, but there are some parts that I don't think it could ever work in.

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JILL BRADEN-BALDERAS: I'd like to close our web cast with just getting an idea from all three of you beginning with Dr. Roubideaux, what you think is the most pressing issue facing American Indian and Alaska Native health care, and what you think is the most pressing thing that needs to be addressed.

YVETTE ROUBIDEAUX, MD: I think the most pressing issue today for American Indians and Alaska Natives is the epidemic of chronic illnesses affecting our population. These are very complicated diseases that not only relate to the medical conditions and poor outcomes that result because of them, but they're caused by a very complex set of factors that include person's own individual choices about their health, family's choices about their health, and the context and the community within which they live. And all of these forces, including the United States and its trend in sort of unhealthy behaviors as well, all of these things are conspiring against American Indians with chronic diseases. And I think that's the one thing we need to address in terms of both prevention and quality treatment.

JILL BRADEN-BALDERAS: Mr. Crouch?

JIM CROUCH, MPH: We need to double the IHS budget for personal health care services. The whole system is grossly underfunded and it does have impacts in all other aspects of health and health outcomes.

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JILL BRADEN-BALDERAS: And Dr. Grim?

CHARLES GRIM, DDS: Well, the nice thing about going last is that I can agree with both of them and still have something to say. For me right now with working in Washington and with our act, seeing itself this close to passage, the passage of the Indian Health Care Improvement Act is probably one of the top things on my radar screen right now. The two things that they mentioned, and if I had to summarize some of our health care needs right now, I think they fall under the rubric of health promotion, disease prevention. We need to do a lot more on that. Chronic diseases are facing our population now in unprecedented numbers. And then behavioral health issues, which sort of underwrite not only the lifestyle choices that people are making, but the mental health and those sorts of needs that our population is now facing.

JILL BRADEN-BALDERAS: Thanks for joining us, Dr. Charles Grim, Mr. Jim Crouch, and Dr. Yvette Roubideaux, and thanks to everyone who called and e-mailed in with questions. We always do our best to get all your questions addressed and we apologize if we didn't have time to answer each one. Thank you so much for tuning in to Ask the Experts. I'm Jill Braden-Balderas with kaisernetwork.org.

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