S. HRG. 111–88

NOMINATION OF YVETTE D. ROUBIDEAUX TO BE DIRECTOR OF THE INDIAN HEALTH SERVICE

HEARING

BEFORE THE

COMMITTEE ON INDIAN AFFAIRS
UNITED STATES SENATE

ONE HUNDRED ELEVENTH CONGRESS

FIRST SESSION

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NOMINATION OF YVETTE D. ROUBIDEAUX TO BE DIRECTOR OF THE INDIAN HEALTH SERVICE

THURSDAY, APRIL 23, 2009

U.S. SENATE,
COMMITTEE ON INDIAN AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 2:15 p.m. in room 628, Dirksen Senate Office Building, Hon. Byron L. Dorgan, Chairman of the Committee, presiding.

OPENING STATEMENT OF HON. BYRON L. DORGAN, U.S. SENATOR FROM NORTH DAKOTA

The CHAIRMAN. We will call the hearing to order.

This is a hearing of the Indian Affairs Committee of the United States Senate. It is a hearing on the nomination of Dr. Yvette Roubideaux for the Director of the Indian Health Service. Dr. Roubideaux, welcome, we are pleased you are with us.

Let me state that President Obama sent Dr. Roubideaux's nomination to the Senate on March 26th. I am pleased to see a physician with on the ground experience and other applicable experience that this candidate has had for this position. Also, Dr. Roubideaux would be the first woman to lead the Indian Health Service, so I know this is also a historic nomination.

I want to start by saying that I believe Dr. Roubideaux will be inheriting an Indian health system that is broken. The Indian Health Service is only funded at about one half of its need. Clinician shortages are rampant. Significant health disparities permeate Indian Country.

In addition, the Indian Health Service is an agency, I believe, with some very serious management problems and very little follow-through, even when those problems are apparent. As I've said in the past, I think there are a lot of really terrific people working for the Indian Health Service. I've seen them and met with them. I've been around them all across this Country. God bless them for the work they do every day.

But the fact is, many of them are working in a system that is unbelievably bureaucratic, in some cases headed by people who are incompetent in managing the system. This is not new. We've held hearings about this. We need to fix it. And my discussions about it and the requirements to fix it should not tarnish a lot of good people who work there. But it certainly ought to be a warning to

the people who are there who have caused very serious management problems.

The result of all of these issues is that Native Americans in our Country suffer health disparities on par with some of the Third World nations. Patients seem only to get care when it is life and limb emergencies. In Indian Country, we have heard from the table where you sit Dr. Roubideaux, don't get sick after June because there is no money to provide you with Contract Health Services. There is a rationing of health care in Indian Country that should be considered, in my judgement, a national scandal and should be headline news, but it is not.

The impact of this broken system is clearly shown in the health disparities. A chart that we will ask to be shown, shows the health disparities between the general population, which is in blue, and American Indians in red. You can see with respect to tuberculosis, infant mortality, the rates of suicide, pneumonia and influenza, alcohol-induced illness, diabetes, you can see the disparity. It is very significant. The mortality rate of tuberculosis is 510 percent higher, suicide rates 70 percent higher, alcoholism 500 percent higher, and diabetes 189 percent higher.

This is not just about numbers, but about people, people's lives. The next photograph you will see is of Jami Rose Jetty. In February, this Committee held a hearing, an oversight hearing on Indian youth suicide, teen suicide. At that hearing a young woman of 16 named Dana Lee Jetty of Spirit Lake Nation in North Dakota testified. She described losing her sister, Jami Rose Jetty, who committed suicide at just 14 years of age. Jami's mother knew there was something wrong with her daughter. She took her to the Indian Health Service over and over again, but they did not diagnose her with depression. And even though her mother knew better, the doctors would say, she is just a typical teenager and they sent the family home.

November of last year, she took her life. Her sister, Dana Lee, found her. And during testimony, Dana said that she felt Jami would still be alive had there been trained mental health professionals available near the Spirit Lake Reservation to diagnose the needs. But Jami didn't receive those services. Her death was tragic and unnecessary.

I have spoken about Avis Little Wind, who was 14, took her life on the same reservation. I have spoken about her several times on the Floor of the Senate. She laid in her bed in a fetal position for 90 days, nobody seemed to miss her. A terribly dysfunctional family, and eventually she took her own life.

I spoke at length last year about Ta'shon Rain Little Light, this is a photograph that her grandmother used. Senator Tester and I were together on the Crow Nation Reservation in Montana when her grandmother began walking towards us as we held a hearing. She held that photograph above her head and that photograph, she said, is of my granddaughter. She said, you should know that she spent the last three months of her life in unmedicated pain. And she too was taken over and over and over again to the Indian Health Service and was told that she was depressed and sent home, over and over again.

Finally, with a referral from the Billings Hospital and a plane ride to Denver got a diagnosis that she had terminal cancer and was about to die. The fact is, this young woman, was diagnosed as just being depressed. She wasn't depressed, she had terminal cancer.

We just have to do so much better. I show you these photographs only to say that all of us, myself, Senators Barrasso, Johnson, and Tester, we represent real people that have real health care problems whose needs in many cases are not being met. The kind of health care problems that we would expect on a routine basis to be met for us, for our family, for the American people. They are not being met and young kids are dying and elders are dying. We have to do something about it.

So we have today before us a new nominee for the position of running the Indian Health Service. I am going to support the nominee. I am very pleased she offered herself for public service. I desperately want her to succeed. We have to improve this; we must. People's lives depend on it.

Before we proceed, let me call on my colleague, Senator Barrasso.

STATEMENT OF HON. JOHN BARRASSO, U.S. SENATOR FROM WYOMING

Senator BARRASSO. Thank you very much, Mr. Chairman. I agree with you and associate myself with your remarks. I have a statement that I will include for the record.

I would like to also join you in saying I do intend to support the nominee. I had a wonderful opportunity to visit with Dr. Roubideaux yesterday, had a great discussion on diabetes, on health care and prevention. We talked at length on the issues that you just discussed, that of the issue of suicide and what we can do to help, working so much with prevention, because in the Wind River Reservation in Wyoming, the life expectancy is 49. When you compare that to other men and women of our State with life expectancies around the age of 80, those are tragic numbers and we need to do better.

Thank you, Mr. Chairman.

[The prepared statement of Senator Barrasso follows:]

PREPARED STATEMENT OF HON. JOHN BARRASSO, U.S. SENATOR FROM WYOMING

Good Morning and thank you Mr. Chairman for holding this hearing on Dr. Roubideaux's nomination for Director of the Indian Health Service.

This position-along with Assistant Secretary for Indian Affairs-is one of the most challenging in the government.

The Indian health care system is complex. It involves an extensive list of health services and programs, in a wide variety of geographic and demographic settings, provided by IHS, Indian tribes, and urban Indian organizations.

In the past, I have pointed out challenges facing the Indian Health Service clinics on the Wind River Indian reservation. Like many other parts of Indian Country, funding is a problem for the Wind River clinics.

But the condition of our facilities is particularly noteworthy.

Built in 1877, the clinic in Fort Washakie is one of the oldest—if not *the* oldest—facility in the Indian health system.

It's hard to imagine, but we are attempting to deliver modern health care services in a 132-year-old clinic. Yet with the current funding system, the Wind River clinics probably will not be replaced or extensively renovated during our lifetimes.

Also, inefficiencies in the management systems of the IHS have real impacts at the reservation level. It is critical that the taxpayer's dollars are used efficiently,

wisely, and effectively. This is especially true when the goal is the delivery of health care.

Dr. Roubideaux's extensive research and educational background are impressive. Her dedication to improve Indian health is unquestionable. There is no doubt that she is an intelligent, thoughtful candidate for this position.

But I am particularly interested in hearing what Dr. Roubideaux intends to bring to the IHS as its Director. What does she want to achieve? When she looks back on her time as Director, what will she point to as her principal accomplishment?

Mr. Chairman, we are in the midst of the nation's health care reform debate. Now, more than ever, the IHS needs an exceptional leader.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Johnson, I know that you wanted to introduce Dr. Roubideaux, if you would be willing to do that.

STATEMENT OF HON. TIM JOHNSON,
U.S. SENATOR FROM SOUTH DAKOTA

Senator JOHNSON. Thank you, Mr. Chairman. It is my honor today to introduce Dr. Roubideaux as the Indian Affairs Committee considers her nomination to be Director of the Indian Health Service. Dr. Roubideaux was born in Pierre and graduated high school in Rapid City in my home State of South Dakota. She is a member of the Rosebud Sioux Tribe, where I am fortunate to have many friends.

The Chairman might be interested to know, her mother was from Standing Rock Reservation, which is straddling both South and North Dakota.

We are very proud to have one of our own be nominated to this position. She has a bachelor's degree and a medical degree from Harvard. As you know, we have many unique challenges that face us in Indian Country, and especially in the Aberdeen Area. We would be well served to have Dr. Roubideaux as the IHS Director. Her experiences as a patient, a doctor and administrator within the IHS system provides her with first-hand knowledge that she needs to be an effective director of the IHS.

I look forward to welcoming Dr. Roubideaux back to South Dakota soon. I also look forward to working with her as IHS Director to ensure that Federal Government does all that they can to fulfill its treaty and trust responsibilities to American Indians.

Thank you.

The CHAIRMAN. Senator Johnson, thank you very much.

Senator Tester.

STATEMENT OF HON. JON TESTER,
U.S. SENATOR FROM MONTANA

Senator TESTER. Thank you, Mr. Chairman, and I too want to thank you for your remarks. I think that they said what a lot of us were going to say, and I appreciate that.

The system is broken. There is no doubt about it. We have seen a lot of instances brought before this Committee and we have seen first-hand the kinds of challenges that IHS has been presented with. And quite frankly, in a lot of those cases, they failed to step up to the plate and hit the ball.

I am impressed with your resume and I think you bring some things to the table that will help this agency move forward into the 21st century in a way that we have all hoped it would have been

moving forward for a long time, and it hasn't. So success is critically important to all of us.

There is one issue, and hopefully you can address this in your opening statement, and it is management experience. Lack of it can be a blessing and it can be a curse. So I think in your particular case, with your on the ground experience with the medical side of things, I like that. I like that a lot. And maybe you could talk about the administrative challenges and how you plan to address them.

But with that, I too look forward to your taking over the Indian Health Service. I think as a Native American woman, you bring a lot of things to that department that can improve it.

Thank you.

The CHAIRMAN. Senator Udall?

STATEMENT OF HON. TOM UDALL,
U.S. SENATOR FROM NEW MEXICO

Senator UDALL. Thank you very much, Chairman Dorgan. Let me say that I had a very nice visit with Dr. Roubideaux and I think her credentials are excellent.

I think maybe sometimes, like Senator Tester said, that not having the so-called management experience you can move in and really shake things up and move them in the right direction. You certainly have an inquisitive mind and curiosity about that process.

One of the things that I hope you address, because I see it as just an addition to the massive problems that the Chairman mentioned, a huge issue is preventive care with our Native communities. We in New Mexico have an epidemic in diabetes and obesity on the reservation. Those problems have increased over time. I remember a nephrologist, a kidney doctor telling me in New Mexico that 30 years ago, when he started practice, he didn't see any Native American clients. And just in the short 30 years that he has been in practice, he is now in the middle of an epidemic.

So it shows in what a short period of time that has changed. This isn't some long, chronic situation. It is something that has occurred rather quickly. I kid my Navajo friends that it is the biliganna diet, the white man diet and all of them laugh. But I think that is a large part of it. And I think if we could put that preventive care in place it would really make a difference. I know you have been a real leader on that, you have focused on that. You have done epidemiological work in the area of diabetes. So we really look forward to working with you.

I think each of the individuals have said, the Senators before me, that you are under-funded. I hope we can aggressively work on that. To me, the most traumatic comparison is that we spend three times as much for Federal prisoners as we do for a patient in the Indian Health Service. So that really says it all to me.

With that, Mr. Chairman, thank you very much for this hearing.

The CHAIRMAN. Senator Udall, thank you very much.

Dr. Roubideaux, the Committee members will ask you questions today following your presentation. And then additional questions may well be submitted to you in writing. Once we have received responses to those questions, it is my intention that we would seek to report out your nomination at our next scheduled business meet-

ing. We will try to move very quickly, because I would like this nomination to be approved by the entire Senate.

The witness list today is Dr. Gerald Hill, who is the President of the Association of American Indian Physicians in Oklahoma City, Oklahoma. We will call on him first.

But before I do, Dr. Roubideaux, do you have family members that you wish to introduce today who are with you?

Dr. ROUBIDEAUX. I would just like to introduce my mother, Cecelia Roubideaux, who is back home in Tucson, Arizona, and will watch this webcast later.

The CHAIRMAN. All right. We wish her well as well.

Dr. Hill, why don't you proceed, and then we will recognize Dr. Roubideaux.

STATEMENT OF DR. GERALD HILL, PRESIDENT, ASSOCIATION OF AMERICAN INDIAN PHYSICIANS

Dr. HILL. Thank you.

Good afternoon, Chairman Dorgan, Ranking Member Issa, and the members of the Committee.

My name is Dr. Gerald Hill. I'm a member of the Klamath Tribe of Oregon and a practicing emergency physician in St. Paul, Minnesota. I am also the elected president of the Association of American Indian Physicians, a national non-profit organization made up exclusively of American Indian and Alaska Native physicians.

It is a great honor to be here today to introduce and express our support for Dr. Yvette Roubideaux in her nomination as Director of the Indian Health Service. The mission of the AAIP is to pursue excellence in Native American health care by promoting education in the medical disciplines, honoring traditional healing practices and restoring the balance of mind, body and spirit.

Dr. Roubideaux, a Harvard-trained physician, is a member of the Association and one of our finest examples. She has earned a national reputation for professional excellence in all of her professional endeavors.

Dr. Roubideaux's Native heritage and understanding of the community, as well as her development into a respected leader, physician, teacher, mentor and colleague, will provider her with a strong foundation should she be confirmed as Director of the Indian Health Service. Further, Dr. Roubideaux has witnessed the challenges of Indian health first-hand. Her work as a physician in the Indian Health Service for the San Carlos Apache Tribe and in the Gila River Indian community required that she not only understand western medicine but also how to apply this knowledge in Native communities.

Dr. Roubideaux is among the most intelligent and dedicated people I have ever met. She has worked as a primary care physician in Native communities; led Native people in the fight against diabetes; mentored Native students; advised tribes and Government agencies; and as President of the AAIP, served as a leader for Native physicians. I have witnessed Dr. Roubideaux in discussion with tribal leaders in several settings. She shows the proper respect and interacts with them in familiar ways; has the courage to speak frankly and honestly to all and always from her heart. It is Dr. Roubideaux's breadth of work in all these areas that sets her

apart and will lead to an outstanding career as Director of the Indian Health Service.

Dr. Roubideaux's most outstanding work is her leadership and passion in the fight against the diabetes epidemic. I know this Committee is keenly aware of Dr. Roubideaux's integral role in the implementation and multiple reauthorizations of the Special Diabetes Program for Indians, which provides funding for 399 IHS, tribal and urban diabetes programs across the Nation. Such accomplishments are what make Dr. Roubideaux an outstanding choice for Director of the Indian Health Service.

Dr. Roubideaux represents for Native people hope and intelligence, compassion and caring, education and achievement and more. She represents the best that Indian people have to offer to our communities and the Nation.

I cannot think of another person more suited to lead the Indian Health Service. On behalf of the Association of American Indian Physicians, we sincerely appreciate this opportunity to introduce Dr. Yvette Roubideaux to the Committee and support her nomination. The vast scope of her knowledge and experience, combined with her passion and commitment to the health and well-being of Native communities, uniquely qualify her for the position of Director of the Indian Health Service.

Thank you for the privilege and honor of introducing this outstanding Native woman to the Committee.

[The prepared statement of Dr. Hill follows:]

PREPARED STATEMENT OF DR. GERALD HILL, PRESIDENT, ASSOCIATION OF AMERICAN INDIAN PHYSICIANS

Good afternoon Chairman Dorgan, Vice Chairman Barrasso, and members of the Committee.

My name is Dr. Gerald Hill. I am a member of the Klamath Tribes of Oregon, and a practicing emergency physician in St. Paul, Minnesota. I am also the elected President of the Association of American Indian Physicians, a national, non-profit organization made up exclusively of American Indian and Alaska Native Physicians. It is a great honor to be here today to introduce and to express our support for Dr. Yvette Roubideaux's nomination for Director of the Indian Health Service.

The mission of the AAIP is to pursue excellence in Native American health care by promoting education in the medical disciplines, honoring traditional healing practices and restoring the balance of mind, body and spirit. Dr. Roubideaux, a Harvard-trained physician, is a member of the Association and one of our finest examples. She has earned a national reputation for excellence in all of her professional endeavors.

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Dr. Roubideaux is among the most intelligent and dedicated people I have ever met. She has worked as a primary care physician in Native American communities, led Native people in the fight against diabetes, mentored Native students, advised tribes and government agencies, and, as president of the AAIP, served as a leader for Native physicians. I have witnessed Dr. Roubideaux in discussion with tribal leaders in several settings. She shows the proper respect and interacts with them in familiar ways, has the courage to speak frankly and honestly to all, and always from her heart. It is Dr. Roubideaux's breadth of work in all these areas that sets her apart and will ultimately lead to an outstanding career as IHS Director.

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Thank you for the privilege and honor of introducing this outstanding Native woman to the Committee.

The CHAIRMAN. Dr. Hill, thank you very much for your comments.

We have been joined by the former Chairman of this Committee, Senator McCain. Senator McCain, I am about to recognize Dr. Roubideaux for an opening statement. Would you like to have an opening statement?

STATEMENT OF HON. JOHN McCAIN, U.S. SENATOR FROM ARIZONA

Senator MCCAIN. Could I just mention that obviously we are very pleased to have Dr. Roubideaux, but also, I think it is worthy of mention, she currently is at the Department of Family and Community Medicine at the University of Arizona. We are very proud of your work and we are very proud and appreciate the many contributions you have made.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator, everyone is trying to claim her at the moment.

[Laughter.]

The CHAIRMAN. South Dakota, and her mother is a member of the Standing Rock Tribe that joins North Dakota. So we have all been very complimentary of Dr. Roubideaux.

Dr. Roubideaux, why don't you proceed with your statement, following which you will entertain questions.

STATEMENT OF YVETTE ROUBIDEAUX, M.D., M.P.H., NOMINEE TO BE DIRECTOR OF THE INDIAN HEALTH SERVICE

Dr. ROUBIDEAUX. Thank you, Chairman Dorgan, Vice Chairman Barrasso, and members of the Senate Committee on Indian Affairs.

My name is Dr. Yvette Roubideaux. It is an honor to appear before you today as President Obama's nominee to be the next Director of the Indian Health Service.

I am a member of the Rosebud Sioux Tribe, which is my father's tribe, and I am also part Standing Rock Sioux Tribe, which is my mother's tribe. I have a long history with the Indian Health Service, first as a patient, then as a physician and a medical administrator.

If confirmed, I look forward to working with your Committee to do whatever we can to improve health care for American Indians

and Alaska Natives. Even though we face enormous challenges in this time of hope and change, I believe we have a unique opportunity to begin the difficult work of restoring health and wellness to American Indian and Alaska Native communities.

I am grateful for all that your Committee has done to improve the health of American Indians and Alaska Natives. I know you understand the significant challenges facing the Indian Health Service. It is a health care system that is confronted with all of the same challenges facing the U.S. health care system today.

But the Indian Health Service, which is different from all other agencies in the Department of Health and Human Services, also faces unique challenges. The Indian Health Service was established to meet the Federal trust responsibility to provide health care to members of federally-recognized tribes. The mission of the Indian Health Service is to raise the physical, mental, social and spiritual health of American Indians and Alaska Natives to the highest levels.

However, this task has become increasingly difficult over time. Rapid population growth, increased demand for services, skyrocketing medical costs, difficulty in recruiting health care professionals, long waits for referral services and the growing burden of chronic diseases, such as diabetes, obesity and cardiovascular disease, have created a significant strain on a system that is struggling to maintain current levels of services and in some areas, faces reductions in services and potential closures.

Despite these challenges, I see evidence of hope and change. As I mentioned, I have a long history with the Indian Health Service. I have seen up close the challenges of providing health care to this population with limited resources.

However, I have also worked on a variety of projects and national initiatives over the past 16 years that have shown me the great potential that exists in the system to improve access to and the quality of health care. I know that thousands of committed and dedicated career staff in the Indian health care system work hard every day to provide health care to their patients under difficult circumstances. And I know that many facilities and programs in the Indian Health Service have implemented innovative programs and have helped solve some of our greatest administrative challenges at the local level. We need to do more to learn from those successes and apply those lessons to other programs in the system.

In addition, with the new Administration, strong allies in Congress and renewed focus and energy on health reform from members of both parties, we have an opportunity to bring change to the Indian Health Service. President Obama is committed to ensuring that our First Americans have access to high quality health care. Even as a Senator, he supported increased Indian Health Service funding and passage of the Indian Health Care Improvement Act. New leadership in the Department of Health and Human Services will provide desperately needed support and direction. Congress has already passed legislation, the American Recovery and Reinvestment Act, that included critical resources for Indian Country. And many members have demonstrated a commitment to doing even more.

In listening sessions held with tribes during the Presidential transition, I heard a great call for change and for a renewed effort to improve health care for our people. With this outpouring of support, I cannot help but feel we are at a unique moment in time where we have the potential to make great strides towards fulfilling the mission of the Indian Health Service and toward improving the health of American Indians and Alaska Natives.

I am ready to serve and work with you to improve health care for American Indians and Alaska Natives. If confirmed, I plan to focus on four priority areas. First, I plan to renew and strengthen the Indian Health Service's partnership with tribes. I believe the only way we can restore our communities to health is to work in partnership with them. Toward that end, I intend to work with tribes to reviewing the existing tribal consultation process and to find ways to make that process more meaningful, so that we can work more closely together on the difficult challenges and decisions that face us in the coming years.

Second, as a part of the effort to reform our national health system, I plan to begin discussions with tribes, our health care providers and our patients on how we can bring reform to the Indian Health Service. We need to undertake a comprehensive review of our system to determine how to better meet the needs of our patients within the parameters of both broader reform effort and the available resources in our system. With respect to both quality and delivery of care, I hope we can look at what we are doing well and do more of it, as well as understand what we are not doing well and come up with specific solutions.

There may be difficult decisions ahead, but I am confident that in partnership with our tribes and with Congress, this Administration can and will make the right decisions.

Third, if I am confirmed, I plan to make improving the quality and access to care a primary goal of all our work in the Indian Health Service. This has been a central goal of my work ever since I decided to become a physician. I believe it is a primary wish of our patients. In order to restore their confidence in our system, we have to demonstrate that we provide high quality care they know they deserve. We need to implement more strategies to increase access to care in our system, to improve the quality of clinical services that we provide, and just as important, to provide better customer service.

Finally, we need to ensure that what we do to improve the Indian Health Service is transparent and accountable, and that we are as fair and inclusive as possible in considering the needs of all of our patients, whether they are seen in INS direct facilities, tribally-managed programs or urban Indian health programs. I know we can make strides to improve care in the Indian Health Service. I have seen the best of what we can do in my work as co-director of the Coordinating Center of the Special Diabetes Program for Indians demonstration projects. This $27.4 million annual Congressional appropriation created a grant program to translate scientific evidence into real world diabetes and cardiovascular disease prevention programs.

This successful initiative has proven that when the Indian Health Service and tribal and urban Indian programs are given

needed resources and adequate technical assistance and support, they can step up to the plate, implement a complex set of evidence-based services, evaluate their activities and deliver positive outcomes that exceed everyone's expectations. These programs demonstrated that the Indian health system has the potential to markedly improve the quality of health care it provides if given the support it needs to be successful.

I realize that we face enormous challenges and that this work will not be completed in days, weeks, months or even years. But if confirmed, I am ready to begin the important work of bringing change to the Indian Health Service. I know our patients are ready for it, and I know there are many tribal leaders, Indian health care staff and providers who have ideas for how we can achieve that goal.

I am confident that we can all work together in this effort, and I will rely on the guidance and support of this Committee as we move forward.

Again, thank you for the opportunity to have a conversation about American Indian and Alaska Native health care today. I am happy to answer any questions.

[The prepared statement and biographical information of Dr. Roubideaux follow:] *

PREPARED STATEMENT OF YVETTE ROUBIDEAUX, M.D., M.P.H., NOMINEE TO BE DIRECTOR OF THE INDIAN HEALTH SERVICE

Chairman Dorgan, Vice Chairman Barrasso, and members of the Senate Committee on Indian Affairs: My name is Dr. Yvette Roubideaux, and it is an honor to appear before you today as President Obama's nominee to be the next Director of the Indian Health Service.

I am a member of the Rosebud Sioux Tribe, my father's tribe, and I am also part Standing Rock Sioux, which is my mother's tribe. I have a long history with the Indian Health Service—first as a patient, and then as a physician and medical administrator.

If confirmed, I look forward to working with your committee to do whatever we can to improve healthcare for American Indians and Alaska Natives. Even though we face enormous challenges, in this time of hope and change I believe we have a unique opportunity to begin the difficult work of restoring health and wellness to American Indian and Alaska Native communities.

I am grateful for all that your Committee has done to improve the health of American Indians and Alaska Natives. I know you understand the significant challenges facing the Indian Health Service. It is a healthcare system that is confronted with all of the same challenges facing the U.S. healthcare system today.

But the Indian Health Service, which is different from any other agency in the Department of Health and Human Services, also faces unique challenges. The Indian Health Service was established to meet the federal trust responsibility to provide healthcare to members of federally recognized tribes. The mission of the Indian Health Service is to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level. However, this task has become increasingly difficult over time. Rapid population growth, increasing demand for services, skyrocketing medical costs, difficulties in recruiting and retaining healthcare professionals, long waits for referral services, and the growing burden of chronic diseases such as diabetes, obesity, and cardiovascular disease have created a significant strain on a system that is struggling to maintain current levels of services and, in some areas, faces reductions in services and potential closures.

Despite these challenges, I now see evidence of hope and change. As I mentioned, I have a long history with the Indian Health Service. I have seen up close the challenges of providing healthcare to this population with limited resources. However, I have also worked on a variety of projects and national initiatives over the past 16 years that have shown me the great potential that exists in the system to im-

* The financial disclosure report of Dr. Roubideaux has been retained in Committee files.

prove access to and quality of healthcare. I know that thousands of committed and dedicated career staff in the Indian healthcare system work hard every day to provide healthcare to their patients under difficult circumstances. And I know that many facilities and programs in the Indian Health Service have implemented innovative programs and have helped solve some of our greatest administrative challenges at the local level. We need to do more to learn from those successes and apply those lessons to other programs in the system.

In addition, with a new Administration, strong allies in Congress, and renewed focus and energy on health reform from members of both parties, we have an opportunity to bring change to the Indian Health Service. President Obama is committed to ensuring that our First Americans have access to high-quality healthcare Even as a senator, he supported increased Indian Health Service funding and passage of the Indian Health Care Improvement Act. New leadership in the Department of Health and Human Services will provide desperately needed support and direction. Congress has already passed legislation—the American Recovery and Reinvestment Act—that included critical resources for Indian country, and many members have demonstrated a commitment to doing even more. And in listening sessions held with tribes during the Presidential Transition, I heard a great call for change and for a renewed effort to improve healthcare for our people. With this outpouring of support, I cannot help but feel that we are at a unique moment in time, where we have the potential to make great strides toward fulfilling the mission of the Indian Health Service, and toward improving the health of the American Indian and Alaska Native population.

I am ready to serve and to work with you to improve healthcare for American Indian and Alaska Native people. If confirmed, I plan to focus on four priority areas.

First, I plan to renew and strengthen the Indian Health Service's partnership with tribes. I believe the only way we can restore our communities to health is to work in partnership with them. Toward that end, I intend to work with tribes to review the existing tribal consultation process and to find ways to make that process more meaningful so that we can work more closely together on the difficult challenges and decisions that face us in the coming years.

Second, as part of the effort to reform our national health system, I plan to begin discussions with our tribes, our healthcare providers, and our patients on how we can bring reform to the Indian Health Service. We need to undertake a comprehensive review of our system to determine how to better meet the needs of our patients within the parameters of both the broader reform effort and the available resources in our system. With respect to both the quality and delivery of care, I hope we can look at what we are doing well and do more of it, as well as understand what we are not doing well and come up with specific solutions. There may be difficult decisions ahead, but I am confident that, in partnership with our tribes and with Congress, this Administration can and will make the right decisions.

Third, if confirmed, I plan to make improving the quality of and access to care a primary goal of all of our work in the Indian Health Service. This has been a central goal of my work every since I decided to become a physician, and I believe it is a primary wish of our patients. In order to restore their confidence in our system, we have to demonstrate that we provide the high-quality care they know they deserve. We need to implement more strategies to increase access to care in our system, to improve the quality of clinical services that we provide, and just as importantly, to provide better customer service.

Finally, we need to ensure that what we do to improve the Indian Health Service is transparent and accountable, and that we are as fair and inclusive as possible in considering the needs of all our patients, whether they are seen in IHS direct service facilities, tribally managed programs, or urban Indian health programs.

I know we can make strides to improve care in the Indian Health Service. I have seen the best of what we can do in my work as the Co-Director of the Coordinating Center for the Special Diabetes Program for Indians Demonstration Projects. This $27.4 million annual congressional appropriation created a grant program to translate scientific evidence into real world diabetes and cardiovascular disease prevention programs. This successful initiative has proven that when Indian Health Service and tribal and urban Indian programs are given needed resources and adequate technical assistance and support, they can step up to the plate, implement a complex set of evidence-based services, evaluate their activities, and deliver positive outcomes that exceed everyone's expectations. These programs demonstrated that the Indian health system has the potential to markedly improve the quality of healthcare it provides if given the support it needs to be successful.

I realize that we face enormous challenges and that this work will not be completed in a matter of days, weeks, months, or even years. But, if confirmed, I am ready to begin the important work of bringing change to the Indian Health Service.

I know our patients are ready for it. And I know there are many tribal leaders, Indian healthcare staff, and providers who have ideas for how we can achieve that goal. I am confident that we can all work together in this effort, and I will rely on the guidance and support of this committee as we move forward.

Again, thank you for the opportunity to have a conversation about American Indian and Alaska Native healthcare today. I am happy to answer any questions.

A. BIOGRAPHICAL INFORMATION

1. Name: (Including any former names or nicknames used.)

Yvette Roubideaux, MD, MPH

2. Position to which nominated:

Director, Indian Health Service

3. Date of nomination:

March 26, 2009

4. Address: (List current place of residence and office addresses.)

Residence:
Tucson AZ 85712

Office:
University of Arizona
500 N. Tucson Blvd., #110
Tucson AZ 85716

5. Date and place of birth:

January 29, 1963
Pierre, South Dakota

6. Marital status: (Include maiden name of wife or husband's name.)

Single

7. Names and ages of children: (Include stepchildren and children from previous marriages.)

None

8. Education: (List secondary and higher education institutions, dates attended, degree received, and date degree granted.)

Stevens High School, Rapid City, SD: 1977-1981; Diploma 1981
Harvard University: 1981-1985; BA 6/85
Harvard Medical School: 1985-1989; MD 6/89
Harvard School of Public Health: 1996-1997; MPH 6/97

9. **Employment record: (List all jobs held since college, including the title or description of job, name of employer, location of work, and dates of employment, including any military service.)**

Internal Medicine Resident, Brigham & Women's Hospital, Boston MA, 1989-1992

Medical Officer/Clinical Director, San Carlos IHS Hospital, San Carlos AZ, 1992-1995

Medical Officer, Hu Hu Kam Memorial Hospital, Sacaton AZ, 1995-1996

Fellow, Commonwealth Fund/Harvard University, Fellowship in Minority Health Policy, Harvard Medical School, Boston MA, 1996-1997

Senior Fellow, University of Washington School of Medicine, Seattle WA, 1997-1998

Assistant Professor, The University of Arizona, 1998-Present (Arizona Prevention Center, 1998-2000; Zuckerman College of Public Health, 2000-2005; College of Medicine, Department of Family & Community Medicine, 2006-Present)

10. **Government Experience: (List any advisory, consultative, honorary or other part-time service or positions with Federal, State, or local governments, other than those listed above.)**

IHS (see employment record)

Medical Epidemiologist, Division of Diabetes Translation, Centers for Disease Control and Prevention (1998-2002) (part-time consultant/intergovernmental personnel agreement)

Steering Committee, American Indian Subcommittee (Chair), Community Interventions Workgroup, Partnership Network Meeting Planning Committee, Operations Committee, Evaluation Workgroup – all under National Diabetes Education Program, National Institutes of Health, Centers for Disease Control and Prevention (1997-2005)

Member, Planning Committee, Diabetes Translation Conference, Centers for Disease Control and Prevention (1998)

Consultant, Division of Diabetes Treatment Prevention, Indian Health Service (2002-2007);

Consultant, National Diabetes Program, Indian Health Service (1999-2000)

Member, NHLBI Working Group on Community Responsive Interventions, National Heart, Lung and Blood Institute (2001)

Consultant, Office of Loan Repayment and Scholarship, National Institutes of Health (2002-2004)

Member, DHHS Secretary's Advisory Committee on Minority Health (2000-2002)

Co-Chair, Indian Health Diabetes Workgroup, Indian Health Service (1997-1998)

Member, Technical Workgroup, Tribal Leader Diabetes Committee, Indian Health Service (2001-2004)

Member, Conference Planning Committee, Indian Health Service Research Conference (2004)

Member, Conference Planning Committee, Prevention of Cardiovascular Disease and Diabetes Among AIANs, Indian Health Service, National Heart, Lung and Blood Institute (2004-2005)

Chair, Grant Application Review Groups, Special Diabetes Program for Indians Diabetes and Cardiovascular Disease Demonstration Projects, Indian Health Service (2004)

Co-Director, Coordinating Center, Special Diabetes Program for Indians Diabetes and Cardiovascular Disease Prevention Demonstration Projects (2004-present)

Director, UA/ITCA Indians Into Medicine Program, The University of Arizona – funded by Indian Health Service (2001-present)

Director, Student Development Core, ITCA/UA, American Indian Research Center for Health, The University of Arizona – funded by Indian Health Service, National Institutes of Health – NARCH Initiative (2001-present)

11. Business relationships: (List all positions held as an officer, director, trustee, partner, proprietor, agent, representative, or consultant of any corporation, company, firm, partnership, or other business enterprise, educational or other institution.)

Consultant, National Indian Health Board, Public Health Accreditation Project (9/08-10/08)

Consultant, Henry J. Kaiser Foundation, Native American Health Policy Fellowship Program (2000-2003)

Consultant, The Commonwealth Fund, Project on Quality of Care in Indian Health (2003-2004)

Consultant, Association of American Indian Physicians, NDEP Move it! Pilot Grant Program (2003-2005)

Consultant, Novo Nordisk, Native American initiative (2005)

Consultant, TIV, Inc., Continuing Medical Education Video on Diabetes in AIANs (2005)

12: Memberships: (List all memberships and offices held in professional, fraternal, scholarly, civic, business, charitable and other organizations.)

Member, American College of Physicians (1992-present)

Member, American Diabetes Association (1998-present)

Member, American Public Health Association (1996-present); Secretary, APHA American Indian, Alaska Native, Native Hawaiian Caucus (1997-1999)

Member, Academy Health (2005-2006)

Member (2000-present), Treasurer (2004-2005), Chair, Elect/Past, (2005-2007), Native Research Network, Inc., non-profit professional organization

Member (1989-present), Member at Large (1996-1997), Treasurer (1997-1998), President, Elect/Past (1998-2001), Association of American Indian Physicians, non-profit professional organization

Member, Advisory Board, Policy Research Center, National Congress of American Indians (2005-present)

Member, National Advisory Committee, RWJF Center for Health Policy at the University of New Mexico (2007- present)

Member (1998-present), American Diabetes Association. Member (1998-present) and Chair (2004-2008), Awakening the Spirit Team, American Diabetes Association (1997-2008)

13. Political affiliations and activities:

(a)	**List all offices/candidacies**	none
(b)	**List all memberships/services**	Registered Democrat Volunteer, Phone Bank, Democratic Party of Pima County, AZ (10/08) – 2 hours total
(c)	**Contributions ≥ $500**	none

14. Honors and awards: (List all scholarships, fellowships, honorary degrees, honorary society memberships, military medals and any other special recognitions for outstanding service or achievements.)

Indian Health Service Scholarship (1983-1989)

Commonwealth Fund/Harvard University Fellowship in Minority Health Policy, Harvard Medical School, Boston MA (1996-1997)

Indian Health Fellowship/Senior Fellow, Native American Center of Excellence, Department of Medicine, University of Washington, Seattle, WA (1997-1998)

Native Investigator Program selection, Native Elder Research Center, Resource Center for Minority Aging Research, University of Colorado Health Sciences Center, Aurora, CO

Outstanding Performance Awards, Indian Health Service (1992-1996)

Exceptional Performance Award, Phoenix Area Council Of Service Unit Directors, Indian Health Service (1993)

Dr. Fang-Ching Sun Memorial Award for outstanding graduate student with a commitment to promote the health and well-being of the underserved, Harvard School of Public health (1997)

Award of Merit, National Diabetes Education Program, NIH/CDC (2000)

Outstanding American Indian Faculty Award, Native American Affairs, The University of Arizona (2002)

Indian Physician of the Year, Association of American Indian Physicians (2004)

National Impact Award, National Indian Health Board, For Awakening the Spirit Team, American Diabetes Association (Team Award, Chair of Team)

Addison B. Scoville Award for Outstanding Volunteer Service, American Diabetes Association (2008)

Physician Advocacy Merit Award, Institute on Medicine as a Profession, Columbia University (2008)

15. Published writings: (List the titles, publishers, and dates of books, articles, reports, or other published materials which you have written.)

Published writings are included below by category:

Scholarly Books and Monographs (Peer Reviewed)

Dixon M, **Roubideaux Y**, eds. Promises to Keep: Public Health Policy for American Indians and Alaska Natives in the 21st Century. American Public Health Association, 2001.

Chapters in Scholarly Books and Monographs

Original Research Featured

Roubideaux Y. The Impact on the Quality of Care. In: Dixon M, Shelton BL, Roubideaux Y, Mather D, Smith Mala C. Tribal Perspectives on Indian Self-Determination and Self-Governance in Health Care Management. Report for the Administration for Native Americans Grant Project, The National Indian Health Board, 1998.

Dixon M, Shelton BL, **Roubideaux Y**, Mather D, Smith Mala C. Tribal Perspectives on Indian Self-Determination and Self-Governance in Health Care Management. Report for the Administration for Native Americans Grant Project, The National Indian Health Board, 1998.

Research Reviews/State of the Field

Roubideaux Y. "Current Issues in Indian Health Policy." Background Paper for Conference "Native American Health and Welfare Policy in an Age of New Federalism." Morris K. Udall Foundation, Henry J. Kaiser Family Foundation and Udall Center for Studies in Public Policy at the University of Arizona, October 1998.

Roubideaux Y. Cross-Cultural Aspects of Mental Health and Culture-Bound Illnesses. In: Primary Care of Native American Patients: Diagnosis, Therapy, and Epidemiology. Galloway JM, Goldberg BW, Alpert JS (Eds). Butterworth Heinemann; 1999.

Dixon M, Mather DT, Shelton BL, **Roubideaux Y**. "Chapter 3. Economic and Organizational Changes in Health Care Systems." In: Dixon M, Roubideaux Y, eds. Promises to Keep: Public Health Policy for American Indians and Alaska Natives in the 21st Century. American Public Health Association, 2001.

Roubideaux Y, Acton K. "Chapter 8. Diabetes in American Indians." In: Dixon M, Roubideaux Y, eds. Promises to Keep: Public Health Policy for American Indians and Alaska Natives in the 21st Century. American Public Health Association, 2001.

Roubideaux Y. "Chapter 9. Cardiovascular Disease." In: Dixon M, Roubideaux Y, eds. Promises to Keep: Public Health Policy for American Indians and Alaska Natives in the 21st Century. American Public Health Association, 2001.

Roubideaux Y, Dixon M. "Chapter 11. Health Surveillance, Research and Information." In: Dixon M, Roubideaux Y, eds. Promises to Keep: Public Health Policy for American Indians and Alaska Natives in the 21st Century. American Public Health Association, 2001.

Roubideaux Y. "Current Issues in Indian Health Policy: Update 2002." Background Paper for Conference "Native American Health and Welfare Policy in an Age of New Federalism." Morris K. Udall Foundation, Henry J. Kaiser Family Foundation and Udall Center for Studies in Public Policy at the University of Arizona, 2002.

Roubideaux Y. "Current Issues in Health Disparities Common in American Indian Communities." Chapter in: Measuring Diabetes Care. Improving Data Quality and Data Use in American Indian Communities. Conference Proceedings, Seattle WA, August 20-22, 2002, Indian Health Service National Diabetes Program, 2003.

Lundgren P, Ross C, **Roubideaux Y**, Thompson R. Effective Diabetes Education: Creating Quality Programs. Special Diabetes Program for Indians Regional Meetings 2004. Conference Proceedings. Indian Health Service, 2004.

Roubideaux Y. Indian Health Care. In: Native America in the New Millennium. Harvard Project on American Indian Economic Development, Harvard Kennedy School of Government, 2005.

Roubideaux Y. Health Care: A Trust Responsibility, A Sovereign Right. In: The State of the Native Nations. Oxford University Press, 2007.

Refereed Journal Articles (Peer Reviewed Publications)

Roubideaux Y, Moore K, Avery C, Muneta B, Knight M, Buchwald D. Diabetes Education Materials: Recommendations of Tribal Leaders, Indian Health Professionals, and American Indian Community Members. Diabetes Educ 2000;26(2):290-4.

Hodge F, Weinmann S, **Roubideaux** Y. Recruitment of American Indians and Alaska Natives into Clinical Trials. Ann Epidemiol 2000;10(8 Suppl):S41-8)

Roubideaux Y. Perspectives on American Indian Health. Am J Public Health 2002; 92(9):1401-3.

Roubideaux Y, Buchwald D, Beals J, Middlebrook D, Manson S, Muneta B, Rith-Najarian S, Shields R, Acton K. Measuring the Quality of Diabetes Care for Older American Indians and Alaska Natives. Am J Public Health 2004; 94:60-65. Erratum in: Am J Public Health 2004;94(4):520.

Zuckerman S, Haley J, **Roubideaux Y**, Lilli-Blanton M. Health Service Access, Use and Insurance Coverage Among American Indians/Alaska Natives and Whites: What Role does the Indian Health Service Play? Am J Public Health 2004; 94(1):53-9.

Moss MP, **Roubideaux Y**, Jacobsen C, Buchwald D, Manson S. Functional Disability and Associated Factors Among Older Zuni Indians. J Cross Cult Gerontol 2004;19(1):1-12.

Rhoades DA, **Roubideaux Y**, Buchwald D. Diabetes Care Among Older Urban American Indians and Alaska Natives. Ethn Dis 200;14(4):574-9.

Roubideaux Y. A Review of the Quality of Healthcare for American Indians and Alaska Natives. The Commonwealth Fund, New York, NY, 2004.

Lilli-Blanton M, **Roubideaux Y**. Understanding and Addressing the Healthcare Needs of American Indians and Alaska Natives. Am J Public Health, 2005;95:759-61.

Lilli-Blanton M, **Roubideaux Y**. Co-Guest Editors, Special Issue on American Indian Health Policy, Am J Public Health, May 2005.

Wilson C, Gilliland S, Cullen T, Moore K, **Roubideaux Y**, Valdez L, Vanderwagen W, Acton K. Diabetes Outcomes in the Indian Health System during the Era of the Special Diabetes Programs for Indians and Government Performance and Results Act. Am J Public Health 2005;95(9):1518-22. Epub 2005 July 28.

Goins RT, Spencer SM, **Roubideaux YD**, Manson SM. Differences in Functional Disability of Rural American Indian and White Older Adults With Comorbid Diabetes. Research on Aging 2005;27(6):643-658.

Roubideaux Y. Beyond Red Lake – the persistent crisis in American Indian health care. N Engl J Med 2005;353(18):1881-3.

Moore K, **Roubideaux Y**, Noonan C, Goldberg J, Shields R, Acton K. Measuring the Quality of Diabetes Care in Urban and Rural Indian Health Programs. Ethn Dis 2006;16(4):772-7.

Jiang L, Beals J, Whitesell NR, **Roubideaux Y**, Manson SM; AI-SUPERPFP Team. Association between diabetes and mental disorders in two American Indian reservation communities. Diabetes Care 2007;30(9):2228-9. Epub 2007 Jun 11.

Jiang L, Beals J, Whitesell NR, **Roubideaux Y**, Manson SM; AI-SUPERPFP Team. Stress burden and diabetes in two American Indian reservation communities. Diabetes Care 2008;31(3):427-9. Epub 2007 Dec 10.

Verney SP, Jervis LL, Fickenscher A, **Roubideaux Y**, Bogart A, Goldberg J. Symptoms of depression and cognitive functioning in older American Indians. Aging Ment Health 2008;12(1):108-15.

Roubideaux Y, Noonan C, Goldberg JH, Manson SM, Valdez SL, Brown TL, Acton KJ. Relation Between the Level of American Indian and Alaska Native Diabetes Education Program Services and Quality-of-Care Indicators. Am J Public Health 2008;98(11):2079-84. Epub 2008 May 29.

General (Non-Peer Reviewed)

Roubideaux Y. "Native American Health Challenges." Arizona Prevention Center Newsletter, August 1999.

Galloway J, **Roubideaux Y**, et al. "The Center for Native American Health: a Unique Collaboration in Indian Health." The IHS Primary Care Provider, 24(10):154-155. October 1999.

Roubideaux Y. "The National Diabetes Education Program American Indian Campaign." The IHS Primary Care Provider, 25(6): 97-100, June 2000.

Roubideaux Y, Helweg P. "The Kaiser Family Foundation Native American Health Policy Fellowship Program." The IHS Primary Care Provider, 26(7): 111-112, July 2001.

Roubideaux Y. "National Diabetes Education Program Adopts A1C Name for the Hemoglobin A1C Test." The IHS Primary Care Provider, 26(11): 154-5, October 2001.

Hernandez A, Parker M, Lewis J, **Roubideaux Y.** Helping Arizona Students Enter the Health Professions. Winds of Change Magazine, American Indian Science and Engineering Society, Fall 2002.

16. Speeches: Provide the Committee with two copies of any formal speeches you have delivered during the last 5 years which you have copies of on topics relevant to the position for which you have been nominated.

Formal speeches delivered in the past 5 years are included below by category. PowerPoint slides will be provided (my speeches were not written word for word – I used slides as an outline).

Scholarly/Research Presentations

- Plenary/General Sessions

"Measuring the Quality of Diabetes Care for American Indians and Alaska Natives." Mini-Course, Native Elder Research Center Native Investigator Program Orientation, Denver, CO, January 14, 2004 (Invited Presentation)

"Measuring the Quality of Diabetes Care for American Indians and Alaska Natives." Resource Centers for Minority Aging Research (RCMAR) Annual Meeting, Charleston SC, March 12, 2004 (Invited Presentation)

"Measuring the Quality of Diabetes Care for American Indians and Alaska Natives." The Commonwealth Fund Annual Grantee Meeting, New York, NY, April 20, 2004

"Measuring the Quality of Diabetes Care for American Indians and Alaska Natives." University of New Mexico School of Medicine Speaker Series, Albuquerque, NM, April 23, 2004

"Measuring the Quality of Healthcare for American Indians and Alaska Natives." IHS Annual Research Conference, Phoenix AZ, May 13, 2004 (Plenary Session – Invited Presentation)

"Improving the Quality of Indian Health Diabetes Education Programs." California Endowment Scholars Research Forum, The California Endowment, August 23, 2004 (Invited Presentation)

"Improving the Quality of Diabetes Care for American Indians and Alaska Natives." Alvin F. Poussaint MD Lecture and Scientific Sessions, Harvard Medical School, Boston MA, February 12, 2005 (Invited Presentation)

"Measuring the Quality of Care in Indian Health Diabetes Education Programs." Public Health Seminar Series, Zuckerman College of Public Health, The University of Arizona, March 29, 2005, Tucson AZ (Invited Presentation)

"Traditional Indian Medicine and Research: Results of an Input Session with Indian Health Researchers." International Meeting on Inuit and Native American Child Health and the 17th Annual IHS Research Conference, Seattle WA, April 30, 2005 (Invited Panel Presentation)

"American Indian/Alaska Native Health Policy." National Congress of American Indians Policy Center Overview, National Congress of American Indians Mid-Year Session, Green Bay, WI, June 12, 2005 (Invited Presentation)

"SDPI Competitive Grant Program – Update." Tribal Leaders Diabetes Committee Meeting, Indian Health Service, Washington, DC, August 10, 2005 (Invited Presentation)

"SDPI Competitive Grant Program – Update." Tribal Leaders Diabetes Committee Meeting, Indian Health Service, Albuquerque NM, November 8, 2005 (Invited Presentation)

"Policy Issues in American Indian/Alaska Native Health." Native Elder Research Center Native Investigator Program Orientation, University of Colorado Health Sciences Center, Denver CO, January 10, 2006 (Invited Presentation)

"Measuring the Quality of Diabetes Care for American Indians and Alaska Natives." American Medical Student Association Seminar, College of Medicine, The University of Arizona, Tucson AZ, April 17, 2006 (Invited Presentation)

"The SDPI Competitive Grant Program: Description and Lessons Learned." Association of American Indian Physicians Annual Conference, August 7, 2006 (Invited Plenary Presentation)

"Tribes and Research: What you need to know." Second Annual New Mexico Tribal Health Research Summit: Creating the Framework for Tribal Research Partnerships, Albuquerque NM, June 25, 2007 (Invited Presentation)

"Health Care in Indian Country: Setting a Research Agenda for Health Care Improvement." Spring Lecture Series, RWJF Center for Health Policy at University of New Mexico, Albuquerque, NM, April 23, 2008 (Invited Presentation)

"Measuring the Quality of Care in American Indian/Alaska Native Diabetes Education Programs." Resource Centers for Minority Aging Research Annual Conference, Ann Arbor/Detroit Michigan, May 9, 2008 (Invited Presentation)

"Community Based Participatory Research: Relevance to Tribes." New Mexico Tribal Health Research Summit, University of New Mexico, Albuquerque NM, June 3, 2008 (Invited Presentation)

"Health Policy and Research." New Mexico Tribal Health Research Summit, University of New Mexico, Albuquerque NM, June 3, 2008 (Invited Presentation)

"Measuring the Quality of Care in American Indian/Alaska Native Diabetes Education Programs." CEED Conference, Denver CO, August 12, 2008 (Invited Presentation)

"Special Diabetes Program for Indians Diabetes Prevention Program." Zia Association of Diabetes Educators Meeting, Albuquerque NM, September 26, 2008 (Invited Presentation)

"Tribal Authority vs. Academic Freedom." Future Directions of Tribal Research in Arizona Conference, Inter Tribal Council of Arizona, Phoenix AZ, October 31, 2008 (Invited Presentation)

- Workshops

"Measuring the Quality of Indian Health Diabetes Education Programs." CDC Diabetes Translation Conference, Chicago IL, May 11, 2004 (Poster Presentation)

"Measuring the Quality of Indian Health Diabetes Education Programs." IHS National Diabetes Program Regional Meetings, Phoenix, Oklahoma City, Seattle, Minneapolis, May 2004 (Invited Presentation)

"Measuring the Quality of Indian Health Diabetes Education Programs." Academy Health Annual Conference, San Diego CA, June 8, 2004 (Poster Presentation)

"Measuring the Quality of Indian Health Diabetes Education Programs." Translating Research Into Practice Conference, DHHS, Washington DC, July 12, 2004 (Invited Presentation)

"Measuring the Quality of Indian Health Diabetes Education Programs." Research Poster Forum College of Medicine, The University of Arizona, September 15, 2004 (Invited Poster Presentation)

"Measuring the Quality of Indian Health Diabetes Education Programs." American Public Health Association Annual Conference, Washington DC, November 7, 2004 (Invited Presentation)

"The Diabetes Epidemic: A Comparison of American Indian/Alaska Native Data with Other Racial and Ethnic Groups." Tribes and Community Perspectives Track, Prevention of Cardiovascular Disease and Diabetes Among American Indians and Alaska Natives 2005, Denver CO, May 17, 2005 (Invited Presentation)

"Special Diabetes Program for Indians (SDPI): Description and Lessons Learned from the SDPI Competitive Grant Program Demonstration Projects." National Indian Health Board 23rd Annual Consumer Conference, October 12, 2006, Denver CO (Invited Presentation)

"Special Diabetes Program for Indians SDPI Competitive Grant Program Demonstration Projects – Overview and Lessons Learned." American Public Health Association 134th Annual Meeting, Boston MA, November 7, 2006 (Invited Presentation)

"IDERP Evaluation: AHRQ Project Background and Results." Indian Health Diabetes Education Recognition Program Workgroup Meeting, IHS Division of Diabetes Treatment and Prevention, Albuquerque, NM, May 24, 2007 (Invited Presentation)

"Tribal and University Research Partnerships." Indian Health Service Annual Research Conference, Phoenix AZ, June 5, 2007 (Invited Presentation)

"Evaluation of the Special Diabetes Program for Indians Diabetes Prevention and Healthy Heart Demonstration Projects." Making Data Count: Measuring Diabetes and Obesity in Indian Health Systems Conference, Tucson AZ, December 18-20, 2007 (Invited Presentation)

"Measuring the Quality of Care in American Indian/Alaska Native Diabetes Education Programs." American Association of Diabetes Educators Annual Meeting, Washington DC, August 7, 2008 (Invited Presentation)

"Studying Diabetes in American Indians/Alaska Natives." Minority Affairs – Ethics Committee Workshop, American College of Epidemiologists Annual Conference, Tucson AZ, September 13, 2008 (Invited Presentation)

"Special Diabetes Program for Indians Healthy Heart Project: Translating research into practice for American Indians and Alaska Natives with diabetes." American Public Health Association Annual Meeting, San Diego, CA, October 28, 2008 (Invited Presentation)

- Special Diabetes Program for Indians Demonstration Project Grantee Meeting Presentations

"Resource Core Overview." Coordinating Center, Special Diabetes Program for Indians Competitive Grant Program Planning Meeting 1, Denver CO, November 17, 19, 2004 (Invited Presentation)

"Community Based Activities Overview." Coordinating Center, Special Diabetes Program for Indians Competitive Grant Program Planning Meeting 1, Denver CO, November 17, 19, 2004 (Invited Presentation)

"The Diabetes Prevention Program." Coordinating Center, Special Diabetes Program for Indians Competitive Grant Program Planning Meeting 1, Denver CO, November 16, 2004 (Invited Presentation)

"CGP Meeting 1 Evaluation." Special Diabetes Program for Indians Competitive Grant Program Steering Committee Meeting, Denver CO, January 10, 2005 (Invited Presentation)

"CGP Technical Assistance Needs Assessment." Special Diabetes Program for Indians Competitive Grant Program Steering Committee Meeting, Denver CO, January 10, 2005 (Invited Presentation)

"Overview of the SDPI Competitive Grant Program Coordinating Center." Tribal Leaders Diabetes Committee Meeting, Denver CO, February 10, 2005 (Invited Presentation)

"CGP Draft Core Elements – DP and CVD Demonstration Project." Special Diabetes Program for Indians Competitive Grant Program Steering Committee Meeting, Denver CO, March 14, 2005 (Invited Presentation)

"Draft Core Elements – DPP Curriculum." Special Diabetes Program for Indians Competitive Grant Program Planning Meeting 3, Denver, CO, March 15, 2005 (Invited Presentation)

"Draft Core Elements – Recruitment." Special Diabetes Program for Indians Competitive Grant Program Planning Meeting 3, Denver, CO, March 15, 2005 (Invited Presentation)

"Draft Core Elements – Case Management." Special Diabetes Program for Indians Competitive Grant Program Planning Meeting 3, Denver CO, March 17, 2005 (Invited Presentation)

"Draft Core Elements – Recruitment." Special Diabetes Program for Indians Competitive Grant Program Planning Meeting 3, Denver, CO, March 17, 2005 (Invited Presentation)

"Progress on Core Elements." Special Diabetes Program for Indians Competitive Grant Program Planning Meeting 4, Denver CO, May 23, 2005 (Invited Presentation)

"Recruitment – Update/Final Core Elements." Special Diabetes Program for Indians Competitive Grant Program Planning Meeting 4, Denver CO, May 24, 2005 (Invited Presentation)

"Using Principles of Social Marketing to Develop Culturally Appropriate Diabetes Education Materials." Special Diabetes Program for Indians Competitive Grant Program Planning Meeting 4, Denver CO, May 24, 2005 (Invited Presentation)

"Recruitment Materials – Draft Common Elements." Special Diabetes Program for Indians Competitive Grant Program Planning Meeting 4, Denver CO, May 24, 2005 (Invited Presentation)

"Retention – Draft Guidelines." Special Diabetes Program for Indians Competitive Grant Program Planning Meeting 4, Denver CO, May 24, 2005 (Invited Presentation)

"Case Management – Update/Final Core Elements." Special Diabetes Program for Indians Competitive Grant Program Planning Meeting 4, Denver CO, May 24, 2005 (Invited Presentation)

"Case Management – Documentation of Care Plans." Special Diabetes Program for Indians Competitive Grant Program Planning Meeting 4, Denver CO, May 24, 2005 (Invited Presentation)

"CVD Curriculum Training Schedule." Special Diabetes Program for Indians Competitive Grant Program Planning Meeting 4, Denver CO, May 24, 2005 (Invited Presentation)

"DMS/RPMS Training Schedule." Special Diabetes Program for Indians Competitive Grant Program Planning Meeting 4, Denver CO, May 24, 2005 (Invited Presentation)

"MOU/Data Sharing." Special Diabetes Program for Indians Competitive Grant Program Planning Meeting 4, Denver CO, May 24, 2005 (Invited Presentation)

"Community Based Activities – Evaluation." Special Diabetes Program for Indians Competitive Grant Program Planning Meeting 4, Denver CO, May 24, 2005 (Invited Presentation)

"Registry – Diabetes." Special Diabetes Program for Indians Competitive Grant Program Planning Meeting 4, Denver CO, May 25, 2005 (Invited Presentation)

"Draft Core Elements – Screening for Prediabetes." Special Diabetes Program for Indians Competitive Grant Program Planning Meeting 4, Denver CO, May 26, 2005 (Invited Presentation)

"DPP Curriculum Training Schedule." Special Diabetes Program for Indians Competitive Grant Program Planning Meeting 4, Denver CO, May 26, 2005 (Invited Presentation)

"DPP Curriculum – Update/Final Core Elements." Special Diabetes Program for Indians Competitive Grant Program Planning Meeting 4, Denver CO, May 26, 2005 (Invited Presentation)

"Recruitment – Update/Final Core Elements." Special Diabetes Program for Indians Competitive Grant Program Planning Meeting 4, Denver CO, May 26, 2005 (Invited Presentation)

"Recruitment Materials – Draft Common Elements." Special Diabetes Program for Indians Competitive Grant Program Planning Meeting 4, Denver CO, May 26, 2005 (Invited Presentation)

"Using Principles of Social Marketing to Develop Culturally Appropriate Diabetes Education Materials." Special Diabetes Program for Indians Competitive Grant Program Planning Meeting 4, Denver CO, May 26, 2005 (Invited Presentation)

"Retention – Draft Guidelines." Special Diabetes Program for Indians Competitive Grant Program Planning Meeting 4, Denver CO, May 26, 2005 (Invited Presentation)

"Community Based Activities – Evaluation." Special Diabetes Program for Indians Competitive Grant Program Planning Meeting 4, Denver CO, May 26, 2005 (Invited Presentation)

"Registry – Prediabetes." Special Diabetes Program for Indians Competitive Grant Program Planning Meeting 4, Denver CO, May 27, 2005 (Invited Presentation)

"DMS/RPMS Training Schedule." Special Diabetes Program for Indians Competitive Grant Program Planning Meeting 4, Denver CO, May 27, 2005 (Invited Presentation)

"CGP Planning Meeting 5 – Preview." Steering Committee Meeting, Special Diabetes Program for Indians Competitive Grant Program Planning Meeting 5, Denver CO, July 18, 2005 (Invited Presentation)

"Demonstration Project Updates – Final Core Elements." Steering Committee Meeting, Special Diabetes Program for Indians Competitive Grant Program Planning Meeting 5, Denver CO, July 18, 2005 (Invited Presentation)

"Planning Meeting 6 – Overview." Steering Committee Meeting, Special Diabetes Program for Indians Competitive Grant Program Planning Meeting 5, Denver CO, July 18, 2005 (Invited Presentation)

"Overview of the Final Core Elements." Special Diabetes Program for Indians Competitive Grant Program Planning Meeting 5, Denver CO, July 19, 2005 (Invited Presentation)

"Recruitment Process." Special Diabetes Program for Indians Competitive Grant Program Planning Meeting 5, Denver CO, July 19, 2005 (Invited Presentation)

"Training Schedules." Special Diabetes Program for Indians Competitive Grant Program Planning Meeting 5, Denver CO, July 19, 2005 (Invited Presentation)

"IRB Process and Templates." Special Diabetes Program for Indians Competitive Grant Program Planning Meeting 5, Denver CO, July 19, 2005 (Invited Presentation)

"Orientation to the SDPI Competitive Grant Program Workshop." Special Diabetes Program for Indians Competitive Grant Program Planning Meeting 5, Denver CO, July 20, 2005 (Invited Presentation)

"Overview of the Final Core Elements." Special Diabetes Program for Indians Competitive Grant Program Planning Meeting 5, Denver CO, July 21, 2005 (Invited Presentation)

"Recruitment Process." Special Diabetes Program for Indians Competitive Grant Program Planning Meeting 5, Denver CO, July 21, 2005 (Invited Presentation)

"Training Schedules." Special Diabetes Program for Indians Competitive Grant Program Planning Meeting 5, Denver CO, July 21, 2005 (Invited Presentation)

"Orientation to the SDPI Competitive Grant Program Workshop." Special Diabetes Program for Indians Competitive Grant Program Planning Meeting 5, Denver CO, July 22, 2005 (Invited Presentation)

"Overview of the SDPI Competitive Grant Program: Core Elements." Indian Health Service Continuation Application Review Meeting, SDPI Competitive Grant Program, Tucson AZ, August 15, 2006 (Invited Presentation)

"Update on CGP Timeline." Steering Committee Meeting, Special Diabetes Program for Indians Competitive Grant Program Planning Meeting 6, Denver CO, October 24, 2005 (Invited Presentation)

"CGP Core Elements/Evaluation Overview." Special Diabetes Program for Indians Competitive Grant Program Planning Meeting 6, Denver CO, October 25, 2005 (Invited Presentation)

"Overview – Data Coordinator Training/Operations Manual." Special Diabetes Program for Indians Competitive Grant Program Planning Meeting 6, Denver CO, October 25, 2005 (Invited Presentation)

"Data Collection Process/Forms - Screening and Recruitment Overview." Special Diabetes Program for Indians Competitive Grant Program Planning Meeting 6, Denver CO, October 25, 2005 (Invited Presentation)

"Data Collection Process/Forms – Baseline Assessment of Core Elements Overview." Special Diabetes Program for Indians Competitive Grant Program Planning Meeting 6, Denver CO, October 25, 2005 (Invited Presentation)

"Overview – Process Evaluation Forms/Core Elements (Intensive Activities)." Special Diabetes Program for Indians Competitive Grant Program Planning Meeting 6, Denver CO, October 26, 2005 (Invited Presentation)

"CGP Core Elements/Evaluation Overview." Special Diabetes Program for Indians Competitive Grant Program Planning Meeting 6, Denver CO, October 27, 2005 (Invited Presentation)

"Overview – Data Coordinator Training/Operations Manual." Special Diabetes Program for Indians Competitive Grant Program Planning Meeting 6, Denver CO, October 27, 2005 (Invited Presentation)

"Data Collection Process/Forms - Screening and Recruitment Overview." Special Diabetes Program for Indians Competitive Grant Program Planning Meeting 6, Denver CO, October 27, 2005 (Invited Presentation)

"Data Collection Process/Forms – Baseline Assessment of Core Elements Overview." Special Diabetes Program for Indians Competitive Grant Program Planning Meeting 6, Denver CO, October 27, 2005 (Invited Presentation)

"Overview – Process Evaluation Forms/Core Elements (Intensive Activities)." Special Diabetes Program for Indians Competitive Grant Program Planning Meeting 6, Denver CO, October 28, 2005 (Invited Presentation)

"Overview – Data Coordinator Training." Special Diabetes Program for Indians Competitive Grant Program Year 2, Meeting 1, Denver CO, Diabetes Prevention Program, December 6, 2005 (Invited Presentation)

"Data Coordinator Training Workshop – Baseline Assessment of Core Elements." Special Diabetes Program for Indians Competitive Grant Program Year 2, Meeting 1, Diabetes Prevention Program, Denver CO, December 6, 2005 (workshop)

"Orientation to the SDPI Competitive Grant Program." Special Diabetes Program for Indians Competitive Grant Program Year 2, Meeting 1, Diabetes Prevention Program, Denver CO, December 7, 2005 (Invited Presentation)

"Overview – Data Coordinator Training." Special Diabetes Program for Indians Competitive Grant Program Year 2, Meeting 1, Diabetes Prevention Program, Healthy Heart Project, Denver CO, December 8, 2005 (Invited Presentation)

"Data Coordinator Training Workshop – Baseline Assessment of Core Elements." Special Diabetes Program for Indians Competitive Grant Program Year 2, Meeting 1, Healthy Heart Project, Denver CO, December 8, 2005 (workshop)

"Orientation to the SDPI Competitive Grant Program." Special Diabetes Program for Indians Competitive Grant Program Year 2, Meeting 1, Healthy Heart Project, Denver CO, December 9, 2005 (Invited Presentation)

"Recruitment/Screening/Enrollment/Consent – Update." Special Diabetes Program for Indians Competitive Grant Program Year 2, Meeting 3, Diabetes Prevention Program, Denver CO, July 11, 2006

"Baseline Assessments – Update." Special Diabetes Program for Indians Competitive Grant Program Year 2, Meeting 3, Diabetes Prevention Program, Denver CO, July 11, 2006

"Intensive Activities – DPP Curriculum (DP) – Update." Special Diabetes Program for Indians Competitive Grant Program Year 2, Meeting 3, Diabetes Prevention Program, Denver CO, July 12, 2006

"Evaluation/Data Submission – Update." Special Diabetes Program for Indians Competitive Grant Program Year 2, Meeting 3, Diabetes Prevention Program, Denver CO, July 12, 2006

"Overview of Workshops." Special Diabetes Program for Indians Competitive Grant Program Year 2, Meeting 3, Diabetes Prevention Program, Denver CO, July 12, 2006

"Orientation of New Staff." Special Diabetes Program for Indians Competitive Grant Program Year 2, Meeting 3, Diabetes Prevention Program, Denver CO, July 12, 2006

"Recruitment/Screening/Enrollment/Consent – Update." Special Diabetes Program for Indians Competitive Grant Program Year 2, Meeting 3, Healthy Heart Project, Denver CO, July 13, 2006

"Baseline Assessments – Update." Special Diabetes Program for Indians Competitive Grant Program Year 2, Meeting 3, Healthy Heart Project, Denver CO, July 13, 2006

"Intensive Activities – DPP Curriculum (DP) – Update." Special Diabetes Program for Indians Competitive Grant Program Year 2, Meeting 3, Healthy Heart Project, Denver CO, July 14, 2006

"Evaluation/Data Submission – Update." Special Diabetes Program for Indians Competitive Grant Program Year 2, Meeting 3, Healthy Heart Project, Denver CO, July 14, 2006

"Overview of Workshops." Special Diabetes Program for Indians Competitive Grant Program Year 2, Meeting 3, Healthy Heart Project, Denver CO, July 14, 2006

"Orientation of New Staff." Special Diabetes Program for Indians Competitive Grant Program Year 2, Meeting 3, Healthy Heart Project, Denver CO, July 14, 2006

"Overview – SDPI Competitive Grant Program." SDPI Competitive Grant Program Technical Assistance Meeting, Tucson AZ, October 23, 2006 (Invited Presentation)

"Overview – Grants Management." SDPI Competitive Grant Program Technical Assistance Meeting, Tucson AZ, October 23, 2006 (Invited Presentation)

"Progress Report." SDPI Competitive Grant Program/Demonstration Projects Steering Committee Meeting, Denver, CO, March 5, 2007 (Invited Presentation)

"Welcome and Overview." SDPI Diabetes Prevention Program Curriculum Training, Tucson AZ, November 27-28, 2007

"Progress Report." SDPI Competitive Grant Program/Demonstration Projects Steering Committee Meeting, Denver, CO, November 16, 2007 (Invited Presentation)

"Semi-Annual Progress Report." SDPI Competitive Grant Program/Demonstration Projects Steering Committee Meeting, Denver, CO, June 27, 2008 (Invited Presentation)

Local Outreach/Continuing Medical Education Presentations:

"The National Diabetes Education Program." Arizona Diabetes Network Teleconference, Rural Health Office, University of Arizona, January 22, 2004 (Invited Presentation)

"Leadership in Indian Health." Native American Nurses Association Annual Conference, Indian Health Service, Phoenix, AZ, October 29, 2004 (Invited Presentation)

"Obesity in Youth." 4th Annual Pascua Yaqui Diabetes Update, Pascua Yaqui Diabetes Prevention Program, Tucson AZ, December 1, 2006 (Invited Presentation)

"Diabetes Prevention: Demonstrating we can do it!" San Carlos Diabetes Prevention Program Conference, San Carlos AZ, January 9, 2008 (Invited Presentation)

"Diabetes in American Indians/Alaska Natives." Tribal Librarians Gathering, Arizona Health Sciences Library, The University of Arizona, September 29, 2008 (Invited Presentation)

National Outreach/Continuing Medical Education Presentations:

"Current Issues in American Indian/Alaska Native Health." American Health Care Journalists Association Conference, Minneapolis, MN, March 29, 2004

"Workshop on Program Evaluation for BIA School Grantee." NDEP Move It! Pilot Program for BIA Schools, Tucson AZ, June 11, 2004 (Invited Presentation)

"The NDEP AIAN Diabetes Prevention Campaign." Association of American Indian Physicians Annual Conference, Tulsa OK, July 28, 2004 (Plenary Session – Invited Presentation)

"The NDEP American Indian/Alaska Native Diabetes Prevention Campaign." Healthier Indian Communities Through Partnerships and Prevention Summit, Indian Health Service, Washington DC, September 22-24, 2004 (Invited Presentation)

"The NDEP American Indian/Alaska Native Diabetes Prevention Campaign." NDEP Partnership Network Meeting, Atlanta GA, December 7, 2004 (Invited Presentation)

Indian Health Service 101, Program Staff, IHS SDPI Competitive Grant Program, University of Colorado Health Sciences Center, Denver CO, December 14, 2004 (Invited Presentation)

"The NDEP American Indian/Alaska Native Prevention Campaigns: We Have the Power to Prevent Diabetes and Take Care of Your Heart: Manage Your Diabetes for Future Generations." Provider Track, Prevention of Cardiovascular Disease and Diabetes Among American Indians and Alaska Natives 2005 Conference, Denver CO, May 17, 2005 (Invited Presentation)

"The NDEP American Indian/Alaska Native Prevention Campaigns: We Have the Power to Prevent Diabetes and Take Care of Your Heart: Manage Your Diabetes for Future Generations." Community Health Professionals and Paraprofessionals Track, Prevention of Cardiovascular Disease and Diabetes Among American Indians and Alaska Natives 2005, Denver CO, May 17, 2005 (Invited Presentation)

"The NDEP American Indian/Alaska Native Prevention Campaigns: We Have the Power to Prevent Diabetes and Take Care of Your Heart: Manage Your Diabetes for Future Generations." Tribes and Community Perspectives Track, Prevention of Cardiovascular Disease and Diabetes Among American Indians and Alaska Natives 2005, Denver CO, May 17, 2005 (Invited Presentation)

"American Indian/Alaska Native Healthcare Challenges." Changing the Face of Medicine Traveling Exhibition Companion Program, James H. Quillen College of Medicine, East Tennessee State University, Johnson City, TN, August 29, 2005 (Invited Presentation)

Overview of American Indian Health. My Company Meeting, Novo Nordisk, Inc. Princeton NJ, October 7, 2005

Indian Health Policy 101 Workshop. National Indian Health Board 22nd Annual Consumer Conference, Phoenix AZ, October 17, 2005 (Invited Presentation)

"Awakening the Spirit: Making the Most of Diabetes Prevention Resources and Policies." Native Diabetes Prevention Conference, Phoenix AZ, January 23, 2006 (Invited Keynote Presentation)

"Awakening the Spirit: Advocacy Kit for the Special Diabetes Program for Indians Reauthorization." Tribal Leaders Diabetes Committee Quarterly Meeting, Reno NV, April 27, 2006 (Invited Presentation)

"Awakening the Spirit: Advocacy Plan for the SDPI Reauthorization." National Indian Health Board Executive Board Meeting, Denver CO, September 6, 2006 (Invited Presentation)

"Advocacy for the Reauthorization of the Special Diabetes Program for Indians (SDPI): Awakening the Spirit and Working Together to Extend the SDPI." National Indian Health Board 23rd Annual Consumer Conference, October 12, 2006, Denver CO (Invited Presentation)

"Future Health Directions: Are First Americans Still Last Americans?" Special Session, American Public Health Association 134th Annual Meeting, Boston MA, November 8, 2006 (Invited Presentation)

"SDPI Reauthorization Update." Special Diabetes Program for Indians Competitive Grant Program Year 3, Meeting 1, Healthy Heart Project/Diabetes Prevention Program, Denver CO, March 7, 2007 (Invited Presentation)

"Awakening the Spirit: Advocacy Kit for the SDPI Reauthorization." Advocacy Committee, American Diabetes Association, Washington DC, March 25, 2007 (Invited Presentation)

"Awakening the Spirit SDPI Advocacy Kit." Tribal Leaders Diabetes Committee Quarterly Meeting, Washington DC, March 26, 2007 (Invited Presentation)

"SDPI Reauthorization Update." In: A First Decade of Success: Special Diabetes Program for Indians Plenary Session, National Indian Health Board 24th Annual Consumer Conference, Portland OR, September 26, 2007 (Invited Presentation)

"Reauthorization of the Special Diabetes Program for Indians." Workshop on Advocacy Tool Kit, National Indian Health Board 24th Annual Consumer Conference, Portland OR, September 26, 2007 (Invited Presentation)

"Briefing on the Special Diabetes Program for Indians." Senate and House Briefings, Washington DC, Wednesday, November 28, 2007 (Invited Presentation)

"Diabetes Trends and Goals." Association of American Indian Physicians Diabetes Conference, Oklahoma City, OK, January 7, 2008" (Invited Presentation)

"Special Diabetes Program for Indians." Call to Congress, American Diabetes Association, April 30, 2008 (Invited Presentation)

"Awakening the Spirit – SDPI Reauthorization." Plenary Presentation and Workshop, Public Health Summit, National Indian Health Board, May 21, 2008 (Invited Presentation)

"Diabetes Prevention." Association of American Indian Physician Annual Conference, Cor D'Alene, Idaho, July 28, 2008 (Invited Presentation)

"Awakening the Spirit: Advocacy Outcomes." American Diabetes Association/Shaping America's Health 2nd Annual Partnership Forum, Washington DC, 8/15/08 (Invited Presentation)

"SDPI Reauthorization – Awaking the Spirit." National Indian Health Board Annual Consumer Conference, Temecula CA, September 25, 2008 (Invited Presentation)

"Roundtable on Tribal Public Health Accreditation." National Indian Health Board Annual Consumer Conference, Temecula CA, September 25, 2008 (Moderator)

"Diabetes Prevention." Zia Association of Diabetes Educators Meeting, Albuquerque NM, September 26, 2008 (Invited Presentation)

Student Presentations:

"Current Issue in Indian Health Presentation", Summer Medical Education Program, COM, June 24, 2004 (Invited Presentation)

"Research Careers Workshop." ITCA/UA American Indian Research Center for Health, Association of American Indian Physicians Annual Conference, Tulsa OK, July 28, 2004 (Moderator)

"The Importance of Summer Programs and Experiences for Health Career Students." INMED Health Careers Forum, Native American Student Affairs, The University of Arizona, April 19, 2005 (Invited Presentation)

"Current Issues in Indian Health." Student Medical Education Program, The University of Arizona, June 23, 2005 (Invited Presentation)

"Medicine and Public Health Careers in Indian Health." INMED Health Career Forum, The University of Arizona, July 14, 2005 (Presentation)

"Research and Health Professional Careers." Research Career Workshop, Association of American Indian Physicians Annual Conference, August 2, 2005 (Student Presentation)

"Research Poster Design 101: Learn the basics of how to develop a research poster presentation. Research Career Workshop, Arizona Health Sciences Center, March 22, 2007 (Student Workshop)

"Research Career Timelines." Native Investigator Program, NERC/RCMAR Meeting, Shelton WA, August 16, 2007 (Presentation)

"Careers Involving Data and Statistics in Indian Health." Making Data Count: Measuring Diabetes and Obesity in Indian Health Systems Conference, Tucson AZ, December 19, 2007 (Invited Presentation)

"Current issues in American Indian/Alaska Native Health." Native Investigator Program Orientation Meeting, University of Colorado Health Sciences Center, Denver CO, January 15, 2007

"Research Poster 101: Design and Development." AIRCH Workshop, Arizona Health Sciences Center, March 26, 2008

"American Indian Health Today." Udall Scholars Orientation, Morris K. Udall Foundation, Tucson AZ, August 3, 2008 (Invited Presentation)

Courses:

"Current Issues in Indian Health Policy." University of Arizona College of Public Health, Winter Session 2004, CPH 596C, January 7-9, 2004 (1 credit)

"Current Issues in Indian Health Policy." University of Arizona College of Public Health, Winter Session 2004, CPH 596C, January 5-7, 2005 (1 credit)

"American Indian Health Policy." Zuckerman College of Public Health, The University of Arizona, CPH 568, Spring 2005 (3 credits)

"American Indian Health Policy." Zuckerman College of Public Health, The University of Arizona, CPH 568, Spring 2006 (3 credits)

Courses – Individual Presentations/Sessions

- University of Arizona

"Diabetes Among Racial/Ethnic Minorities." Racial and Ethnic Health Disparities: A Comparative Approach, Spring 2004, CPH 520, March 23, 2004

"Leadership in American Indian Health." Health Policy: Leadership and Current Issues, Spring 2004, CPH 596J, March 24, 2004

"Diabetes in American Indians/Alaska Natives: Public Health Strategies." Racial and Ethnic Health Disparities: A Comparative Approach, Spring 2004, CPH 520, March 25, 2004

"Environmental Health on Indian Reservations." Environmental and Occupational Health Course, Spring 2004, CPH575, University of Arizona College of Public Health, April 8, 2004

"Environmental Health on Indian Reservations." Environmental and Occupational Health Course, Fall 2004, CPH575, University of Arizona College of Public Health, September 30, 2004

"Environmental Health on Indian Reservations." Environmental and Occupational Health Course, Spring 2005, CPH575, University of Arizona College of Public Health, February 17, 2005

"Diabetes Among Racial/Ethnic Minorities." Racial and Ethnic Health Disparities: A Comparative Approach, Spring 2005, CPH 520, March 22, 2005

"Diabetes in American Indians/Alaska Natives: Public Health Strategies." Racial and Ethnic Health Disparities: A Comparative Approach, Spring 2005, CPH 520, March 24, 2005

"Environmental Health on Indian Reservations." Environmental and Occupational Health Course, Fall 2005, CPH575, University of Arizona College of Public Health, September 22, 2005

"Diabetes Among Racial/Ethnic Minorities." Racial and Ethnic Health Disparities: A Comparative Approach, Spring 2006, CPH 520, March 28, 2006

"Diabetes in American Indians/Alaska Natives: Public Health Strategies." Racial and Ethnic Health Disparities: A Comparative Approach, Spring 2006, CPH 520, March 30, 2006

"Environmental Health on Indian Reservations." Environmental and Occupational Health Course, Spring 2006, CPH575, University of Arizona College of Public Health, March 30, 2006

"Diabetes Among Racial/Ethnic Minorities." Racial and Ethnic Health Disparities: A Comparative Approach, Spring 2007, CPH 520, March 20, 2007

"Diabetes in American Indians/Alaska Natives: Public Health Strategies." Racial and Ethnic Health Disparities: A Comparative Approach, Spring 2007, CPH 520, March 22, 2007

"Comparative Healthcare Systems for Americans." FACES in Health Professions Internship Class, Spring 2007, CPH 393A, April 4, 2007

"Diabetes." Racial and Ethnic Health Disparities: A Comparative Approach, Spring 2009, CPH 520, March 23, 2008

"Diabetes Prevention." Racial and Ethnic Health Disparities: A Comparative Approach, Spring 2008, CPH 520, March 25, 2008

"American Indian Health." FACES in Health Professions Internship Class, Spring 2008, CPH 393A, March 25, 2008

- Harvard Medical School

"Current Issues in Indian Health Policy." Issues in Minority Health Policy Seminar, Harvard Medical School, Boston MA, May 4, 2004

"Current Issues in Indian Health Policy." Issues in Minority Health Policy Seminar, Harvard Medical School, Boston MA, May 3, 2005

"Current Issues in Indian Health Policy." Issues in Minority Health Policy Seminar, Harvard Medical School, Boston MA, May 2, 2006

"Current Issues in American Indian/Alaska Native Health." Issues in Minority Health Policy Seminar, Harvard Medical School, Boston MA, May 1, 2007

"Current Issues in American Indian/Alaska Native Health." Issues in Minority Health Policy Seminar, Harvard Medical School, Boston MA, April 28, 2008

- Centers for Disease Control and Prevention

"Current Issues in Indian Health Policy." Special Short Course/CME/Certificate Course, ATSDR Environmental Public Health Training Program, Atlanta GA, June 1-2, 2005

17. Selection:

(a) Do you know why you were selected for the position to which you have been nominated by the President?

I believe I was selected for the position based on my commitment to, and my experience in, working to improve health care for American Indians and Alaska Natives.

(b) What in your background or employment experience do you believe affirmatively qualifies you for this particular appointment?

I am an American Indian physician with 16 years experience in a variety of capacities in American Indian and Alaska Native healthcare, including medical practice, medical administration, research, education, and health policy with a focus on improving the quality of healthcare for American Indians and Alaska Natives.

I have worked on the front lines in the Indian Health Service as a physician, as a clinical director (medical director) of an Indian Health Service hospital in rural Arizona on the San Carlos Apache reservation, and on a number of national initiatives that involved Indian Health Service and/or tribal issues. As a result of these experiences, I understand the significant health challenges facing this population as well as the administrative challenges facing the Indian Health Service, including the difficulties associated with delivering healthcare to this population with limited resources.

In addition, my work as a researcher and educator brings a unique and needed perspective to this position in this time of increased accountability and transparency. My research has focused on the quality of care in the Indian health system, and my experience in this area can help us better evaluate the quality of care in the Indian Health Service. My most recent relevant experience was as the Co-Director of the Coordinating Center of the Special Diabetes Program for Indians Demonstration Projects. We were responsible for the day-to-day administration and coordination of this $27.4 million a year initiative for the past 5 years and implemented evidence-based diabetes and cardiovascular disease prevention programs in 66 IHS, tribal and urban Indian health programs through a grant process and with a comprehensive evaluation. The initiative has been successful; the grant programs demonstrating positive outcomes for their patients, and the lessons learned from this initiative will help inform my future work.

I have also directed two programs to recruit American Indian students into health and research professions, and I understand the challenges facing the Indian Health Service in terms of recruitment and retention. Finally, my extensive experience working with tribes gives me a unique understanding of the importance of tribal consultation and of working with tribal communities to address disparities in American Indian and Alaska Native health.

B. FUTURE EMPLOYMENT RELATIONSHIPS

1. Will you sever all connections with your present employers, business firms, business associations, or business organizations if you are confirmed by the Senate?

Answer: Yes

2. Do you have any plans, commitments, or agreements to pursue outside employment, with or without compensation, during your service with the government?

Answer: No

3. Do you have any plans, commitments, or agreements after completing government service to resume employment, affiliation, or practice with your previous employer, business firm, association, or organization?

Answer: No

4. Has anybody made a commitment to employ your services in any capacity after you leave government service?

Answer: No

5. If confirmed, do you expect to serve out your full term or until the next Presidential election, whichever is applicable?

Answer: Yes

C. POTENTIAL CONFLICTS OF INTEREST

1. Describe all financial arrangements, deferred compensation agreements, and other continuing dealings with business associates, clients, or customers.

Answer: Other than my University of Arizona optional retirement plan and my Thrift Savings Plan (both described in the financial information section), I have no financial arrangements, deferred compensation agreements, or other continuing business dealings.

2. Indicate any investments, obligations, liabilities, or other relationships which could involve potential conflicts of interest in the position to which you have been nominated.

Answer: In connection with the nomination process, I have consulted with the Office of Government Ethics and the Department of Health and Human Service's designated agency ethics official to identify potential conflicts of interest. Any potential conflicts of interest will be resolved in accordance with the terms of an ethics agreement that I have entered into with the Department's designated agency ethics official and that has been provided to this Committee. I am not aware of any other potential conflicts of interest.

3. Describe any business relationship, dealing, or financial transaction which you have had during the last 10 years, whether for yourself, on behalf of a client, or acting as an agent, that could in any way constitute or result in a possible conflict of interest in the position to which you have been nominated.

Answer: In connection with the nomination process, I have consulted with the Office of Government Ethics and the Department of Health and Human Service's designated agency ethics official to identify potential conflicts of interest. Any potential conflicts of interest will be resolved in accordance with the terms of an ethics agreement that I have entered into with the Department's designated agency ethics official and that has been provided to this Committee. I am not aware of any other potential conflicts of interest.

4. Describe any activity during the past 10 years in which you have engaged for the purpose of directly or indirectly influencing the passage, defeat, or modification of any legislation or affecting the administration and execution of law or public policy.

Answer: I testified in favor of passage of the Indian Health Care Improvement Act in 2000 in my role as President of the Association of American Indian Physicians. I visited Congressional staff on a few occasions in the past few years to educate about the Special Diabetes Program for Indians reauthorization and asked for their support. These activities were done as a private citizen and/or volunteer.

5. Explain how you will resolve any potential conflict of interest, including any that may be disclosed by your responses to the above items.

Answer: In connection with the nomination process, I have consulted with the Office of Government Ethics and the Department of Health and Human Service's designated agency ethics official to identify potential conflicts of interest. Any potential conflicts of interest will be resolved in accordance with the terms of an ethics agreement that I have entered into with the Department's designated agency ethics official and that has been provided to this Committee. I am not aware of any other potential conflicts of interest.

6. Do you agree to have written opinions provided to the Committee by the designated agency ethics officer of the agency to which you are nominated and by the Office of Government Ethics concerning potential conflicts of interest or any legal impediments to your serving in this position?

Answer: Yes

D. LEGAL MATTERS

1. Have you ever been disciplined or cited for a breach of ethics by, or been the subject of a complaint to any court, administrative agency, professional association, disciplinary committee, or other professional group?

Answer: No

2. Have you ever been investigated, arrested, charged, or held by any Federal, State or other law enforcement authority for violation of any Federal, State, county, or municipal law, regulation, or ordinance, other than for a minor traffic offense?

Answer: No

3. Have you or any entity, partnership or other association, whether incorporated or unincorporated, of which you are or were an officer ever been involved as apart in an administrative agency proceeding or civil litigation?

Answer: No

4. Have you ever been convicted (including pleas of guilty or nolo contendere) of any criminal violation other than a minor traffic offense?

Answer: No

5. Please advise the Committee of any additional information, favorable or unfavorable, which you feel should be disclosed in connection with your nomination.

Answer: None

E. RELATIONSHIP WITH THE COMMITTEE

1. Will you ensure that your department/agency complies with deadlines for information set by congressional committees?

Answer: Yes

2. Will you ensure that your department/agency does whatever it can to protect congressional witnesses and whistle blowers from reprisal for their testimony and disclosures?

Answer: Yes

3. Will you cooperate in providing the committee with requested witnesses, including technical experts and career employees, with firsthand knowledge of matters of interest to the committee?

Answer: Yes

4. Please explain how if confirmed, you will review regulations issued by your department/agency, and work closely with Congress, to ensure that such regulations comply with the spirit of the laws passed by Congress.

Answer: I will review regulations and work closely with Congress to ensure they comply with the spirit of the laws passed by Congress.

5. Are you willing to appear and testify before any duly constituted committee of the Congress on such occasions as you may be reasonably requested to do so?

Answer: Yes

F. GENERAL QUALIFICATIONS AND VIEWS

1. How does your previous professional experiences and education qualify you for the position for which you have been nominated?

Answer: As an American Indian physician, I have 16 years experience working in American Indian and Alaska Native health, including as a physician working for the IHS, as a health administrator (clinical director) of an IHS hospital and clinic serving 10,000 people on a Southwest Indian reservation, as a researcher and educator focusing on improving the quality of healthcare for AIANs, and as a leader in large, national Indian health initiatives, several of which involved IHS.

2. Why do you wish to serve in the position for which you have been nominated?

Answer: I wish to serve as the IHS Director to help further the mission of the organization and to help improve the quality of healthcare for American Indians and Alaska Natives.

3. What goals have you established for your first two years in this position, if confirmed?

Answer: My goals include renewing and strengthening the partnership of the agency with tribes, and working to improve/reform the Indian Health Service to better meet its mission.

4. What skills do you believe you may be lacking which may be necessary to successfully carry out this position? What steps can be taken to obtain those skills?

Answer: I have administrative experience in the IHS system and knowledge of the basic administrative structure and processes of the agency, so while I am not currently an administrator inside IHS, I believe that my close work with the agency over the years has kept my working knowledge of the agency at a level to where I will be successful.

5. Please discuss your philosophical views on the role of government. Include a discussion of when you believe the government should involve itself in the private sector, when society's problems should be left to the private sector, and what standards should be used to determine when a government program is no longer necessary.

Answer: For the IHS, the role of government is set by the U.S. Constitution, U.S. Supreme Court decisions, Presidential Executive Orders/Memoranda, and legislative language. It is generally agreed that the U.S. government has a trust responsibility to provide for the health and welfare of members of federally recognized tribes, and the Indian Health Service provides for the health portion of this responsibility. The IHS should do the best it can to meet this responsibility with the resources available to it. The standards to determine when a government program is no longer necessary must include tribal consultation on the need for the program, along with a clear evaluation of the program's effectiveness.

6. Describe the current mission, major programs and major operational objectives of the agency to which you have been nominated.

Answer: The mission of the IHS is to raise the physical, mental, social and spiritual health of all American Indians and Alaska Natives to the highest possible level. The IHS differs from other HHS agencies because it is primarily a healthcare system. It primarily provides clinical, preventive and public health services that are managed by IHS, tribes and urban Indian health programs. Services are organized through a network of over 600 hospitals, clinics and health stations on or near reservations that serve 1.9 million members of federally-recognized tribes in 35 states. Primary care is provided according to local resources, and then specialty care and referrals for private healthcare services are

provided through the contract health care program. The goal is to ensure that comprehensive, culturally acceptable personal and public health services are available and accessible to American Indian and Alaska Native people.

7. What do you believe to be the top three challenges facing the department/agency and why?

Answer: The top three challenges are: 1) funding levels that do not meet the level of need; 2) a growing population with chronic disease; and 3) significant challenges in access to and quality of care in IHS, tribal and urban Indian health programs

8. In reference to question number 6, what factors in your opinion have kept the department/agency from achieving its missions over the past several years?

Answer: The lack of funding increases to meet the growing needs of the IHS service population have resulted in significant downsizing and restructuring to try to maintain an acceptable level of healthcare services. The result has been a devastating reduction in services, poor access to services, provider turnover, and deferrals/denials of needed care resulting in a severely rationed healthcare system. In addition, restructuring and consolidation of functions in HHS has not taken into account the unique needs of the IHS and as a result, inefficiencies in administrative functions have occurred, further keeping the IHS from meeting its mission.

9. Who are the stakeholders in the work of this department/agency?

Answer: The stakeholders include AI/AN patients, federally recognized tribes, the U.S. government and the U.S. healthcare system and its providers (since IHS depends on the private sector for so much of its services) and Congress and its constituents (since federal dollars are used to provide services).

10. What is the proper relationship between the position to which you have been nominated and the stakeholders identified in question number nine?

Answer: As a public servant, my job is to listen and consider the viewpoints and wishes of these stakeholders in the work of the agency and in all decisions.

11. The Chief Financial Officers Act requires all government departments and agencies to develop sound financial management practices.

(a) What do you believe are your responsibilities, if confirmed, to ensure that your department/agency has proper management and accounting controls?

Answer: The IHS Director is responsible for ensuring that proper management and accounting controls are in place and that they are monitored on a regular basis.

(b) What experience do you have in managing a large organization?

Answer: In terms of medical administrative experience, I have experience as a medical director/clinical director of a rural IHS hospital and clinic serving a population of 10,000. I also have served on the IHS Phoenix Area Council of Clinical Directors, which gave me experience in understanding the administration of IHS at the Area and Headquarters levels. In my capacity as a University faculty member, I have managed several grants, contracts and projects related to research, education and training, many of which were collaborative efforts with federal agencies, including IHS, or other universities. For the past 4 years I have served as co-director of the Coordinating Center for the Special Diabetes Program for Indians Diabetes and Cardiovascular Disease Prevention Demonstration Projects. These projects are being implemented in 66 Indian health sites

across the nation from an annual Congressional appropriation of $27.4 million each year for 5 years. Our coordinating center has been responsible for the day-to-day coordination and leadership of this large demonstration project, including initial training, facilitation of the collaborative process for developing the project interventions and evaluation, implementation in 66 very diverse IHS, tribal and urban Indian health programs across the country, ongoing quality assurance and assessment of progress, and process and outcome evaluation of the overall program. Significant leadership and management skill were required to successfully implement such a complex initiative in so many diverse sites. A total of $164.4 million was authorized for this initiative, and the positive outcomes of the program as measured by its evaluation indicate the success of our coordination of the program.

12. The Government Performance and Results Act requires all government departments and agencies to identify measurable performance goals and to report to Congress on their success in achieving these goals.

(a) What benefits, if any, do you see in identifying performance goals and reporting on progress in achieving these goals?

Answer: I believe it is critical for programs to have clear goals and objectives at the start of the program, and that all activities have to clearly help meet those goals and objectives. Programs must be accountable to how they are working to achieve those goals and objectives.

(b) What steps should Congress consider taking when a department/agency fails to achieve its performance goals? Should these steps include the elimination, privatization, downsizing, or consolidation of departments and/or programs?

Answer: I believe that Congress should work with the agency to be sure they both agree on the stated goals and objectives of programs and also agree on realistic performance goals. The assessment of performance should be undertaken by both Congress and the agency, and a plan for improvement, if needed, should be developed together.

(c) What performance goals do you believe should be applicable to your personal performance, if confirmed?

Answer: The performance of the IHS Director should be evaluated based on whether there were achievements/improvements that helped further the mission of the organization. The problems of the agency are complex, and a complex solution is likely needed. Therefore, progress toward meeting the mission should be the goal.

13. Please describe your philosophy of supervisor/employee relationships. Generally, what supervisory model do you follow? Have any employee complaints been brought against you?

Answer: My philosophy of supervisor/employee relationships includes a shared responsibility for good outcomes and performance. It is the supervisor's responsibility to make the goals, expectations and outcomes clear in order for the employee to be successful. The employee must understand that once goals are clear, it is his/her responsibility to meet those goals or ask for help in meeting them. Good communication is the hallmark of a successful supervisor/employee relationship, and participation of both in the discussion and setting of goals is preferrable. I believe in the concept of progressive discipline for problem employees – i.e., problems are discussed, clear expectations are set, joint agreements for improvement are implemented, and progress is reassessed at specific times. Only one employee complaint against me has been submitted; after a discussion and review with my supervisor, it was determined to be a misunderstanding, and the complaint was dismissed.

14. Describe your working relationship, if any, with the Congress. Does your professional experience include working with committees of Congress? If yes, please explain.

Answer: My experience with Congress has been almost exclusively as a private citizen who has visited congressional staff on a few occasions to educate them about pending Indian health legislation.

In addition, in May 2000, I testified before the Senate Committee on Indian Affairs in support of reauthorization of the Indian Health Care Improvement Act.

15. Please explain what you believe to be the proper relationship between yourself, if confirmed, and the Inspector General of your department/agency.

Answer: The IHS Director and the Inspector General should have an appropriate business relationship and work together on issues to ensure an open and fair process for assessing and resolving any problems.

16. In the areas under the department/agency's jurisdiction to which you have been nominated, what legislative action(s) should Congress consider as priorities? Please state your personal views.

Answer: I believe Congress should consider adequate funding to meet the level of need for the IHS, and should support legislation that helps further the mission of the agency. I also encourage Congress to pass the Indian Health Care Improvement Act.

17. Within your area of control, will you pledge to develop and implement a system that allocates discretionary spending in an open manner through a set of fair and objective established criteria? If yes, please explain what steps you intend to take and a time frame for their implementation.

Answer: I plan to review all current programs and determine whether clear and appropriate measures/criteria are in place to show that the agency is meeting its mission. In consultation with tribes, I will establish clear goals and objectives for any new funding along with clear reporting and criteria to measure success.

G. FINANCIAL DATA (will not be released to the public)

1. Provide a complete and current financial net worth statement which itemizes in detail:

(a) The identity and value of all assets held, directly or indirectly, with a value in excess of $1000. This itemization should include, but not be limited to, bank accounts, securities, commodities futures, real estate, trusts, investments, and other personal property held in a trade or business or for investment. Household furnishing, clothing and automobiles need not be reported.

Answer:	Bank Accounts:	Chase Premier Checking 1	$ 1,580.99
		Chase Premier Checking 2	$ 1,625.60
		Chase Plus Savings	$ 60,084.20
	Primary Residence	Single Family Home - Estimated Value	$300,000.00
	Retirement Account	403(b) Arizona University System	$124,248.67
	Retirement Account	Thrift Savings Plan	$ 58,304.22

(b) The identify and value of each liability owed, directly or indirectly, which is in excess of $1000. This should include, but not be limited to, debts, mortgages, loans and other financial obligations for which you, your spouse, or your dependents have a direct liability or which may be guaranteed by yourself, your spouse, or your dependents. In identifying each such liability, indicate the nature of the liability, the name of the person owed and the terms of payment:

Mortgage – Home	Chase Home Finance	$163,932.80
Auto Loan	Compass Bank	$ 9,085.67

2. Provide a list of all other liabilities owed, directly or indirectly, having a value in excess of $1000 at any time during the last 12 months. Identify the nature of each liability, the amount, and the name of the person owed. Describe the terms of each liability, the security or collateral for each liability, and the current status of the debt repayment.

Answer: None

3. Provide the identity, date, and amount of all transactions, directly or indirectly, in securities, commodities futures, real estate or other investments, having a value in excess of $1000, which have taken place within the last 12 months. For purposes of this paragraph, the identify of individuals or charitable organizations need not be reported but should be indicated.

Answer: None

4. Provide the identity and description of any interest in an option, mineral lease, copyright or patent held, directly or indirectly, during the past 12 months and indicate which, if any, have been divested and the date of the divestment.

Answer: None

5. Describe the terms of any beneficial trust or blind trust of which you, your spouse, or your dependents may be a beneficiary. In the case of a blind trust, provide the name of the trustee(s) and a copy of the trust agreement.

Answer: None

6. Provide a description of any fiduciary responsibility or power of attorney which you hold for or on behalf of any other person.

Answer: I am designated as power of medical attorney and financial attorney for my mother in case she is unable to make decisions by herself.

7. List sources and amounts of all items of value in an amount exceeding $250 received by you, your spouse, and your dependents during each of the last 3 years. This should include, but not be limited to, salaries/wages, fees, dividends, capital gains or losses, interest gifts, rents, royalties, patents and honoraria. Gifts received from members of your immediate family need not be listed.

Answer:

2008

The University of Arizona	Salary	$103,977.03
National Indian Health Board	Contract	$ 12,000.00
Institute on Medicine as a Profession	Award	$ 10,000.00
University of New Mexico	Honoraria	$ 2,000.00
University of Colorado Denver	Honorarium	$ 500.00
Inter Tribal Council of Arizona	Honorarium	$ 300.00
National Institutes of Health	Honorarium	$ 1010.00
Indian Health Service	Honorarium	$ 500.00

2007

The University of Arizona	Salary	$100,263.06
Indian Health Service	Contract	$ 28,875.00

2006

The University of Arizona	Salary	$ 99,934.12
Indian Health Service	Contract	$ 12,875.00
University of Oklahoma	Honorarium/ Travel	$ 750.53

8. List sources, amounts and dates of all anticipated receipts from deferred income arrangements, stock options, executory contracts, and other future benefits which you expect to derive from current or previous business relationships, professional services, and firm memberships, employers, clients and customers.

Answer: Other than my University of Arizona optional retirement plan and my Thrift Savings Plan (both described in the financial information section), I do not expect to receive any future benefits from current or previous business relationships, professional services, firm memberships, employers, clients, or customers.

9. Have you filed a Federal income tax return for each of the past 10 years?

Answer: Yes

10. Have your taxes always been paid on time?

Answer: Yes

11. Were all of your taxes, Federal, State and local, current (filed and paid) as of the date of your nomination?

Answer: Yes

12. Has the Internal Revenue Service ever audited your Federal tax return?

Answer: No

13. have any tax liens, either Federal, State, or local, been filed against you or against any real property or personal property which you own either individually, jointly, or in partnership.

Answer: No

14. Provide for the Committee copies of your Federal income tax returns for the past 3 years. These documents will be made available only to Senators and staff persons designated by the Chairman and Ranking Minority Member. They will not be made available for public inspection.

Copies of federal income tax returns for the past three years are attached.

The CHAIRMAN. Dr. Roubideaux, thank you very much.

I am going to defer my questions until the end of the process. I will call on the Vice Chairman, Senator Barrasso.

Senator BARRASSO. Thank you very much. You have had a chance to answer most of the questions that I had yesterday.

Listening to Dr. Hill talking about your intelligence, as well as your dedication, and both will serve you very well in this job, but it is, I believe, your dedication which is going to make the real difference in the success that I see you having in the years to come. So I am very grateful for that.

I did a little research last night. I told you about the Indian Health Service building that we have in Wyoming, and I said, it must be at least 100 years old. I think somewhere in here we had the number, and I have lost it right now, I think it is approximately 130 years old. So I am still welcoming you to visit us in Wyoming at the Wind River Reservation and see what we can do to help things there.

Yesterday you and I talked a bit about diabetes management and treatment. I told you about a number of young men who were with us on Sunday in Casper, Wyoming, at a deployment service for members of the military. They performed a tribal ceremony, a send-off, a blessing. Looking at them, I had great concerns for their own health, for the potential for diabetes, for their life expectancy. Could you just take a couple of seconds to share with us your vision and maybe some ideas you have on how we can really come to grips and, even more successfully under your leadership, address these problems?

Dr. ROUBIDEAUX. Thank you. Yes, the problems of the health status of the American Indian and Alaska Native population are great. Chronic diseases such as diabetes and obesity are threatening the lives of our people. What is so heartbreaking about it is we are seeing young children who are obese, and we are seeing young children with diabetes. We know that if they have these conditions early in life, they are also going to experience the complications early in life as well. And that is heartbreaking. We don't want this new generation of American Indians to die before their parents. We want them to live long and healthy lives.

So first, we do need to look at the Indian Health Service and look what we have done well in terms of treating and preventing diabetes. Fortunately, your Committee has supported the Special Diabetes Program for Indians. I believe these resources have gone to great use in terms of helping us begin the process and the fight against diabetes, both prevention and treatment of this illness.

If confirmed, as I look at the Indian health care system, I definitely want to improve the quality of care, I want to improve access to care and to make sure our patients are getting needed health care services.

Senator BARRASSO. I will just go with one other question, Mr. Chairman. We are having a major debate here in the Senate and in Congress on overall reform of health care in America. We passed a bill last year through this Committee and through the Senate that had to do with the Indian Health Service and didn't make it all the way through the process. Are there thoughts you have on ways that we can improve the Indian Health Service from a legisla-

tive standpoint to make you more successful in your job as the new Director?

Dr. ROUBIDEAUX. Well, yes. As you know, the Indian Health Care Improvement Act was passed by the Senate but didn't make it through Congress last year. Tribes have supported this bill for years because they see it as a way to improve and modernize the Indian Health Service. Both the President and I support passage of this legislation.

So I am looking forward to working with you to find solutions to ensure that we pass this important piece of legislation.

The CHAIRMAN. Senator Johnson.

Senator JOHNSON. Congratulations, Dr. ROUBIDEAUX.

Is it possible to address the issues of preventive care, diabetes, obesity, cancer, suicide and mental health, among other things, within your current budget?

Dr. ROUBIDEAUX. Well, you have hit the nail on the head. It is clear that the Indian Health Service funding is woefully inadequate to meet the needs of this population. It is clear that we can do a lot better job if we had more resources.

Of course, these are difficult budgetary times, and everybody is being asked to do more with less. But if you look at the Indian Health Service, I am confident that it needs a significant increase in additional resources to help address some of these problems.

In addition, the President and I know money is not the only solution. So I plan to look at what we are doing in the system, what we are doing well and try to spread the lessons learned of that around in the system, and make sure that if there are things we are not doing well that we correct them. So I think there is a lot we can do toward preventing disease and treating disease.

In addition, I am looking forward to talking with our tribal leaders. I think that the solutions to restoring our communities to health and wellness is to partner with our tribes. Now more than ever, we need their help. Because the clinic cannot deal with these health problems alone. Many of the health problems have their roots in other conditions in the community. So I am really looking forward to working with our tribes on solutions to these problems.

Senator JOHNSON. Where is there such a level of suicide among our Native Americans?

Dr. ROUBIDEAUX. The story of suicide in Native Americans, especially young teenagers, is heartbreaking. It is heartbreaking to see a young life end before they have had a chance to make their potential contribution they could to our society. I think that problems like suicide have deep roots throughout all of the issues we face in Indian Country, and that it is important, when we look at the solution for suicide, that we work closely with our communities and we work with as many partners as we can to try to figure out how to adequately identify people at risk, how to treat them and respond to them and keep them safe. But we also have to definitely work on correcting those factors in our communities that are making our children think that they don't have a life that is worth living. We want them to live longer and we want them to be healthy.

So I am looking forward, if confirmed, to working with you to talk about what some of those solutions might be and also working with our tribes.

Senator JOHNSON. One last question. It seems to me that the level of education and income ought to be addressed along with health care. They are intertwined. As long as we lack education and income, we will have a problem with obesity among other things. Do you agree with that?

Dr. ROUBIDEAUX. Yes. I think that in order for a person to be healthy, they need to be living a healthy life. And if they don't know how to live a healthy life, then they don't have a chance. In our communities, we have a problem with poor schools, we have problems with crime, we have problems with substance abuse. All of those things are barriers to the successful lives of our population.

I look forward to working with our tribes to see if there are ways that we as the Indian Health Service can help provide more health education into the community. I think it is important that everybody should know how to eat healthy, how to make healthy choices, the importance of exercise. And to understand how the clinic works and make sure that they can get access to good quality care.

So if confirmed, I look forward to working with you and our tribes on this problem as well.

Senator JOHNSON. Thank you, I yield back.

The CHAIRMAN. Senator Johnson, thank you very much.

Senator McCain?

Senator MCCAIN. Congratulations again, Doctor, and we look forward to working with you on issues that you obviously have very in-depth knowledge of and are highly qualified to address.

One of the problems that we have seen throughout my time on this Committee is the failure, at least perceived failure, on the part of the tribes to be adequately consulted when priorities are set by the Department of Health and Human Services and the Indian Health Service as well. So I think it is important, as you mentioned in one of your answers, that you travel to Indian Country as extensively as possible, particularly at the beginning of your tenure.

As you know, most of the tribes that I know feel there is a big disconnect between Health and Human Services and the Indian Health Service and the tribal priorities. Sometimes I think those concerns are real, sometimes maybe not. It is just a lack of information flowing all the way to the tribal governments.

Nearly $500 million in stimulus money goes to the Indian Health Service, as you know; $227 million of it will be spent on construction of IHS facilities. Will you have an input into what those priorities are?

Dr. ROUBIDEAUX. Well, I am aware, and I am grateful for the funding in the stimulus package for facilities in the Indian health care system. What I can tell you is that upon confirmation and when I assume this office, I can look into this issue and look at how priorities are made for how this funding is going to be distributed.

Senator MCCAIN. Do you know if those priorities have been established yet?

Dr. ROUBIDEAUX. I know that there are existing priority lists for facilities and maintenance and construction. I imagine that those existing priorities may have been used, but I am going to need to look into this more once if confirmed to be IHS Director.

Senator MCCAIN. I don't know whether those decisions have been made or not, and maybe some of them are tentative. But let me recommend to you, $227 million for construction of IHS facilities, an additional $227 million, doesn't come along very often. So let me be a little presumptuous and strongly recommend you jump right into that process now.

As you know, there have been alot of projects on the priority list that have been on there for years and years and years. You also know that the construction projects are unfunded by nearly $3.5 billion. As of fiscal year 2008, the maintenance backlog is estimated to be $408 million.

So how this money is spent I think is very important. I would be very interested in how our Native American tribal leadership sets those priorities. A lot of times they don't want to, because they don't want to, as you well know, maybe alienate some other tribes by setting the priorities. But I think you should ask our tribal organizations what their priorities are, so that they are consulted.

Finally, the issue of diabetes we are very well aware of. I think we also know that wellness and fitness plays a big role in that. You have seen it, as I have, time after time. So I hope you will devote some of your efforts on the issue of obesity, because we all know, you know better than I that the incidence increases dramatically. And that goes down to wellness and fitness.

So I want to congratulate you. I am sure that your nomination will be held up and there will be great controversy surrounding it, but we will try and get it done as quickly as possible. I am sure the Chairman will agree.

Thank you very much, Doctor, and thank you for your willingness to serve. We are very proud of you.

Dr. ROUBIDEAUX. Thank you.

The CHAIRMAN. Senator McCain, thank you very much.

Senator Johanns.

STATEMENT OF HON. MIKE JOHANNS, U.S. SENATOR FROM NEBRASKA

Senator JOHANNS. Thank you very much, Mr. Chairman.

Doctor, it is good to see you again. I of course had an opportunity to visit with you at some length and I appreciated that opportunity. And of course, I join with Senator McCain in saying congratulations and I wish you the very best. I am very anxious to work with you on issues important to Nebraska.

Let me follow up on the issue of diabetes, which we had a conversation about. It is hard for me to imagine that we improve Indian health very much if we don't address the issue of diabetes in a very meaningful sort of way. I go to a reservation in Nebraska, the Omaha reservation, and they have a dialysis center there, doing great things, doing exactly what you want them to do. Somebody shares with me that 40 to 50 percent of the adult population there has diabetes. And of course, that just brings everything with it, heart problems and it is just a bad deal. My father had adult onset diabetes.

Give me some ideas, if you will, in terms of how do we attack that? How do we knock this rate down? What are some of the things that science or just good medical practices tell us that would

make a difference here? If you could be in charge of everything for a day, and resources were not an issue, which of course they always are, what would you do? What would you recommend to the Senate that we do?

Dr. ROUBIDEAUX. If confirmed, I would be pleased to work with you on this problem of diabetes in American Indians and Alaska Natives. You are correct, it is a huge problem. It is causing so much of a burden on our population and a huge part of the budget in the Indian Health Service is spent on the complications of diabetes.

I think we can focus efforts in two areas, in both prevention and treatment. I think the Special Diabetes Program for Indians was a great start, but we clearly need to do more. I think we can do more efforts regarding prevention in our communities. Maybe we could do more prevention education in our schools with our children. Maybe we can do more education with our teenagers, more work with our tribes to make sure healthy foods are available in the grocery stores, to make sure that there is more exercise and safe walking paths so that people can be fit and healthy. So there is a lot we can do toward prevention.

This is based on science. We know based on the Diabetes Prevention Program that lifestyle changes, including losing up to 7 percent of body weight through healthy eating and through regular exercise, not running marathons, but 30 minutes five days a week, can reduce the risk of diabetes by 58 percent. We know that is possible and being a scientist, I really believe in using evidence-based strategies to be able to improve the health of our population.

So in the area of prevention, we know what to do, we just need to more of it. I think there is a lot of great lessons learned in the Special Diabetes Program for Indians. All of the great things that have been done there, and I would like us to share the lessons learned of that program as well.

And again, treatment, we know what we need to do for diabetes. So if confirmed, I am looking forward to working with you all to see what else can we do to address this serious epidemic. And let's turn it around as soon as possible.

Senator JOHANNS. I appreciate the answer. I know many have worked on this issue for a long time. There is some great science out there. We do have a lot of answers.

But I would just wrap up by saying, I really look forward to working with you on a whole host of issues. I have met with my tribes and they were very excited about you. My hope is that we can get you back to Nebraska some time. So I will just extend an invitation to you now, and I hope your schedule will permit that.

Dr. ROUBIDEAUX. Thank you very much.

Senator JOHANNS. Okay, great. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Johanns, thank you very much.

Dr. Roubideaux, the diabetes issue is a very important one. I began work on that so, so long ago, flying into the Three Affiliated Tribes on the Fort Berthold Reservation. I flew in on a small airplane one day with the late Mickey Leland, who later died in a plane crash in Ethiopia, I believe. I was on the Hunger Committee with Mickey when we were both in Congress. We began to take a

look at this issue of diabetes on Indian reservations in this Country, in addition to the hunger issues on Indian reservations.

I am very interested in working with you, as I indicated earlier, and with other members of this Committee, on the diabetes issue. It is the case where it is not just double, triple, quadruple, but in some cases eight and ten times the national average. It affects virtually every other aspect of health care for American Indians who suffer from diabetes. So we have a number of programs, Special Program on Diabetes. The issue of detection, treatment and screenings and all of those issues are very important. This Committee, and I especially, want to spend a lot of time on that with my colleagues.

A couple of quick points. Number one, our colleague, Senator Tester, raised the point, and I raised it with you yesterday or the day before, and that is, the Indian Health Service is in desperate need of good management. Your experience, your background would not be in managing a large organization. I think you would be the first to admit that you don't come here saying, I have a lot of experience managing 15,000 people.

But you come here with a lot of other great qualities, which commends me to very aggressively support you. But I think the number two spot that you are going to have to fill, will take someone with a very significant background in management. You and I had a long discussion about some of what I think is the incompetence in the bureaucracy, the structural cement through which you have to walk in the Indian Health Service to get things done.

I think only with a very strong administrator working with you will you be successful to do that. Your response to that?

Dr. ROUBIDEAUX. Yes, I agree with you. I need to have the highest quality people working with me, if I am confirmed as IHS Director, to help support all of the initiatives that we together want to implement. I know it is a large, complex organization. And I know that there is a lot to be done and there are enormous challenges. So I will definitely, if confirmed, I will go back and look at that position and look at the responsibilities and look at the possible candidates for that position and make a good choice.

But also in terms of making sure we have great, effective managers in our system, I am going to make sure I take a look at all of our staff and do what I can to encourage their excellence as they work on these difficult, challenging problems.

The CHAIRMAN. Well, you and I talked about specifics, not specific people, but specific complaints, specific practices the other day. So I think I have alerted you to some of the concerns. I described to you circumstances where, an employee has had multiple, three or four or five EEOC complaints filed against them in the Indian Health Service, and on three or four occasions, the case is adjudicated against the Indian Health Service employee and that employee continues to be employed.

In my judgment, it would take a nanosecond to decide, whatever it takes, we are going to get rid of employees like that. And I am hoping that you will go to this job dedicated, number one, to promoting Indian health and number two, to fixing the problems inside the Indian Health Service management structure.

Are you familiar with the term locum tenens?

Dr. ROUBIDEAUX. Yes, I am.

The CHAIRMAN. And what is that?

Dr. ROUBIDEAUX. It means that you hire people under contract to come in for a short period of time to fill a vacancy.

The CHAIRMAN. And when you are with the Indian Health Service at a facility, and you are trying to find a new doctor to come in, and you instead contract for a temporary doctor, how much more does that cost the Indian Health Service?

Dr. ROUBIDEAUX. Oh, the cost of contracting for health care providers is enormous. It can be two to three times the cost of a regular health care provider. It is a huge drain on our resources.

The CHAIRMAN. And how prevalent is that practice?

Dr. ROUBIDEAUX. Unfortunately, because of the budget shortfalls that we have, some facilities are not able to recruit and retain the number of physicians and other health care staff that they need. But they still need to provide health care to the people in the community.

So one option is to hire doctors under contract to come in for a period of time. I agree with you, the optimal solution would be that all of the doctors work in the clinic and are there for long periods of time. But unfortunately, the resources in the Indian Health Service are woefully inadequate. So what happens is we have staffing shortages.

The CHAIRMAN. I understand that. One of the first things I'd like you to do when you are confirmed, and I believe you will be, would be to report to this Committee the amount of money that is spent in these locum tenens, temporary doctors program. My understanding is, and I accept the fact that sometimes it is hard to find a doctor to come to one of these facilities.

But if the absence of finding a doctor means you go out and hire a temporary doctor and pay twice as much money, and my understanding is that is not unusual at all. If that is the case, if we are short of money for health care, and paying twice as much for doctors because we are hiring temporary doctors through contracting firms, and in some cases, some of them are only doing it through one special, preferred firm, and again paying double for the doctor's services, I am wondering whether that is a very smart way to handle the taxpayers' money.

Dr. ROUBIDEAUX. Well, I am looking forward to working with you on finding solutions to our shortages with health care providers. I would prefer that we hired health care providers that were in the clinics, lived in the community, who were there, so that we could provide continuity of care for our patients. We would provide better quality care if we could do that. But we are short of resources, and I look forward to working with your Committee, if confirmed, to finding solutions to how we can get more resources for staff that we can hire, and incentives, not only to recruit those providers, but also to retain them.

It is very challenging to work in a rural area. You are out in the middle of nowhere, there is a lack of resources, you are away from major city areas. There are a number of very great, wonderful, dedicated health care providers that are working in our clinics who need much more recognition, especially the ones who have been in

for 10, 20, 30 years. Because they have demonstrated a commitment to improving health for our people.

So yes, I am looking forward to, if confirmed, working with you on this problem.

The CHAIRMAN. But I might also say, Dr. Roubideaux, that it might be hard to recruit doctors to work in poorly managed facilities. It might be that a doctor might take a look at a facility and say, you know what, that is the last place in the world I want to work. It doesn't have anything to do with the community, just talk to people who work there.

I say that because I have visited facilities, I will give you a couple of examples. I visited a facility in which the doctor that took me around was wonderful. I was deeply impressed by the doctor, overworked, waiting room full, not good facilities. The doctor said, here is where the new x-ray machine is going to go. He showed me the space they had prepared for it.

And I said, when is it coming? He said, I don't know. He said, it was approved I think two years ago, and it is all ready, but the paper has not been signed by the regional office. I said, how long has that been? He said, oh, a long, long time. It just sits there and has never been signed. I said, Doctor, that is unbelievable. You say it is approved and is awaiting a signature at a regional office and it has been sitting there? He said, absolutely. He said, it just drives us crazy, because this should be here. This should be here to help my practice.

So I mean, I think past the difficulty of recruiting is also the bureaucracy that exists in the system. We have a hospital that is right now not taking patients into the hospital. And that hospital is diverting patients elsewhere because it doesn't have proper staffing, it has a serious set of management problems.

But it is not because people don't know about it. I went there, sat around the table with all of the people that ran the hospital, asked the regional director of health care to come to that town and sit around the table with me. That was over a year ago. Things have gotten worse, not better. It is very frustrating.

So I told you at the start of this, you face a big challenge, and you are going to have to be tough to try to fix some of these things. Because the fact is, we can't let these things continue. The existing or former head of the Indian Health Service pledged that he was going to fix this last problem I described. It has not gotten fixed, it has gotten worse.

Somehow, not even the head office seems to be able to manage a regional office that is just stuck in the glue of its own incompetence. So that is not a question, that is just an observation. You can probably understand my frustration just by the description of what we have done.

We are going to need your help to work together to write a new Indian Health Care Improvement bill. We are determined to do that, we have brought on a new staff person here in the Indian Affairs Committee. The minority and majority staff work together on this Committee for common purpose. We are going to write a bill. We hope to get a bipartisan bill through the Senate once again.

And we are going to do this in a couple of stages. We will write a typical improvement bill that is better than the last one, because

we will now have some ability to do that. Then we are going to do something even more than that. We are going to try to step up toward a broader reform. If we can offer cards for Medicare, and we have signed the line on treaties to say to the Indian folks, we have taken your land, we have given you reservations, we promised you health care. If we have done those things and intend to keep those promises, and we should, then there isn't any reason we ought not give them some alternatives for health care as well. And that is a card to go to a hospital somewhere, or some other facility, whether it be Indian Health or some other health care facility to meet their health care needs.

So that represents a second piece of reform. I want to work with my colleagues, Senator Johnson, Senator Johanns. Senator Johnson, for example, he understands, I think Senator Johanns does as well, because they have the same geographical circumstance. Indian reservations in our area are not located near a big metropolitan area. So Indian Health Service represents the preferred and the first and often the only circumstance where Native Americans can access health care.

I didn't mean to give a presentation here, but I am going to really lean on your advice and help as we prepare our Committee members and our staff work to prepare some improvements in Indian health care. We hope very much in this session of Congress, finally, at last, at long, long last, we will get that done.

Do you have any concluding comments, Dr. Roubideaux?

Dr. ROUBIDEAUX. I would just like to say thank you, Chairman Dorgan, and the rest of the Committee, for having this opportunity to talk about American Indian and Alaska Native health today. I know there are enormous challenges, I know there are problems. But if confirmed, I am really looking forward to working with you to find solutions, so that we can say that we have all contributed to improving the health of American Indian and Alaska Native people.

The CHAIRMAN. Well, let me end on a positive note as well. All it not hopeless. I think the fact that someone with great qualifications will step forward to say, let me be part of fixing things, that gives me great cause for hope. And you do inherit thousands of people in that system who today, right now, are working, going door to door in their clinic, helping people, terrific people. My compliments to them and God bless them for doing it.

So there are a lot of assets and a good foundation to build upon. So all is not lost here. If we work together, we can fix what's wrong, we can improve it and we can make it right. This hearing gives me hope that you are willing to serve and willing to help us make a difference.

Senator Johnson, anything further? Senator Johanns?

All right. Thank you very much. This hearing is adjourned.

[Whereupon, at 3:15 p.m., the Committee was adjourned.]

APPENDIX

UNITED STATES SENATE - OFFICE OF THE SECRETARY
NOMINATION REFERENCE AND REPORT RECEIPT

REFERRED TO COMMITTEE: Indian Affairs SH-838

DATE DELIVERED: March 26, 2009 RECEIVED BY: via e-mail

Department of Health and Human Services

PN251 (White House copy of nomination included.)

Yvette Roubideaux, of Arizona, to be Director of the Indian Health Service, Department of Health and Human Services, for the term of four years, vice Robert G. McSwain, resigned.

The White House, MAR 26 2009

To the

Senate of the United States.

I nominate Yvette Roubideaux, of Arizona, to be Director of the Indian Health Service, Department of Health and Human Services, for the term of four years, vice Robert G. McSwain, resigned.

BARACK OBAMA

NOMINATION REFERENCE AND REPORT

PN251

AS IN EXECUTIVE SESSION,
SENATE OF THE UNITED STATES,
March 26, 2009.

Ordered, That the following nomination be referred to the Committee on Indian Affairs:

Yvette Roubideaux, of Arizona, to be Director of the Indian Health Service, Department of Health and Human Services, for the term of four years, vice Robert G. McSwain, resigned.

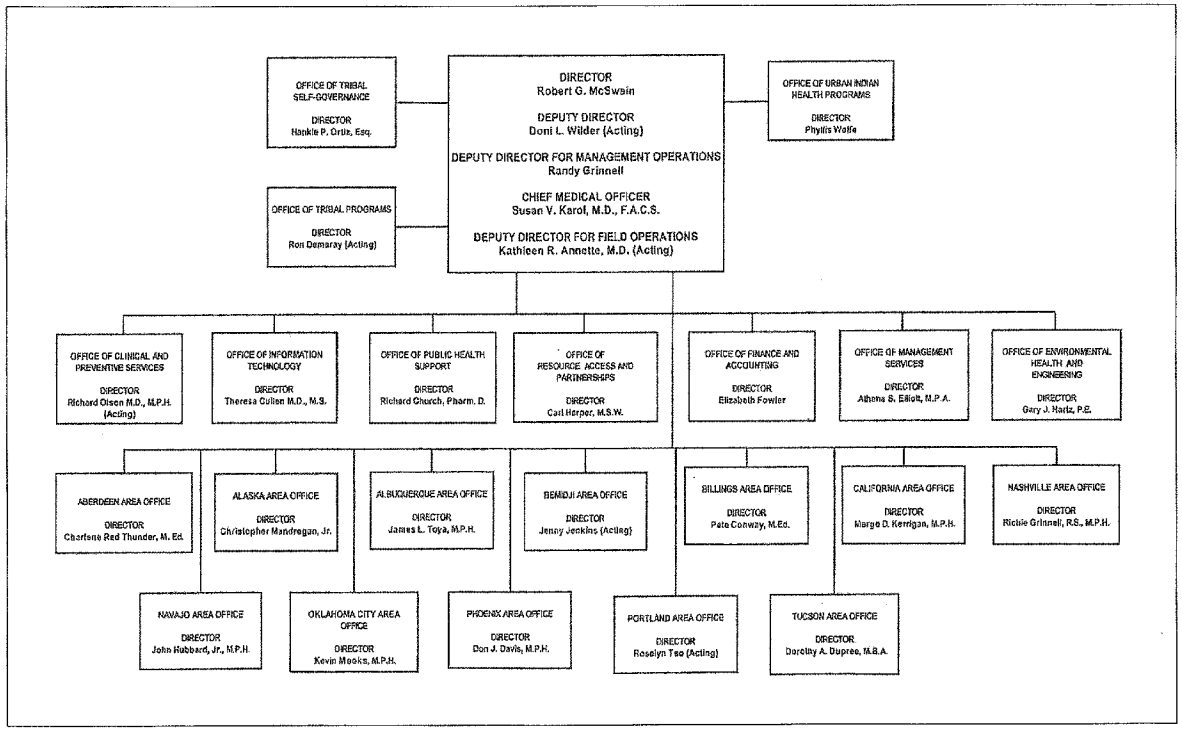
_____, 2009.

Reported by Mr. Dorgan

with the recommendation that the nomination be confirmed.

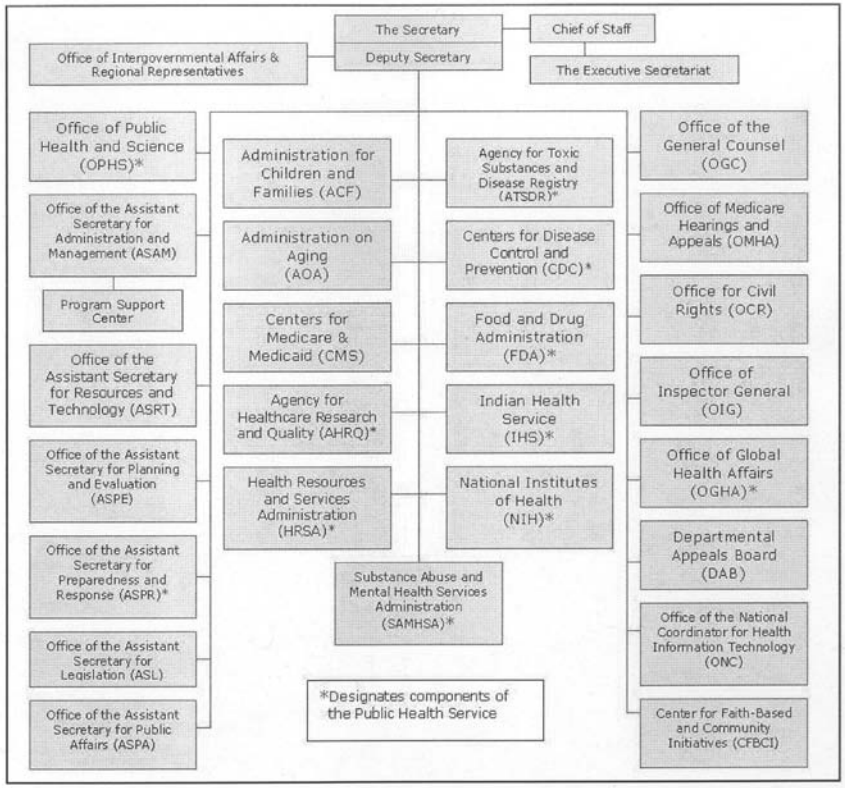
☐ The nominee has agreed to respond to requests to appear and testify before any duly constituted committee of the Senate.

Indian Health Service Organizational Chart



Retrieved from http://www.ihs.gov/PublicInfo/Publications/IHSManual/ORG_CHARTS/Org_Charts_July_2008/org_chart.cfm on April 14, 2009.

Department of Health and Human Services Organizational Chart



Retrieved from http://www.hhs.gov/about/orgchart/ on April 14, 2009.

March 27, 2009

Mr. Edgar M. Swindell
Associate General Counsel/Ethics
Designated Agency Ethics Official
U.S. Department of Health and Human Services
Room 710-E, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Dear Mr. Swindell:

The purpose of this letter is to describe the steps that I will take to avoid any actual or apparent conflict of interest in the event that I am confirmed for the position of Director, Indian Health Service, U.S. Department of Health and Human Services.

As required by 18 U.S.C. § 208(a), I will not participate personally and substantially in any particular matter that has a direct and predictable effect on my financial interests or those of any person whose interests are imputed to me, unless I first obtain a written waiver, pursuant to 18 U.S.C. § 208(b)(1), or qualify for a regulatory exemption, pursuant to 18 U.S.C. § 208(b)(2). I understand that the interests of the following persons are imputed to me: any spouse or minor child of mine; any general partner of a partnership in which I am a limited or general partner; any organization in which I serve as officer, director, trustee, general partner or employee; and any person or organization with which I am negotiating or have an arrangement concerning prospective employment.

Upon confirmation, I will resign from my position as Assistant Professor at the University of Arizona. For a period of one year after my resignation, I will not participate personally and substantially in any particular matter involving specific parties in which the University of Arizona is a party or represents a party, unless I am first authorized to participate, pursuant to 5 C.F.R. § 2635.502(d).

In October 2008, I resigned from my consulting position with the National Indian Health Board. Pursuant to a contract between the National Indian Health Board and the University of Arizona, my employer, I have continued to provide services to the National Indian Health Board and I will continue to provide services until April 2009. For a period of one year after the end of my services, I will have a "covered relationship" under 5 C.F.R. § 2635.502 with the National Indian Health Board. Pursuant to 5 C.F.R. § 2635.502(d), I will seek written authorization to participate in particular matters involving specific parties in which the National Indian Health Board is a party or represents a party.

In order to avoid potential conflicts of interest during my appointment as Director, I, any future spouse, or any minor children of mine will not acquire any interests in entities listed on the

FDA prohibited holdings list or in entities involved, directly or through subsidiaries, in the following industries: (1) research, development, manufacture, distribution, or sale of pharmaceutical, biotechnology, or medical devices, equipment, preparations, treatment, or products; (2) veterinary products; (3) healthcare management or delivery; (4) health, disability, or workers compensation insurance or related services; (5) food and/or beverage production, processing or distribution; (6) communications media; (7) computer hardware, computer software, and related internet technologies; (8) wireless communications; (9) social sciences and economic research organizations; (10) energy or utilities; (11) commercial airlines, railroads, shiplines, and cargo carriers; or (12) sector mutual funds that concentrate their portfolios on one country other than the United States. In addition, we will not acquire any interests in sector mutual funds that concentrate in any of these sectors.

Sincerely,

Yvette Roubideaux

Yvette D. Roubideaux

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. BYRON L. DORGAN TO YVETTE ROUBIDEAUX, M.D., M.P.H.

1) **We discussed in the hearing your minimal experience in management and administration. You list on your Committee questionnaire, your leadership as the Co-Director of the Coordinating Center for the Special Diabetes Program for Indians, the hub of the 66 Tribal programs for diabetes, as applicable experience.**
    a. **How will your administrative experience at the Coordinating Center for the Special Diabetes Program for Indians assist you in managing the large IHS agency?**
    b. **Do you feel that you can be a decisive manager and leader of IHS? How so?**

ANSWER: As Co-Director of the Coordinating Center for the Special Diabetes Program for Indians Demonstration Projects, I was responsible for the day-to-day coordination of this 66-site intervention. Implementation of this complex, evidence-based prevention initiative required both leadership and management skills, including the ability to understand and accommodate the diverse needs of the 66 Indian Health Service, tribal, and urban Indian health program grant sites; the establishment of a communication system; the coordination of common activities; motivation and training for hundreds of grant program staff; development and implementation of a complex evaluation; and monitoring of site performance. It was my responsibility to ensure that the $27.4 million provided the initiative was spent wisely and effectively.

I believe my work on this initiative provided me with exactly the kind of experience I need to effectively bring change to the IHS. I understand what it takes to administer a large initiative in which the objective is to improve the quality of care delivered to diverse communities, and which is accountable for outcomes. I also have administrative experience as a clinical director (medical director) of an IHS hospital that served 10,000 people on the San Carlos Apache Indian reservation, and this experience helped me understand the day-to-day management of an IHS facility and all of the challenges they face. In addition, I have worked on many national initiatives with IHS

that gave me experience in how things work on both the regional and national levels within the agency.

I am confident I can be a decisive and effective manager and leader of the Indian Health Service. As I mentioned in my testimony, I have a long history with IHS as a patient, a physician, and an administrator. I have had the opportunity to work with IHS professional staff at both the clinical and administrative levels, and I understand the depth and scope of the challenges facing the agency. If confirmed, I look forward to working with Congress and the staff at both IHS and the Department of Health and Human Services to quickly identify high-priority problem areas and act decisively to address them.

2) **IHS is funded at about 52% of need and you have stated that this is a top problem that needs to be addressed. Part of the problem is that the agency never asks for adequate funding to meet its mission.**
    a. **What will you do to ensure the level of funding needed to meet the IHS mission is made available?**
    b. **What is your opinion regarding elevating the IHS Director to an Assistant Secretary level within the Department of Health and Human Services? Do you think this initiative would increase the agency's visibility and possibly result in improved funding?**

ANSWER: There is no question that IHS simply does not have enough resources to meet the needs of the population it is responsible for serving. While the President and I both understand that more money is not the whole answer, a significant increase in resources for IHS is essential for the agency to be able to effectively fulfill its mission. Virtually every independent estimate – including estimates of the tribes themselves – suggests that IHS funding is woefully inadequate to meet its level of need, and that IHS patients receive far less care than their counterparts in other government health programs. The President's proposed increase for IHS is a step in the right direction, but we need to do more.

I recognize that we are operating within extremely difficult budgetary constraints, and that every federal department and agency is being asked to do more with less. Nothing less should be expected of IHS, and I plan to promote greater efficiency and maximize resources whenever possible. However, if confirmed, I look forward to working with Congress to do whatever we can within those constraints to make more resources available to the Indian Health Service.

With respect to elevating the position IHS Director to the level of Assistant Secretary at HHS, I understand that tribes have recommended this for many years because of the importance of the government-to-government relationship and the trust responsibility of all agencies in HHS to tribes and their members. I will look into the issue to determine what will be the best solution. I want there to be no question, however, about my commitment to ensuring that the health and human services needs of Native Americans are addressed at the highest levels throughout the Department.

3) **In your testimony you mention a belief that in partnership with tribes, Congress, and this Administration difficult decisions can be addressed. Many Tribes believe that when the IHS makes decisions tribal comments, opinions and desires are not always apparent or included.**
    a. **What do you believe are some of the most difficult decisions?**
    b. **How will you ensure transparency of decision making including process?**

ANSWER: Whenever government officials are working with an inadequate pool of resources, they are forced to make difficult decisions about the most effective ways to put those resources to use. At IHS, this means deciding whether and at what levels to fund a variety of functions – including clinical services, facility construction, health information technology, administrative budgets, and others – all of which are in desperate need of more resources. In addition, in the months ahead, difficult decisions will need to be made about areas of IHS that are most in need of reform, especially where outcomes and effectiveness cannot be demonstrated at the facility, program, or personnel level. With a new Administration and with the broader debate over health reform well underway, IHS is at an important crossroads. As a result, these decisions are become more important – and more difficult.

As I discussed in my testimony, I believe we need to ensure that what we do to improve the Indian Health Service is transparent and accountable. With that goal in mind, if confirmed, I intend to work with tribes to review the existing tribal consultation process and to find ways to make that process more meaningful so that we can work more closely together on the difficult challenges and decisions that face us in the coming years. I am also committed to ensuring that we are as fair and inclusive as possible in considering the needs of all our patients, whether they are seen in IHS direct service facilities, tribally managed programs, or urban Indian health programs.

4) **In February, 2008, the Senate passed the Indian Health Care Improvement Act, but unfortunately the House was not able to pass the legislation. In the next Congress, the Committee will continue to work to pass an Indian health bill**

and bring reform to the Indian health system which will improve the health of Native Americans. Additionally, health care reform is at the forefront of the national dialogue and thus it is pertinent that we are prepared.

a. **What do you see as being the priority for Indian health legislation this Congress? Are you committed to working with the Committee to develop Indian health legislation in this Congress and what will be your approach?**
b. **Do you have specific ideas for Indian health care reform, what are they?**
c. **How will you integrate the agency and more importantly your vision for agency reform into these types of discussions in the future? Will you continue Director McSwain's initiative of "Renewing the Indian Health System or develop an initiative of your own?"**

ANSWER: Both the President and I support passage of IHCIA as an important first step to update and modernize the IHS. While I understand that formal legislation has not yet been introduced this Congress, if confirmed, I look forward to working with you and other members of the Senate Indian Affairs Committee to pass that important legislation, and to develop other ways to further improve the health of American Indian and Alaska Natives. In addition, I believe it must be a top legislative priority to make more resources available to IHS in an effort to begin addressing the significant gap between available funding and need.

With respect to reform, as I mentioned in my testimony, if confirmed, I intend to review and improve the tribal consultation process; ensure that IHS participates in, and benefits from, the broader effort to reform our health system; make the quality of and access to health care an agency-wide priority; and work to promote transparency, accountability, and fairness. With these general priorities in mind, I look forward to working members of Congress, tribes, Indian health experts, and IHS staff to develop ideas for reform, ensure those ideas are part of the broader health reform discussion, and implement them at IHS.

Finally, I understand that Mr. McSwain recently began a "conversation" about "Renewing the Indian Health System" and held a recent round of discussions designed to solicit input from the IHS Areas. While I plan to review the input received on this initiative, if confirmed, it is my intention to conduct an examination of all ongoing reform initiatives at IHS to determine how best to proceed with my priority to reform the agency.

5) **IHS has disproportionately higher clinician vacancy rates: physician vacancy rate of 17%, nursing vacancy rate of 18%, and dental vacancy rate of 24%. Certain IHS Areas, specifically the Aberdeen Area, seem to suffer much more from clinician shortages than other Areas of the Indian health system.**

   In Belcourt, North Dakota, the Quentin Burdick IHS Hospital has experienced extensive diversions in health care services due to the lack of clinicians to staff the facility. When services cannot be provided at the IHS facility there are numerous negative consequences such as: requiring the use of the already underfunded Contract Health Service dollars, proximal non-IHS facilities get an influx of Indian patients and often times do not see payment for their services, and arguably the federal government is not fulfilling its trust responsibility. The clinician shortages and subsequent diversions in health care service result in the U.S. not fulfilling their trust responsibility to Native Americans.

   a. **Do you see clinician shortages as a major problem in Indian Country and is the situation more severe in certain Areas of IHS?**
   b. **What will you do to address the recruitment and retention of IHS clinicians?**
   c. **Will you commit to reform efforts such as advancing telehealth programs and creating partnerships in rural Indian Country and what process will be used to accomplish this?**

ANSWER: As you know, the IHS has faced high vacancy rates for many years. These staffing shortages are due in part to the challenge of recruiting and retaining qualified professionals in rural areas, where many IHS facilities are located, with limited resources. In addition, the stress of working in a system with limited resources is a great challenge for our providers. I experienced problems recruiting and retaining physicians over 10 years ago when I worked in IHS, and the problem continues today. With respect to the question of whether the situation is more severe in some IHS Areas than in others, I understand that Areas with significantly greater shortages of healthcare professionals include the Navajo Area, the Aberdeen Area, and the Billings Area.

The IHS Scholarship and Loan Repayment Programs have been a critical resource in attracting health professionals. I also understand the IHS has attempted to address this problem by working to make salaries more competitive and offering better bonus pay under certain circumstances, and I believe these efforts should be explored further. In addition, I believe my priorities with respect to reforming IHS and improving quality and access will lead to greater opportunities for clinicians to be a part of the solution,

and to propose good ideas for changing and improving the care at their facilities, which is likely to help with retention.

If confirmed, I will ask IHS staff to prepare a status report on current health professional vacancy rates and actions the agency is taking to recruit and retain healthcare professionals. I look forward to working with you to strengthen IHS's ongoing efforts in this area, and to identify new ways to recruit and retain high-quality health professionals in our hospitals and clinics.

Finally, I am aware of several successful uses of telehealth programs in Indian country, which have helped provide a supportive component to the overall provision of healthcare within the IHS. As you note, it will be important to develop partnerships with universities and other organizations in order to ensure that these and similar programs are as effective as possible. While I am pleased that $2.5 million was included for telehealth programs in the FY 2009 budget, if confirmed, I will review all current telehealth programs in IHS, identify potential opportunities for expansion of those programs, and work with Congress to increase the resources available to fund these initiatives.

6) **Youth suicide is a tragedy in Indian Country. The Committee held a hearing on this issue on February 26th, 2009. I told the story at your nomination hearing of a youth that testified at that hearing from the Spirit Lake Nation in North Dakota. Dana Lee Jetty told the story of losing her 14-year-old sister to suicide. Dana Lee feels her sister would not have committed suicide if she had had access to qualified mental health professionals. Suicide is a serious problem in Indian Country and we need to address this issue.**
    a. **How will you ensure that prevention and treatment of non-chronic diseases, such as mental health disorders, get equal attention and funding allocation?**
    b. **What is the single biggest barrier IHS faces in addressing youth suicide and what would be your plan to address it?**

ANSWER: I am aware of the heartbreaking problem of suicide on our reservations. Behavioral health in general operates separate from medical services. The resulting "silos" of care have meant inadequately coordinated care, missed opportunities for intervention in primary care and community settings, poor understanding and general demoralization regarding the treatability of behavioral health concerns among medical staff, and a lack of direct participation by behavioral health leadership in the design and implementation of healthcare systems across Indian country.

If confirmed, I plan to continue the Director's initiative on Behavioral Health to keep the focus on this problem at the highest level in the organization. I also plan to review existing efforts at IHS to address this problem and work closely with our tribes and their communities to help improve identification, referral and response, training opportunities, treatment, and prevention. It will be important to take the lessons learned from communities that have developed effective strategies to address youth suicide and apply them system-wide.

Finally, the single biggest barrier to addressing youth suicide is the lack of help for those at risk. There are simply not enough health professionals trained to identify and treat those at risk for suicide, and the resources available to address the underlying conditions of poverty, addiction, crime, and lack of education that lead to the hopelessness these youths face are insufficient. If confirmed, I plan to consult with tribes on how we can do more in our communities to increase awareness of this problem, and to address these underlying conditions and risk factors.

7) **This Committee has received considerable testimony on the epidemic of domestic and sexual violence against American Indian and Alaska Native women. I'm sure you are aware of the statistics: 34% of Indian women will be raped in their lifetimes, and 39% will face domestic violence. There are a number of reasons for the problem. The Committee will seek to address this issue through the Tribal Law and Order Act that I recently introduced with Vice Chairman Barrasso, and other members of this Committee [Senators Tester, Udall, Cantwell, Johnson, Murkowski are also co-sponsors].**
One provision of our bill would require Indian Health Service and Bureau of Indian Affairs employees to testify in tribal court to help local prosecutions of domestic and sexual violence. Under current law and practice, IHS and BIA officials routinely ignore tribal court subpoenas to testify in support of prosecutions.
    a. **Would you support the provision to require Indian Health Service employees to testify in tribal court?**

There is no question that the high rates of domestic violence and sexual abuse against AIAN women presents a severe problem, and that prosecuting offenders of these crimes must be a top priority. I understand that the question of whether to require IHS and BIA employees to testify in tribal court in these cases has implications with respect

to a number of sensitive issues. If confirmed, I will review this matter to determine whether and why subpoenas are being ignored. I would also be happy to work with you and your colleagues to explore ways to more effectively prevent domestic violence and sexual assault in Indian country.

8) **In 2003, IHS and the Veteran's Health Administration (VHA) signed a Memorandum of Agreement (MOA). The MOU was designed to improve communications between agencies and tribal governments and to create opportunities to develop strategies for sharing information, services and information technology. However, Native American veterans are still forced to spend considerable amounts of money to obtain services from the VHA that they could have received at their own IHS or tribal facility.**
    a. **What would you do to ensure that Native American veterans receive the care they deserve with the least amount of "out-of-pocket" funding?**

ANSWER: I understand that IHS and VHA have developed a coordination of care policy intended to make it very clear to both IHS and VHA service providers – and more importantly to Indian veterans and their families and communities – how the two agencies will share the responsibility of providing the best care possible. I have been told this policy is in the review and clearance process.

If confirmed, I will review the MOU and the progress to date on its provisions, including the coordination-of-care policy. In addition, I will consider options to strengthen this collaboration and to improve the way we communicate with other federal agencies, tribes, and our patients about access to services.

9) **At numerous Committee hearings, such as the Youth Suicide Hearing in February, we have learned collection of health data is difficult. There is variation in health statistics and general lack of consistent data in Indian Country. Without comprehensive and accurate data on health disparities and health care services available, it is difficult to address and positively impact the Indian health system. Director McSwain has talked about the development of an IHS data mart which will allow IHS to predict and plan for prevention programmatic needs.**
    a. **Why is poor data collection a barrier to providing adequate health care to Indian Country?**

b. **If you are confirmed, do you plan to continue with Director McSwain's data mart initiative? Or do you have another plan for how to improve data collection in Indian Country?**
c. **How will you work with Tribes to allow access to the data that will be stored in the data mart or similar system, while still complying with privacy laws?**

ANSWER: Public health surveillance is essential for assessing the needs of the population that IHS serves. Poor data collection can hinder decision-making, program planning, and the effort to establish priorities. If confirmed, I will review progress on the data mart initiative, and consult with tribes and IHS staff about how to develop and build on the work that has already been done to improve the agency's data collection efforts.

Tribes have consistently asked for access to data that is relevant to their communities so that they can prioritize and address the many health problems they face. However, as you note, it is important to protect the privacy of both individual patient data and tribal data. If confirmed, I will review how data is currently stored and what protections are in place with respect to the privacy of health information. I intend to consult with tribes to find ways to balance their need for data with the need for privacy.

10) **The Quentin N. Burdick Memorial Hospital located in Belcourt, ND, has had intermittent diversions of services over the past year. There was little to no notice provided to patients or employees of these diversions resulting in much frustration and anger. These types of interruptions cause compromised access to care and labor-management relations.**
    a. **What steps will you take to ensure that these situations do not arise during your tenure?**
    b. **Would you be willing to institute a labor-management partnership at IHS?**

ANSWER: While I am not aware of all the details related to the situation you describe, I can assure you that, if confirmed, I will quickly gather all the facts and work with Congress, patients, and staff to find ways to minimize diversions and the disruptions they cause. After a thorough review of the situation, I am willing to consider any options that will help us achieve that goal.

In addition, I understand that IHS is in labor management negotiations for a national collective bargaining agreement with the Laborers' International Union of North America (LIUNA). LIUNA represents over 90% of the IHS bargaining unit employees, including those employees duty stationed at the Quentin N. Burdick Memorial Hospital. Part of the national collective bargaining agreement that is currently under negotiation includes an article which will reestablish a national labor-management council between the IHS and LIUNA as well as establish local councils.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. JOHN BARRASSO TO YVETTE ROUBIDEAUX, M.D., M.P.H.

1) ACCOUNTABILITY

The IHS must be prudent and accountable in using taxpayer money. Previous Committee hearings have revealed the need for greater efficiency and improvements in the IHS internal management systems. The GAO report on property mismanagement issued last year is but one example of the need for improvements.

How will you ensure there is greater efficiency and accountability in the IHS management and health care delivery systems?

ANSWER: I agree that IHS must be prudent and accountable with taxpayer money, and, if confirmed, I plan to promote greater efficiency and maximize resources whenever possible.

Specifically, I believe IHS has an opportunity to maximize its resources by strengthening partnerships with tribes as well as with state and local governments and other health organizations. In addition, as I mentioned in my testimony, I know that many facilities and programs in IHS, tribal, and urban Indian health programs have developed innovative initiatives and have helped solve some of our greatest clinical and administrative challenges at the local level. We need to do more to learn from those successes and apply those lessons to other programs in the system.

If confirmed, I will also use IHS's performance management system to hold all senior executive managers accountable, and work to ensure that their performance measures are pertinent to their areas of responsibility and the agency's priorities.

Finally, if confirmed, I will work to make IHS's management and health care delivery systems more accountable by ensuring there are transparent measures of process and outcomes in place across the agency. Managers will need to demonstrate progress on these measures on an ongoing basis; a lack of progress will prompt review, a new plan for improvement, and a new set of measures.

2) STRATEGIES

Your written testimony indicated that the agency needs to implement more strategies to increase access to care in the Indian health system, to improve the quality of clinical services provided, and just as importantly, to provide better customer service.

What are some of those strategies that could be employed now to meet these goals?

ANSWER: As I mentioned in my answer to the previous question, I believe IHS can maximize its resources by strengthening partnerships with tribes as well as with state and local governments and other health organizations, and that we should apply successful initiatives and solutions developed by specific facilities and programs in IHS, tribal, and urban Indian health programs to other areas of the system. Both of these strategies can help IHS meet the goals I outlined in my testimony of improving the quality of and access to care and providing better customer service.

In addition, some simple strategies for meeting these goals include educating patients and providers on how the system works, setting new standards of care, disseminating information on availability of preventive services, encouraging team-based approaches to care, and providing training for staff on better customer service.

If confirmed, I will also undertake a thorough review of what IHS is doing in each of these areas, and work with Congress and the leadership at the Department to develop specific short- and long-term strategies for making necessary improvements.

Of course, one of the biggest barriers to accessible and quality healthcare in IHS is the lack of funding for needed services. The President's proposed increase for IHS is a step in the right direction, but we need to do more. If confirmed, I look forward to working with Congress to do whatever we can to make more resources available to the Indian Health Service.

3) <u>IMPROVING/REFORMING THE SYSTEM</u>

Your biographical information indicated that your goals in the first two years in this position are to improve/reform the IHS to better meet its mission.

Could you elaborate more on how you intend to reform the system?

How do you plan to implement tele-health more extensively throughout the Indian health system?

How would you improve the accuracy of patient data records, including the improved interface between the Resource and Patient Management System and tribal patient management systems, and successfully implement an Electronic Health Record system throughout Indian Country?

ANSWER: As I mentioned in my testimony, if confirmed, I intend to review and improve the tribal consultation process; ensure that IHS participates in, and benefits from, the broader effort to reform our health system; make the quality of and access to health care an agency-wide priority; and work to promote transparency, accountability, and fairness. With these general priorities in mind, I look forward to working with members of Congress, tribes, Indian health experts, and IHS staff to develop ideas for reform, ensure those ideas are part of the broader health reform discussion, and implement them at IHS.

With respect to telehealth, I am aware of several successful uses of telehealth programs in Indian country, which have helped increase access to needed services. It will be important to develop partnerships with universities and other organizations in order to ensure that these and similar programs are as effective as possible. If confirmed, I will review all current telehealth programs in IHS, identify potential opportunities for expansion of those programs, and work with Congress to increase the resources available to fund these initiatives.

Finally, an effective electronic health record and health IT system is critical for IHS to deliver quality care and to more efficiently manage and support its health programs. As you know, for the past 25 years, the IHS has developed, deployed, and supported an award winning HIT system, RPMS, throughout the Indian health care system. If confirmed, I plan to review progress on the implementation of health IT at IHS, including how the agency currently interfaces with tribal programs, and will work with tribes to ensure that the entire system is certified, widely used, and effective in driving better patient outcomes. I will also seek to ensure that the successes of IHS's health IT system are included as part of the upcoming national debate over health care reform.

4) <u>FAIR ALLOCATION OF FUNDING</u>

The Indian health system is a complicated set of programs and complex funding allocation formulas. Your biographical information indicated that in developing and implementing a system that allocates funding in an open manner through a set of fair and objective established criteria, you will review the programs and determine whether clear and appropriate measures or criteria are in place.

How will you make those determinations regarding the measures and criteria that are in place?

How will you involve Indian tribes in making those determinations?

ANSWER: If confirmed, I plan to review all funding allocation formulas in terms of when and how they were developed. In consultation with tribes, I will work to ensure these allocation formulas are up-to-date and fair. I will also ensure that they have measures in place to determine whether the funding allocations resulted in the anticipated improvements or outcomes, and whether adjustments need to be made.

As I noted in my testimony, if confirmed, I will make it a top priority to ensure meaningful tribal consultation across all areas of IHS, including decisions related to funding allocations for IHS programs.

5) **HEALTH CARE FACILITIES**

The backlog in and unmet needs for health care facility construction is extensive and is in the billions of dollars. The IHS clinics on the Wind River Indian reservation have a facility that was built in 1877 originally for the military and is now serving as the primary health care facility for the Eastern Shoshone and Northern Arapaho Indian tribes. It is particularly troubling that health care services which require handicap-accessibility, and sterile, modern facilities, equipment are being provided in a building which is over 130 years old.

What will you do to assist the Wind River Indian reservation in obtaining a new facility for health care services?

ANSWER: If confirmed, I will review the facility construction needs of the Wind River Indian reservation and determine how it fits into existing priority lists for new facility construction. I also plan to consult with tribes on the existing priority list for facility construction, and discuss with both tribes and Congress options for ensuring that more communities can get the facilities they need as soon as funding becomes available.

The Joint Venture (JV) program demonstrates the shared commitment of Indian tribes and the federal government in providing additional health facilities within the Indian health system and the staff necessary to support the facilities.

How will you enable more Indian tribes to participate in the JV program?

ANSWER: I understand that the Joint Venture program provides opportunities for tribes to enter into agreements with IHS under which tribes can provide new facilities and lease them to the IHS in exchange for funding for staffing, equipment, and operation of the facility. I am told that the Congress has asked the IHS to update its list of potential Joint Venture projects, and that the IHS is preparing a solicitation for proposals that will be sent to all Tribal Leaders by August of this year.

If confirmed, I will review the JV program and consult with tribes on how we can improve the program. In addition, I will make it a top priority to ensure meaningful tribal consultation across all areas of IHS, including decisions related to facility construction and staffing.

6) **ELDER CARE**

The Indian population is growing and in many cases living longer than in past years.

Q: How can the IHS and Indian tribes work together to address the needs of the Indian elder population?

ANSWER: The IHS faces a crisis in the future with the growing elder AIAN population. Many elder care needs, including long-term care, were not originally included in the scope of services or funding for IHS. As a result, we must be proactive in addressing this problem. In clinics and hospitals, we can increase efforts to address chronic diseases and other diseases that disproportionately affect the elderly, like dementia. In our communities and our patients' homes, IHS needs to partner more with tribes to make elder and long-term care services more accessible and to support family caregivers with training and education. In fact, many tribes provide long-term care and clinical services through non-IHS funding sources such as CMS. Telehealth technology can also help us extend the reach of services.

If confirmed, I plan to review IHS's existing elder care efforts, and will consult with both Congress and tribes on how we can work together to ensure that our elders have the full range of services available to them.

7) **CONTRACT SUPPORT COSTS**

Contract support costs are important to supporting the many health care services and programs that Indian tribes or tribal organizations are providing to their patients. However, past budgets have not requested full funding for these costs resulting in an ever growing shortfall. These shortfalls have then forced Indian tribal contractors to reduce services to cover the shortfalls. The projected shortfall for FY2010 may exceed $200 million.

Can you explain how you will address the contract support costs shortfall?

ANSWER: I understand that IHS is experiencing a significant shortfall when it comes to providing funding to cover contract support costs, which, as you note, are critical to supporting tribes and tribal organizations that want to administer programs and provide services directly to their patients. The result of budget shortfalls has been that, in many cases, the only tribes that can contract or compact to manage services are those that can leverage other resources. This leaves other tribes unable to exercise their rights to self-governance and self-determination. All tribes should have the opportunity to decide if they want to manage their own programs or continue to have the IHS manage those programs.

If confirmed, I look forward to working with you to find additional resources to cover contract support costs. However, we also need to ensure that the effort to cover these costs is part of a larger effort to increase resources for IHS, and doesn't take away from the already underfunded budget for other programs, including funding for IHS direct-service tribes.

8) FISCAL ISSUES

The IHS has been authorized to receive third party reimbursements, however, the Committee has been informed that the IHS may not be effectively seeking these reimbursements.

How will you ensure that the IHS will improve the collection of third party reimbursements?

ANSWER: Clearly, third-party reimbursements are a critical resource for our health facilities. In some cases, over half of a facility's budget depends on these collections. In general, the IHS does a good job with respect to collections from Medicare and

Medicaid; however, I am aware there are problems with private insurance collections, especially given our limited ability to follow up on claims with insufficient staff.

If confirmed, I look forward to working with Congress and agency staff to discuss options for improving the efficiency and effectiveness of these collections, including by promoting staff training and ensuring the effective use of IHS's finance and IT systems.

The Unified Financial Management System was implemented in the IHS. However, this system must be managed in an efficient manner. We have been informed that under this system, there is an area pool for program funding consisting of all the facilities in the area and, if any clinic in the area has overspent in one category (e.g., diabetes), then the whole area pool is locked. No more spending can be conducted until that pool is replenished which may be funding from other clinics or third party reimbursements. So, essentially clinics spending within their budgets may end up subsidizing other clinics going over budget.
In addition, we have been informed that the locked spending prevents the other clinics from paying their bills and contract health providers in a timely manner - even though the clinic may be within their budget.

How will you review this system and ensure that these inefficiencies are addressed?

ANSWER: I understand that the implementation of the Unified Financial Management System at IHS has presented a number of challenges. While setting up an entirely new set of accounting and budgeting rules and systems at an agency as large and sprawling as IHS is undoubtedly difficult, I believe that, with effective management, the new rules and systems can result in greater transparency and accountability at IHS. In addition, I understand that efforts are already underway to address this issue, and that the new system is close to being fully phased-in across all IHS Areas.

If confirmed, I will review the progress IHS has made in implementing the system and identify any problem areas that need to be addressed, with the goal of putting an effective and efficient system in place as quickly as possible.

The various programs, such as the Contract Health Service or facility programs, have different funding allocations for the IHS and tribal health facilities. These funding allocations should be fair, include a consideration of all key factors, and be interpreted consistently across the IHS regions. But it appears that the Wind River

Indian reservation service unit has remained one of the lowest funded service units in its Area and perhaps in the country.

How will you ensure that funding across the Indian health system will be allocated in a fair and effective manner?

ANSWER: I understand that some facilities and Areas are underfunded compared to others. The IHS currently uses several formulas that take into account user counts, local health care prices and costs, Indian population health status, hospital availability, and other factors related to geography and access. These formulas were developed with tribal input and consultation and many have been in place a number of years.

As I noted in my answer to a previous question, if confirmed, I plan to review all funding allocation formulas in terms of when and how they were developed. In consultation with tribes, I will work to ensure these allocation formulas are up-to-date and fair. I will also ensure that they have measures in place to determine whether the funding allocations resulted in the anticipated improvements or outcomes, or whether adjustments need to be made.

In addition, increasing overall resources available to IHS will help the agency distribute funding more equitably. The President's proposed increase for IHS is a step in the right direction, but we need to do more. If confirmed, I look forward to working with Congress to do whatever we can to make more resources available to the Indian Health Service.

Recruitment and retention is important to maintain continuity of care and improving health services to patients. The IHS personnel system should be updated to reflect appropriate health professional standards to help the clinics recruit and retain personnel, particularly in establishing competitive pay grades and personnel qualifications.

How will you ensure that the personnel system is competitive and will improve recruitment and retention efforts?

ANSWER: As you know, the IHS has faced high vacancy rates for many years. These staffing shortages are due in part to the challenge of recruiting and retaining qualified professionals in rural areas, where many IHS facilities are located, with limited resources. In addition, the stress of working in a system with limited resources is a

great challenge for our providers. I experienced problems recruiting and retaining physicians over 10 years ago when I worked in IHS and the problem continues today.

The IHS Scholarship and Loan Repayment Programs have been a critical resource in attracting health professionals. I also understand the IHS has attempted to address this problem by working to make salaries more competitive and offering better bonus pay under certain circumstances, and I believe these efforts should be explored further. In addition, I believe my priorities with respect to reforming IHS and improving quality and access will lead to greater opportunities for clinicians to be a part of the solution, and to propose good ideas for changing and improving the care at their facilities, which is likely to help with retention.

If confirmed, I look forward to working with you to strengthen IHS's ongoing efforts in this area, and to identify new ways to recruit and retain high-quality health professionals in our hospitals and clinics.

COORDINATION

The IHS has entered several partnerships with other agencies, including the Substance Abuse and Mental Health Services Administration and the Veteran's Administration, to improve Indian health. These partnerships may have the potential to reduce disparities and improve Indian health, but coordination should be achieved to ensure and demonstrate positive outcomes.

How will you improve the coordination and collaboration between these agencies to improve Indian health?

ANSWER: Effective coordination and collaboration between our federal agencies – particularly those that serve overlapping constituencies – is critical. I understand that IHS is currently working with SAMHSA to develop strategies for how the two agencies can work more effectively together. I also understand that IHS and VHA have had a senior-level workgroup in place since HHS and VA signed an MOU in 2003, and that the workgroup meets frequently to facilitate effective coordination between the two agencies. If confirmed, I will review all of IHS's existing partnerships, including those with MOUs in place with other federal agencies, to determine outcomes to date and areas for improvement.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. MARIA CANTWELL TO YVETTE ROUBIDEAUX, M.D., M.P.H.

1) **The Indian Self-Determination and Education Assistance Act (ISDEAA) permits tribes to contract or compact for Indian health programs which allows them to take primary responsibility for establishing local priorities and allocating resources to most effectively address those priorities. Tribal economies are strengthened with the creation of jobs, building of administrative capacities, and management expertise. The ISDEAA polices of encouraging local control have led to the expansion of health services, increased third party reimbursement, development of new programs, and construction of new health facilities.**

   Do you support Tribal assumption of IHS programs and other grant funding opportunities where it would be efficient under the Indian Self-Determination and Education Assistance Act? Specifically, do you support this type of funding for the Special Diabetes Program for Indians?

ANSWER: I support the right of tribes to self-determination and self-governance and believe that IHS should do what it can to support tribes who want to exercise that right by managing their own health programs. If confirmed, I intend to work with tribes and Congress to explore all funding mechanisms that will help further the mission of the IHS within congressionally established parameters.

2) **Nationally 61 percent of American Indians/Alaska Natives reside in urban areas and my home state of Washington is no exception. Studies have shown that urban Native Americans/Alaska Natives suffer significant health disparities when compared to other racial groups in urban settings. These disparities include lower birth weights, poor birth outcomes and more communicable diseases. The 34 Urban Indian Health Organizations, two of which are located in Washington State, provide important healthcare service to the urban Native American/Alaska Native populations. As I am sure you know, President Bush had proposed eliminating funding for these Urban Indian Health Organizations.**

   What are your views on the urban Indian health program and where do you see it fitting into the Indian Health Service?

ANSWER: As you note, American Indians and Alaska Natives (AIANs) living in urban areas comprise a significant percentage of the total AIAN population – today, over half of all AIANs live in urban areas. I strongly support urban Indian health programs, which provide culturally competent care that is not available from other health providers for this growing population.

While I know that tribes support their members in urban areas, unfortunately, the lack of resources for IHS can result in a competition for funding between the two groups. I am grateful to the President and Congress for including funding for these programs in this year's budget. If confirmed, I hope to work with our tribes, Congress, and our urban Indian health programs to find ways to provide additional support for these programs without taking away needed resources from IHS or tribal programs.

3) **Many Contract Heath Services (CHS) dependent areas lack facilities infrastructure to deliver health services such as, radiology, specialty diagnostics and laboratory services; and have no choice but to purchase specialty care from the more expensive private sector. This creates inequities in the levels of health care across the Indian health system. Additionally access to services is restricted not only by general funding shortfalls, but also by the fragmentation of resource into a large number of independently operated Tribal health programs. This can result in excess funds in one operating unit while other units are forced, for funding reasons, to deny care in life threatening situations.**

   Will you address funding and resource inequities in the Indian Health Service programs to ensure that funding and health services are consistent across the IHS system?

   Are you willing to include such recommendations as part of the overall health reform effort as the administration and Congress work on developing ideas on health reform?

ANSWER: As you point out, the challenges of providing care to diverse communities through a variety of mechanisms, coupled with a woefully inadequate pool of resources, have resulted in significant funding disparities between various IHS operating units. If confirmed, I will work to ensure that the resources provided to IHS are distributed equitably, including by reviewing existing funding allocation formulas to determine if changes are necessary.

That said, IHS simply does not have enough resources to meet the needs of the population it is responsible for serving. While the President and I both understand that more money is not the whole answer, a significant increase in resources for IHS is essential for the agency to be able to effectively fulfill its mission. The President's proposed increase for IHS is a step in the right direction, but we need to do more. If confirmed, I look forward to working with Congress to do whatever we can to make more resources available to the Indian Health Service.

In addition, I will work to ensure that the IHS and the populations it serves have a seat at the table in the debate over health reform. We must ensure that health reform does not adversely impact our patients with respect to coverage options and third-party reimbursements for our system. We also have an opportunity to share lessons learned from IHS – including with respect to funding and resource inequities – as we discuss ways to reform the national health system.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. TOM COBURN TO YVETTE ROUBIDEAUX, M.D., M.P.H.

1) **My staff has found it challenging to get requests for information fulfilled by the Indian Health Service. Most recently, I brought concerns about an alleged case of severe contract fraud at the Navajo Area Indian Health Services to the attention of Robert McSwain, the former head of IHS. In the letter sent a month ago, I asked for a series of documents to help in our investigation and so far we have heard nothing. Will you commit to making sure that we receive the information?**

ANSWER: While I am unaware of the details of this specific situation, if confirmed, I intend to ensure that IHS is as responsive as possible to members of Congress when they raise concerns or request information. In addition, I will look into the status of your request and provide you with an update as soon as possible.

2) **For several years, and now three directors of the IHS (not counting acting directors), I have been requesting that IHS address a serious threat to patients at the Claremore Indian Hospital. As you may know, despite being one of the busiest facilities in the IHS system, the continued threat of domestic violence cases and its central location in the middle of town, IHS has refused to provide basic armed security for patients and staff. In that same time, the system has purchased a pharmaceutical robot costing hundreds of thousands of dollars. I have received assurances from your two immediate predecessors that the problem would be addressed shortly, but still no viable solution has been offered after all this time. Will you commit to providing the basic security necessary to address this problem, and if so, when do you expect to implement your decision?**

ANSWER: Again, while I am not aware of all the details related to that situation, I understand that situations like the one you describe can raise difficult questions related to jurisdiction and resources. I can assure you that, if confirmed, I will quickly gather all the facts, and work with you in any way I can to address the problem.

3) **Over 60 percent of all Native Americans live in urban areas, yet most IHS services are located in traditional reservation and/or rural areas. Does the traditional IHS brick and mortar approach to health care, designed decades ago, make sense in 2009?**

ANSWER: Certainly, the landscape of need in Indian health has changed dramatically since the IHS was established in 1955. As you note, the majority of American Indians and Alaska Natives now live in urban areas, where they may have potential access to other sources of care. However, there are many reservation areas where IHS is the only healthcare provider for miles, and, due to many barriers, patients are unable to travel long distances to see other non-IHS providers. As a result, I believe the traditional IHS approach not only makes sense, but is important to preserve.

Having said that, I also believe we need to think of new ideas and options to address the growing needs of this population – indeed, the Indian Health Care Improvement Act in the 1970s authorized IHS to support urban Indian health programs precisely because the trends you note demanded a new approach. If confirmed, I look forward to working with you to discuss some of these options with the goal of doing whatever we can to improve healthcare for all American Indians and Alaska Natives.

4) **Do you believe that tribal citizens have a right to choose the health care provider that makes the most sense for their families?**

ANSWER: I believe that tribal citizens have the same rights as every other U.S. citizen, including the right to choose their health provider. Unfortunately, like many other Americans, tribal citizens often do not have the opportunity to fully exercise that right. Due to many factors, including poverty and geography, choices may be limited. I am hopeful that the debate over national health reform will lead to more choices for all tribal citizens. I also believe those choices must include IHS, which makes it more important to reform and improve quality at IHS now so that the agency can compete effectively with other providers.

5) **What specific measurements will you bring to IHS that will allow the public to measure the specific impact of your leadership of the agency on IHS patients, and the success of IHS initiatives?**

ANSWER: If confirmed, I plan to ensure that all initiatives are accountable, have process and outcome measures that are transparent, and report frequently on their progress to Congress and the public. But the true measurement of effective leadership at the IHS will be progress toward improved health outcomes for the American Indian and Alaska Native population.

6) **In your testimony, you cite several problems with health care in Indian country. Will increasing federal funding alone solve many, most or any of these problems?**

ANSWER: There is no question that there are areas where the Indian Health Service needs to do a better job. If confirmed, I look forward to working with the members of this committee and others in Congress to identify problems, and to do whatever is needed to ensure that IHS does its job, and does it well. Specifically, as I mentioned in my testimony, I intend to review and improve the tribal consultation process; ensure that IHS participates in, and benefits from, the broader effort to reform our health system; make the quality of and access to health care an agency-wide priority; and work to promote transparency, accountability, and fairness.

The President and I both understand that more money is not the whole answer, and I plan to promote greater efficiency and maximize resources whenever possible. However, I want to be clear that the major impediment to success in the IHS is the woefully inadequate funding levels, and that, alongside reforms designed to promote efficiency and improve performance, significant increases are needed for the agency to successfully meet its mission.

7) **Given your long history of administering health care for Native Americans, how would you change IHS to increase competition and provide more quality health care?**

ANSWER: I believe we need to improve quality in a transparent manner. Our patients need to know that they are being seen by quality providers and that they are receiving the highest-quality care according to current standards. If confirmed, I plan to work with providers to find ways to ensure that we are delivering care according to standards, and ask them to develop ways to improve quality at the local level and to communicate these efforts to their patients.

With these general priorities in mind, I also look forward to working members of Congress, tribes, and Indian health experts to develop and implement ideas for ways to improve quality at IHS.

8) **In your testimony, you cite the purpose of IHS is to meet federal trust responsibility to provide health care to members of federally recognized**

tribes. In your opinion, is the IHS meeting that commitment today? Do you believe that simply offering health care—regardless of quality or outcomes--meets the nation's obligation to Native Americans?

ANSWER: I believe that everything we do to help further the mission of the Indian Health Service, in consultation with tribes, helps the federal government meet its trust responsibility. The provision of health care is one part of that responsibility; the mission of the IHS is to raise health to the highest level. Improving quality and outcomes helps meet that mission. However, it is clear that more needs to be done.

9) **Given your experience as a former IHS administrator, name one program or initiative that you felt was not a priority for IHS in meeting its most pressing objective to deliver quality health care?**

ANSWER: I have often been frustrated by what appears to be excessive travel by IHS staff to foreign countries to talk about what IHS is doing. While I understand the importance of sharing lessons learned and recognize that foreign travel is appropriate in some circumstances, I believe some of the resources spent on overseas travel could go to better use to provide quality healthcare for our patients. If confirmed, I will review IHS's current budget for foreign travel and make cuts where appropriate.

10) **According to the Department of Health and Human Services: "In 2006, 36 percent of American Indians and Alaska Natives had private health insurance coverage. 24 percent of AI/ANs relied on Medicaid coverage. 33 percent of AI/ANs had no health insurance coverage in 2006."**
    a. **Given that federal regulations make the IHS the "payor of last resort" for contract health services, and that recent versions of the Indian Health Care Improvement Act extend this policy to all IHS services, do you believe the IHS and its tribal partners adequately capture reimbursements owed by third parties?**

ANSWER: I believe there is room for improvement when it comes to educating patients on the importance of applying for other coverage as a way to increase access for themselves and their families. I also believe there is room for improvement when it comes to IHS's collection of third-party reimbursements. Clearly, third-party reimbursements are a critical resource for our health facilities. In some cases, over half of a facility's budget depends on these collections. In general, the IHS does a good job with respect to collections from Medicare and Medicaid; however, I am aware there are

problems with private insurance collections, especially given our limited ability to follow up on claims with insufficient staff.

If confirmed, I look forward to working with Congress and agency staff to ensure IHS is maximizing its ability to collect from private insurance.

11) By every statistic available, the IHS is failing to achieve its goal to address and prevent chronic diseases. For instance, according to result from the Government Performance and Results Act (GPRA), only 59 percent of female patients (21-64) were receiving pap smear tests at least once in three years. That rate has dropped by 3 percent since 2002, and is far from the stated long term goal of 90 percent. Yet, during this same time, the IHS budget has risen from $2.3 billion to over $3 billion. Do you believe that IHS has adequately prioritized the scarce resources it has been given, or is there room for improvement? If so, where?

ANSWER: There is no question that there are areas where the Indian Health Service needs to do a better job. In addition, the burden of chronic disease on the system is enormous, and there is room for improvement in preventive efforts.

I believe IHS has an opportunity to maximize its resources by strengthening partnerships with tribes as well as with state and local governments and other health organizations. In addition, as I mentioned in my testimony, I know that many facilities and programs in IHS, tribal, and urban Indian health programs have developed innovative initiatives and have helped solve some of our greatest clinical and administrative challenges at the local level. We need to do more to learn from those successes and apply those lessons to other programs in the system.

However, I believe the primary impediment to improvements in IHS is the significant gap between funding and level of need. Moreover, there are numerous examples that show how dedicated IHS professionals go above and beyond the call of duty to provide quality care and services with extremely limited resources, and where IHS has been able to put any additional resources it receives to good use. In fact, as you may know, I was the Co-director of the Coordinating Center of the Special Diabetes Program for Indians' demonstration projects. This program provides an excellent example of how IHS, when given additional resources and adequate technical assistance, can exceed expectations and deliver positive outcomes. If confirmed, I intend to continue to make putting IHS's resources to good use a primary objective of the agency.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. JOHN MCCAIN TO YVETTE ROUBIDEAUX, M.D., M.P.H.

1) **There's all too often a perceived disconnect between the IHS and the higher functions at the Department of Health and Human Services (DHHS). In particular, DHHS hasn't adequately incorporated tribal recommendations in its final budget requests, despite tribal participation throughout the budget process by the National Indian Health Board and other bodies. This has resulted in the Administration budgeting for far less than what the tribes tell us they require.**
    a. **Can you assure the Committee that as IHS Director you will cultivate collaboration between the Secretary, Assistant Secretary for Health, the tribes, and tribal organizations when developing a responsible IHS budget that effectively raises the health status of American Indians and Alaska Natives?**

ANSWER: If confirmed, one of my top priorities will be to work to renew and strengthen IHS's partnership with tribes. It is clear that they want a more meaningful tribal consultation process, and, if confirmed, I plan to coordinate with them on how to improve the consultation process in developing the IHS budget. I am confident that Secretary-designate Sebelius and Dr. Howard Koh, the President's nominee to be Assistant Secretary for Health, are equally committed to those goals, and, if confirmed, I absolutely plan to coordinate efforts with them.

2) **The Indian Heath Care Facilities Priority System identifies the construction and renovation needs for the top 10 priority Indian inpatient care facilities and the top 10 priority outpatient care facilities. These needs are assessed and ranked by IHS, and eventually transmitted to Congress through the President's annual budget. According to IHS, these construction projects are unfunded by nearly $3.5 billion as of FY 2008, and the maintenance backlog of current facilities is estimated at $408 million.**
    a. **Clearly, there is an extreme need for new and replacement hospitals and clinics serving Indian tribes. Do you believe there should be a base funding amount that serves as a minimum annual amount for IHS facility construction in the President's budget?**
    b. **Can you assure the Committee Several of these pending construction projects have been on the "Priority List" since at least 1991. What is your position on completing the existing priority list before it's replaced with a new area distribution system that some in Congress have previously proposed?**

ANSWER: I agree there is an enormous need in the IHS for new facility construction. If confirmed, I intend to consult with tribes on the existing priority list for facility construction, and discuss options with tribes and with Congress for ensuring that more communities can get the facilities they need as soon as funding becomes available. In addition, I look forward on working with Congress to develop a timely approach to

adequately funding the well-documented need for new and replacement health care facilities.

3) **I believe we must do more to ensure the ability of the elderly and disabled American Indians and Alaska Natives to access Medicaid and Medicare, in particular, the prescription drug benefits available under Medicare Part D. Currently, the Indian Health Care Improvement Act authorizes the use of Indian Health Service funding to pay for Medicare Parts A and B premium payments for Indians, but not for Part D.**
    a. **Would you support amending the Indian Health Care Improvement Act to allow the use of IHS funds to pay the monthly premium of an Indian who is a Medicare Part D eligible individual enrolled in a prescription drug plan or Medicare Advantage-Prescription Drug Plan (MA-PD)?**
    b. **Do you support retaining administrative guidelines that deem IHS and tribal health care "credible coverage" or do you believe that a legislative fix to ensure beneficiaries are protected in statute?**

ANSWER: I agree we need to do more to ensure elderly American Indians and Alaska Natives and those with disabilities have access to the prescription drugs and other Medicare and Medicaid services they need. If confirmed, I will seriously consider any feasible proposals that may be advanced as amendments to the Indian Health Care Improvement Act. I hope to have the opportunity to work with you toward that end. Of course, as you well know, an infusion of IHS funds will be necessary to accomplish the goals of any such proposal.

In addition, it is my understanding that any provider of prescription drug coverage can have its coverage deemed as "creditable coverage" provided that beneficiaries receive at least the same level of prescription drug coverage as provided in Part D. As required by CMS, IHS has performed an analysis of its drug coverage and has certified with CMS that its drug coverage meets the requirements of the creditable coverage definition. While I do not anticipate amending this policy, if confirmed, I will examine this issue closely to determine whether a change – administrative or legislative – is warranted.

4) **As you know, Indian communities tend to lack the necessary resources to appropriately treat victims of child abuse. I have long been a proponent of authorizing IHS to increase the use of telemedicine in collaboration with public or private universities, including a medical university or other facilities, experienced in pediatrics to assist the IHS in diagnosing and treating child abuse (S. 1899, 109th Congress, the Indian Child Protection and Family Violence Prevention Act Amendments of 2006).**
    a. **Under your tenure, can we expect to see a greater emphasis on the use of telemedicine in providing treatment on reservations?**

ANSWER: I am aware of several successful uses of telehealth programs in Indian country, which have helped provide a supportive component to the overall provision of healthcare within the IHS. As you note, it will be important to develop partnerships with universities and other organizations in order to ensure that these and similar programs are as effective as possible. While I am pleased that $2.5 million was included for telehealth programs in the FY 2009 budget, if confirmed, I will review all current telehealth programs in IHS, identify potential opportunities for expansion of those programs, and work with Congress to increase the resources available to fund these initiatives.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. LISA MURKOWSKI TO YVETTE ROUBIDEAUX, M.D., M.P.H.

Dr. Roubideaux, I appreciate your commitment to Indian Country, and I will certainly be willing to work with you in ensuring that the federal government meets its obligation in providing health care to Native Americans and Alaska Natives. In my home state of Alaska, our Alaska Native tribes deliver 99% of Indian Health Service programs. Over the last decade Indian Tribes and Alaska Native organizations have proven to be very effective in delivering basic health care to the most remote areas of this country. As our tribes have proven to be effective managers, they have been hindered by lack of adequate funding for contract support costs. I will certainly be willing to work with you to address the health needs of our tribal communities, and appreciate your commitment to Indian Country.

1) **If confirmed, in your role as Director, will you be willing to advocate for the adequate funding of contract support costs? In what ways will you support our self governance tribes so that they can continue to address the great health disparities that exist in their tribal communities?**

ANSWER: I understand that IHS is experiencing a significant shortfall when it comes to providing funding to cover contract support costs, which, as you note, are critical to supporting tribes and tribal organizations that want to administer programs and provide services directly to their patients. The result of budget shortfalls has been that, in many cases, the only tribes that can contract or compact to manage services are those that can leverage other resources. This leaves other tribes unable to exercise their rights to self-governance and self-determination. All tribes should have the opportunity to decide if they want to manage their own programs or continue to have the IHS manage those programs.

If confirmed, I look forward to working with you to find additional resources to cover contract support costs. However, we also need to ensure that the effort to cover these costs is part of a larger effort to increase resources for IHS and doesn't take away from the already underfunded budget for other programs, including funding for IHS direct service tribes.

2) **The Samuel Simmonds Memorial Hospital in Barrow is the number one hospital on the IHS inpatient facility priority list. If confirmed, will you work**

with us during the budget and appropriations process to ensure that appropriate funds are included to complete the construction of the hospital?

I am aware of Barrow's location on the facility construction priority list and, if confirmed, I plan to work with you during the appropriations process on this issue. More generally, I intend to consult with tribes on the existing priority list for facility construction, and discuss options with tribes and with Congress for ensuring that more communities can get the facilities they need as soon as funding becomes available. In addition, I look forward on working with Congress to develop a timely approach to adequately funding the well-documented need for new and replacement health care facilities.

3) **As you know, $85 million was appropriated to the Indian Health Service in the American Recovery and Reinvestment Act for Health Information Technology. We hear that the IHS intends to use the ARRA money to upgrade the IHS RPMS system. Some self governance tribes regard the RPMS as inadequate to meet the challenges of Indian Health faces. If confirmed, will you ensure that self governance tribes are not left out of the ARRA Health IT money?**

ANSWER: An effective electronic health record and health IT system is critical for IHS to deliver quality care and to more efficiently manage and support its health programs. As you know, for the past 25 years, the IHS has developed, deployed, and supported an award winning HIT system, RPMS, throughout the Indian health care system. I am aware of the funding in ARRA for health IT, and, if confirmed, I will review the status of IHS's plans for allocating these funds. Like you, I am committed to ensuring that these expenditures will benefit all health care programs within the Indian Health Service.

4) **Do you believe that the position of the IHS director should be upgraded to that of Assistant Secretary?**

ANSWER: I understand that tribes have recommended this for many years because of the importance of the government-to-government relationship and the trust responsibility of all agencies in HHS to tribes and their members. I will look into the issue to determine what will be the best solution. I want there to be no question, however, about my commitment to ensuring that the health and human services needs of Native Americans are addressed at the highest levels throughout the Department.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. JON TESTER TO YVETTE ROUBIDEAUX, M.D., M.P.H.

1) **I admire, and appreciate your 16 years of scholarly and community work dedicated to improving healthcare in Indian Country. However, the skills you gained in those years are much different than running a $4 billion/year federal agency to serve 2.5 million American Indians in some of America's most remote locations.**
   a. **Do you believe that IHS is currently well-managed?**

ANSWER: Based on my experience working both inside and outside the system, I know that there are thousands of hard-working, dedicated individuals in IHS who are committed to helping to improve the lives and health of American Indians and Alaska Natives, and who go above and beyond the call of duty to provide quality care and services with extremely limited resources. That said, there is no question there are areas where IHS needs to do a better job.

   b. **Given your lack of management experience, can you improve the current system? Specifically how?**

ANSWER: In fact, I have extensive experience as a manager – both inside the system and in other arenas. As Co-Director of the Coordinating Center for the Special Diabetes Program for Indians Demonstration Projects, I was responsible for the day-to-day coordination of this 66-site intervention. Implementation of this complex, evidence-based prevention initiative required both leadership and management skills, including the ability to understand and accommodate the diverse needs of the 66 Indian Health Service, tribal, and urban Indian health program grant sites; the establishment of a communication system; the coordination of common activities; motivation and training for hundreds of grant program staff; development and implementation of a complex evaluation; and monitoring of site performance. It was my responsibility to ensure that the $27.4 million provided the initiative was spent wisely and effectively.

I believe my work on this initiative provided me with exactly the kind of experience I need to effectively bring change to the IHS. I understand what it takes to administer a large initiative in which the objective is to improve the quality of care delivered to diverse communities, and which is accountable for outcomes. I also have administrative experience as a clinical director (medical director) of an IHS hospital that served 10,000 people on the San Carlos Apache Indian reservation, and this experience

helped me understand the day-to-day management of an IHS facility and all of the challenges they face. In addition, I have worked on many national initiatives with IHS that provided me with an understanding of how things work on both the regional and national levels within the agency.

I am confident I can be a decisive and effective manager and leader of the Indian Health Service. As I mentioned in my testimony, I have a long history with IHS as a patient, a physician, and an administrator. I have had the opportunity to with IHS professional staff at both the clinical and administrative levels, and I understand the depth and scope of the challenges facing the agency. If confirmed, I look forward to working with Congress and the staff at both IHS and the Department of Health and Human Services to quickly identify high-priority problem areas and act decisively to address them.

c. How will you make up for your lack of experience? Deputies? Staff? Consultants?

ANSWER: As I mentioned in my answer to the previous question, I believe I bring extensive management experience to the table. Having said that, if confirmed, I will also work to ensure that I have the most qualified and experienced staff around me to provide me with the support I need.

d. How will your scholarly work improve the agency?

ANSWER: As part of my scholarly work, I have focused for many years on program evaluation and improving quality, and I believe that these skills will be especially helpful in making the work of IHS more transparent and accountable. I also believe that my academic experiences will allow me to bring a deliberative, evidence-based approach to the agency as it develops policies to improve the health of American Indians and Alaska Natives.

2) Many experts suggest that IHS is a bureaucratic mess, requiring complete overhaul.

a. Do you believe that? To what degree?

ANSWER: I believe that there is significant room for improvement at IHS. That is why one of my priorities, if confirmed, will be to bring reform to IHS. Having said that, I recognize that IHS is operating within extremely difficult budgetary constraints, and

that every federal department and agency is being asked to do more with less. Nothing less should be expected of IHS, and, if confirmed, I plan to promote greater efficiency and maximize resources whenever possible.

b. How will you restructure the agency to better serve your patients?

ANSWER: I plan to consult with tribes, agency staff, and patients to determine priority areas for improvement on both small and large scales. I believe IHS has an opportunity to maximize its resources by strengthening partnerships with tribes as well as with state and local governments and other health organizations. In addition, as I mentioned in my testimony, I know that many facilities and programs in IHS, tribal, and urban Indian health programs have developed innovative initiatives and have helped solve some of our greatest clinical and administrative challenges at the local level. We need to do more to learn from those successes and apply those lessons to other programs in the system. While there may be a need for additional reorganization at IHS, if confirmed, I plan to explore all options in consultation with tribes and with Congress.

c. Have you ever fired an employee for poor performance? Will you, if it means hurting that individual and perhaps their family, if it means improving Indian healthcare?

ANSWER: There have been occasions where I have had to let go employees for poor performance. With respect to the IHS, I have heard the stories about poor-performing managers and employees in the system, and I share the frustration and concern about ensuring these employees are dealt with appropriately rather than simply being shuffled around. In an agency with limited resources, and in an environment where quality must be a top priority, poor employee performance is unacceptable.

While I intend to review the agency's employee performance tools, I also believe that we can address these issues through more effective training of both supervisors and staff.

Having said that, I also want to be clear about the fact that, every day, thousands of dedicated IHS professionals go above and beyond the call of duty to provide quality care and services with extremely limited resources. If confirmed, I will work to ensure that the stellar work of the vast majority of IHS staff is not tarnished by a few poor-performing employees.

d. What will you look for in hiring qualified staff?

ANSWER: First, staff should meet requirements for a particular position, which should be clear and documented. Second, staff should fit the organizational culture I intend to instill at IHS – i.e., they should be willing to work in a positive manner, and be open to new ideas and approaches to improving health care for American Indians and Alaska Natives.

3) As you know, the federal government is gearing up to comprehensively reform our nation's healthcare system.

a. How do you see the future of Indian healthcare in that effort?

ANSWER: Health reform will directly impact the IHS in a number of important ways. First, increased access to other public and private coverage for all American Indians and Alaska Natives, whether they use the IHS or not, will help reduce demands on the Indian health system. Second, patients with additional coverage can help bring more money into the system through billing and reimbursements.

American Indians and Alaska Natives should benefit from any increased access to healthcare without losing their access to and level of care from IHS. The gap between current IHS funding and the level of need is significant, and any efforts to improve access to and quality of care will benefit our patients. If confirmed, I will work to ensure that the IHS and the populations it serves have a seat at the table in the debate over health reform. We must ensure that health reform does not adversely impact our patients with respect to coverage options and third-party reimbursements for our system. We also have an opportunity to share lessons learned from IHS as we discuss ways to reform the national health system. For example, IHS's health IT system is known to be one of the best in the federal government.

b. Will we need the Indian Health Service if successful on the overall goals of providing health coverage to every American?

ANSWER: Yes. There are many reservation areas where IHS is the only healthcare provider for miles, and, due to many barriers, patients are unable to travel long distances to see other non-IHS providers. Moreover, IHS is the only provider that specifically addresses the unique cultural and health needs of American Indians and

Alaska Natives. Accordingly, I believe preserving IHS will be a critical part of the effort to reform the national health system. Of course, promoting greater access to all coverage options – including alternatives to IHS – will only benefit American Indians and Alaska Natives.

4) **In a letter last summer, Director McSwain told me that IHS fails to collect 40% of complete reimbursements from third parties, such as Medicaid, Medicare and private insurance, and even less for partial reimbursements. $765 million collected in 2007 leaves $510 million uncollected. As you know, $500 million can do a lot of good in Indian Country.**
   a. **How can you improve IHS 3rd party collections?**

ANSWER: Clearly, third-party reimbursements are a critical resource for our health facilities. In some cases, over half of a facility's budget depends on these collections. In general, the IHS does a good job with respect to collections from Medicare and Medicaid; however, I am aware there are problems with private insurance collections, especially given our limited ability to follow up on claims with insufficient staff.

If confirmed, I look forward to working with Congress and agency staff to develop ways to improve the efficiency and effectiveness of these collections, including promoting staff training and ensuring the effective use of IHS's finance and IT systems.

   b. **How will you enroll more tribal members in those programs?**

ANSWER: Barriers to enrollment include a reluctance or misunderstanding of how enrollment can help the local facility. There is also a lack of staff to conduct outreach and facilitate enrollment. If confirmed, I plan to work with agency staff to provide more education on the importance of outreach and enrollment, and to develop strategies to help more tribal members access these critical programs.

   c. **Would you consider using alternatives in evaluating the agency's procedures at the facilities and recommend improvements like the VA did years ago?**

ANSWER: If confirmed, I will consider any option that will help improve third-party collections and remove barriers to enrollment in IHS facilities and programs.

5) **Along those lines, I also hear from Montana hospitals that have problems collecting *from* IHS for services they provide to tribal members.**
    a. **Would you consider IHS participating in a demonstration project in Montana to establish a reliable reimbursement system for community hospitals?**

ANSWER: I am aware of the problem of IHS's paying for private health care services. This problem primarily relates to a lack of funding for contract health services, as well as staffing shortages. With respect to contract health services, I have heard the stories of so many patients who have waited months and even years for referrals, and how limited funding for these services has resulted in a priority system that only pays for "life or limb" care. Given the severity of the situation, this is consistently a top priority in tribal consultation.

If confirmed, I will make it a priority to review how IHS is handling these referrals to determine how to improve the process, and to ensure that the rules in this area are clear and well-understood by both our patients and our referral partners. I am also willing to consider options for improvement to ensure that hospitals in Montana and elsewhere are adequately reimbursed.

However, while the President and I both understand that more money is not the whole answer, a significant increase in resources for these services is essential for the agency to be able to effectively fulfill its mission.

6) **Last July, GAO reported that IHS misplaced nearly $16 million worth of property over the past several years including all-terrain vehicles, tractors, Jaws-of-Life equipment and thousands of computers, some of which contained databases of personal information including social security numbers, medical records, etc. This is another management issue.**
    a. **How will you use your managerial control to reduce fraud, waste and abuse?**

ANSWER: With respect to the GAO investigation, I understand that it is ongoing and that the GAO will release a report soon. I also understand that IHS has been working with GAO and its own Inspector General to identify problems with its property management system and identify to address those problems and otherwise improve the effectiveness of the system.

I believe we all share the same goal of a property management system that effectively documents and accounts for all IHS equipment and property, and that holds employees accountable for lost or stolen property. If confirmed, if I find that laws have been broken, I will work to ensure that the situation is dealt with swiftly and appropriately.

In addition, I plan to review the GAO report, and I look forward to working with you to ensure that this issue is adequately addressed.

7) **As you know, each reservation is unique, with unique challenges. In Montana for example, much like Arizona and South Dakota, distances are often a barrier to good health care.**
   a. **How well do you know Montana?**

ANSWER: I have visited Montana in the past and have witnessed first-hand the state's great beauty. And as a native South Dakotan and a resident of Arizona, I am well aware of the vast distances that many rural residents must travel to receive care.

   b. **Do you have family there?**

ANSWER: I do not have family in Montana.

   c. **Friends?**

ANSWER: I have friends who have lived in Montana in the past, and who love to go back to visit. I also know some health providers who work in the IHS in the state.

   d. **Have you visited?**

ANSWER: Yes, I have visited Montana on a few occasions in the past.

   e. **Will you visit with me and see firsthand, the beauty and challenges we face?**

ANSWER: If confirmed, I would love to visit Montana with you.

8) **One of the most serious problems in Indian healthcare is lack of qualified providers.**

a. **What are your plans for filling significant IHS vacancies for local doctors and nurses?**

ANSWER: As you know, the IHS has faced high vacancy rates for many years. These staffing shortages are due in part to the challenge of recruiting and retaining qualified professionals in rural areas, where many IHS facilities are located, with limited resources. In addition, the stress of working in a system with limited resources is a great challenge for our providers. I experienced problems recruiting and retaining physicians over 10 years ago when I worked in IHS and the problem continues today. I understand that Areas with significantly greater shortages of healthcare professionals include the Navajo Area, the Aberdeen Area, and the Billings Area.

The IHS Scholarship and Loan Repayment Programs have been a critical resource in attracting health professionals. I also understand the IHS has attempted to address this problem by working to make salaries more competitive and offering better bonus pay under certain circumstances, and I believe these efforts should be explored further. In addition, I believe my priorities with respect to reforming IHS and improving quality and access will lead to greater opportunities for clinicians to be a part of the solution, and to propose good ideas for changing and improving the care at their facilities, which is likely to help with retention.

If confirmed, I will ask IHS staff to prepare a status report on current health professional vacancy rates and actions the agency is taking to recruit and retain healthcare professionals. I look forward to working with you to strengthen IHS's ongoing efforts in this area, and to identify new ways to recruit and retain high-quality health professionals in our hospitals and clinics.

b. **Have you seen THE PATH Act that Chairman Dorgan and I introduced earlier this year? It will create grant programs for tribal colleges to train Indian students to become medical professionals.**
c. **Do you support the bill?**

ANSWER: I look forward to reviewing this legislation. I share your goal of training more Indian students to become medical professionals, and, if confirmed I look forward to working with you to advance this goal.

9) **The problems with IHS and Indian healthcare are well-documented.**
   a. **What are your *priorities* for addressing the serious challenges facing the agency?**

ANSWER: There is no question that there are areas where the Indian Health Service needs to do a better job. If confirmed, I look forward to working with the members of your committee and others in Congress to identify problems, and to do whatever is needed to ensure that IHS does its job, and does it well. Specifically, as I mentioned in my testimony, I intend to review and improve the tribal consultation process; ensure that IHS participates in, and benefits from, the broader effort to reform our health system; make the quality of and access to health care an agency-wide priority; and work to promote transparency, accountability, and fairness.

Having said that, I want to be clear about the fact that currently, IHS simply does not have enough resources to meet the needs of the population it is responsible for serving. While the President and I both understand that more money is not the whole answer, a significant increase in resources for IHS is essential for the agency to be able to effectively fulfill its mission. Virtually every independent estimate – including estimates of the tribes themselves – suggests that IHS funding is woefully inadequate to meet its level of need, and that IHS patients receive far less care than patients in other government health programs. The President's proposed increase for IHS is a step in the right direction, but we need to do more.

I recognize that we are operating within extremely difficult budgetary constraints, and that every federal department and agency is being asked to do more with less. Nothing less should be expected of IHS, and I plan to promote greater efficiency and maximize resources whenever possible. However, if confirmed, I look forward to working with Congress to do whatever we can within those constraints to make more resources available to the Indian Health Service.

10) I hear a lot from Indian veterans struggling to get adequate healthcare. When they go to their local IHS clinic, they're told, "You're a vet, go to VA." When they go to VA, they're told, "You're an Indian, go to IHS." Long story short, they don't get the care they need.

a. How can you work with the Veteran's Administration to improve coverage of Indian vets?

ANSWER: Effective coordination and collaboration between our federal agencies – particularly those that serve overlapping constituencies – is critical. I understand that IHS and VHA have had a senior-level workgroup in place since HHS and VA signed an

MOU in 2003, and that the workgroup meets frequently to facilitate effective coordination between the two agencies. If confirmed, I will review all of IHS's existing partnerships, including those with MOUs in place with other federal agencies, to determine outcomes to date and areas for improvement.

11) As a member of the Rosebud Sioux Tribe in South Dakota, I imagine you visited IHS facilities many times in your youth. Please, tell us about your experience.

a. Did you see Indian or non-Indian doctors and nurses? Did it matter? Why?

ANSWER: During my time in South Dakota, I saw some Indian nurses, but never saw an Indian doctor. I decided to become a doctor because I thought I could make a difference in improving health care for my people.

b. Did you talk about prevention?

ANSWER: I don't recall the doctors talking about prevention.

c. Did you talk about mental health?

ANSWER: I don't recall the doctors talking about mental health.

d. Based on your experience, what is the most important thing you can do to improve the agency?

ANSWER: I believe that we need to restore the confidence of our patients in the system by showing them we acknowledge that we need to do better, and letting them know what we are doing to improve care.

12) Please explain the differences between non-Indian health care and culturally appropriate healthcare.

a. Why is it important?

ANSWER: Culturally appropriate healthcare has the potential to result in better patient outcomes. By understanding the culture and context in which the patient lives, the doctor has a better chance of successfully treating his or her health conditions. Patients are also more likely to embrace care that is culturally competent.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. TOM UDALL TO YVETTE ROUBIDEAUX, M.D., M.P.H.

1) **The IHS Contract Health Program allows Native Americans to use non -IHS facilities when Indian facilities are unable to provide treatment. This is a lifeline for Native Americans. Unfortunately, Contract Health Services are significantly underfunded – possibly by as much as 50% - leaving Native Americans without access to much needed health care. While the recently signed omnibus increased IHS Contract Health Services 20% from FY08, it still falls far short from being fully funded.**
    a. **Do you support a much more significant budget request for Contract Health Services from the President to ensure that the Contract Health Service Program meets the needs of Native Americans?**

ANSWER: I am aware of the serious shortfalls we face in funding for contract health services. I have heard the stories of so many patients who have waited months and even years for referrals, and how limited funding for these services has resulted in a priority system that only pays for "life or limb" care. Given the severity of the situation, this is consistently a top priority in tribal consultation.

If confirmed, I will make it a priority to review how IHS is handling these referrals to determine how to improve the process, and to ensure that the rules in this area are clear and well-understood by both our patients and our referral partners.

However, while the President and I both understand that more money is not the whole answer, a significant increase in resources for these services is essential for the agency to be able to effectively fulfill its mission.

    b. **What ideas do you have for reducing staff shortages, long waiting periods and deferred care and for improving the quality of services and facilities for our Native Americas?**

ANSWER: I believe we need to do more to recruit and retain healthcare providers, including looking at options to improve salaries and incentives, and also to involve them to a greater extent in finding solutions to improve care. In addition, some facilities in the system have figured out how to reduce waiting periods and to improve access for patients – we need to take those lessons learned and apply them to other areas of the system. Finally, we need to do more to ensure our providers are following

standards of care and providing the best quality care in a culturally appropriate manner.

2) **Being subjected to the appropriations process and the federal budget contributed to the woeful underfunding of the Indian Health Service. One solution is to change the funding mechanism to an entitlement program, such as with a new eligibility category for Native Americans under Medicare. What are your thoughts on such an approach?**

ANSWER: There is no question that IHS simply does not have enough resources to meet the needs of the population it is responsible for serving. While the President and I both understand that more money is not the whole answer, a significant increase in resources for IHS is essential for the agency to be able to effectively fulfill its mission. The President's proposed increase for IHS is a step in the right direction, but we need to do more.

I recognize that we are operating within extremely difficult budgetary constraints, and that every federal department and agency is being asked to do more with less. Nothing less should be expected of IHS, and I plan to promote greater efficiency and maximize resources whenever possible. However, if confirmed, I look forward to working with Congress to do whatever we can within those constraints to make more resources available to the Indian Health Service, including by considering new and creative funding mechanisms.

3) **Many of the health clinics, where they exist, are seriously outdated. Many new facilities (especially primary care clinics) are needed in underserved areas, and are scheduled for renovation on the IHS Health Care Facilities FY 2010 planned construction list – but with much too long a delay.**
    a. **What ideas do you have for improving the facilities and conditions of the Indian health clinics and hospitals in a timely way?**
    b. **How would you prioritize IHS funding for renovating exiting facilities and for building new ones in underserved areas in the next four years?**
    c. **Would you accept an invitation to visit Gallup Indian Service in New Mexico, which is in desperate need of renovation?**

ANSWER: I agree there is an enormous need in the IHS for new facility construction. If confirmed, I intend to consult with tribes on the existing priority list for facility

construction, and discuss options with tribes and with Congress for ensuring that more communities can get the facilities they need as soon as funding becomes available. In addition, I look forward on working with Congress to develop a timely approach to adequately funding the well-documented need for new and replacement health care facilities.

If confirmed, I would be happy to visit Gallup Indian Medical Center in New Mexico.

4) **Many of the health concerns of Native Americans are rooted in the community, rather than just being due to individual behavior. Access to clean water and sanitation, access to fresh fruits and vegetables, access to quality schools, and confidence in a future with a livable-wage job are important to health prevent alcohol and drug abuse, obesity, depression, homicide and suicide. As you know, genetic factors (such as CCM) and environmental issues (such as uranium and lead exposure) are special concern for Indian health, as well.**
    a. **As IHS Director, how will you address these public health problems?**
    b. **What are your thoughts for reducing health disparities of Native Americans?**
    c. **What are your thoughts about increasing American Indians in the IHS workforce?**

ANSWER: As I mentioned in my testimony, if confirmed, one of my priorities will be to strengthen IHS's partnership with tribes. Such partnerships are the only way we can address the range of challenges facing the American Indian and Alaska Native population, including the need to improve the health of our people. IHS clinics alone cannot improve health – our tribes and our communities must also be part of the solution.

We can help reduce health disparities by improving access to and quality of healthcare for this population in a culturally appropriate manner. A critical first step would be to reauthorize the Indian Health Care Improvement Act, which would establish objectives for minimizing these disparities. In addition, a significant increase in resources for IHS is essential for the agency to be able to effectively fulfill its mission.

Finally, IHS has always had a goal of increasing the role of American Indians and Alaska Natives in their own health care, and research has shown that health care providers are more likely to serve in their own communities and stay for the long term. Difficulties in recruiting and retaining qualified health professionals have long been recognized as a significant factor impairing Indians' access to health care services. If

confirmed, I would work to address the health professional shortage by increasing recruitment and retention efforts; supporting the expansion of loan repayment programs for students entering health professions; and expanding professional and continuing education programs for individuals working for tribal and urban Indian health providers and federal health agencies. If confirmed, I look forward to working with you on this important issue.

5) **As you know, Veterans who reside on tribal lands face many of the same daunting challenges as rural veterans – such as access to treatment and a lack of specialized health care. What communication have you already had with the VA, and what are your plans for IHS assisting our veterans.**

ANSWER: Effective coordination and collaboration between our federal agencies – particularly those that serve overlapping constituencies – is critical. I understand that IHS and VHA have had a senior-level workgroup in place since HHS and VA signed an MOU in 2003, and that the workgroup meets frequently to facilitate effective coordination between the two agencies. If confirmed, I will review all of IHS's existing partnerships, including those with MOUs in place with other federal agencies, to determine outcomes to date and areas for improvement.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. MAX BAUCUS TO YVETTE ROUBIDEAUX, M.D., M.P.H.

1) **According to the IHS in 2005, about 12% of American Indian/Alaska Native (AI/AN) homes lacked safe drinking water supplies and adequate waste disposal facilities, compared to about 1% of all U.S. homes.**

   How do you propose to address the problem of American Indian and Alaska Native homes lacking safe drinking water and adequate waste disposal facilities? What can we do in Congress to address this issue?

ANSWER: An important part of the public health functions of IHS is to work on safe water and waste disposal in Indian communities. I am told that the IHS currently has the long-term goal to decrease the percentage of AIAN homes with unsafe drinking water to less than 6%. This goal is included in the IHS Strategic Plan, validated by a marginal cost study, and shared by our tribal, federal and local partners. If confirmed, I will review all efforts of IHS so far in these areas, and look forward to working with tribes, our communities, and Congress to create partnerships and find additional resources in an effort to address this important problem.

2) **The IHS does not provide the same health care services in each area it serves. Services vary from place to place and from time to time. Services provided to any particular Indian community will depend on financial resources (appropriations and third party reimbursements) and available personnel and facilities. As a result, according to Indian health organizations, some services are "rationed," with the most critical care given first (Level 12).**

   Will you put into plan a method to make health care services more equitable?

ANSWER: I understand that some facilities and Areas are underfunded compared to others. The IHS currently uses several formulas that take into account user counts, local health care prices and costs, Indian population health status, hospital availability, and other factors related to geography and access. These formulas were developed with tribal input and consultation and many have been in place a number of years.

If confirmed, I plan to review all funding allocation formulas in terms of when and how they were developed. In consultation with tribes, I will work to ensure these allocation formulas are up-to-date and fair. I will also ensure that they have measures in place to

determine whether the funding allocations resulted in the anticipated improvements or outcomes, and whether adjustments need to be made.

In addition, increasing overall resources available to IHS will help the agency distribute funding more equitably. The President's proposed increase for IHS is a step in the right direction, but we need to do more. If confirmed, I look forward to working with Congress to do whatever we can to make more resources available to the Indian Health Service.

We currently are investigating the write-offs of third party reimbursements, will you personally look into this matter and see that collections within the IHS are undertaken and not written off?

ANSWER: Clearly, third-party reimbursements are a critical resource for our health facilities. In some cases, over half of a facility's budget depends on these collections. In general, the IHS does a good job with respect to collections from Medicare and Medicaid; however, I am aware there are problems with private insurance collections, especially given our limited ability to follow up on claims with insufficient staff.

If confirmed, I plan to review the findings and recommendations of your the investigation, and look forward to working with Congress and agency staff to ensure IHS is maximizing its ability to collect from private insurance.

3) **IHS per capita expenditures on health services are often less than per capita expenditures in other federal health-related programs such as the Bureau of Prisons or the Veterans Administration. A multi-part study showed the disparities that exist in personal medical services between IHS and mainstream health care systems. It is called the Federal Employees Health Benefits Disparity Index (FDI) study. It is based on the Federal Employees Health Benefits Plan as the benchmark mainstream personal medical services plan against which to compare IHS health services. The study found that actual FY2004 IHS appropriations for personal medical services would provide 56.8% of the appropriations needed to give IHS users personal medical services equivalent to the Federal Employees Health Benefits Plan, and that an additional $1.7 billion would be needed to raise the level of IHS personal medical services to 100% of the Federal Plan.**

Do you see additional appropriations from Congress the solution to funding disparity between the medical care Indians receive as compared to the general population? Are there other methods of solving the funding disparity other than appropriations?

ANSWER: There is no question that IHS simply does not have enough resources to meet the needs of the population it is responsible for serving. While the President and I both understand that more money is not the whole answer, a significant increase in resources for IHS is essential for the agency to be able to effectively fulfill its mission. As you note, virtually every independent estimate - including estimates of the tribes themselves - suggests that IHS funding is woefully inadequate to meet its level of need, and that IHS patients receive far less care than their counterparts in other government health programs. The President's proposed increase for IHS is a step in the right direction, but we need to do more.

I recognize that we are operating within extremely difficult budgetary constraints, and that every federal department and agency is being asked to do more with less. Nothing less should be expected of IHS, and I plan to promote greater efficiency and maximize resources whenever possible. Specifically, I believe IHS has an opportunity to maximize its resources by strengthening partnerships with tribes as well as with state and local governments and other health organizations. In addition, as I mentioned in my testimony before the Senate Indian Affairs Committee, I know that many facilities and programs in IHS, tribal, and urban Indian health programs have developed innovative initiatives and have helped solve some of our greatest clinical and administrative challenges at the local level. We need to do more to learn from those successes and apply those lessons to other programs in the system.

However, if confirmed, I look forward to working with Congress to do whatever we can within those constraints to make more resources available to the Indian Health Service.

4) **IHS allocations of base funding do not fully take into account changes in population, health needs, and health services. One result has been that different IHS areas and service units receive widely varying levels of funding, as measured by per capita funding (based on GAO report, Feb. 1991). Studies have found significant funding variations within the IHS --- estimating that in FY2004 161 of the 266 operating units were funded at or below 60% of FEHBP-equivalent services, while 49 operating units were funded at over 80% of need (source: IHS, FY2004 FDI Summary Results).**

Given reports on funding allocations and disparities of funding that fund some units below 60% while funding others at over 80% of need, what will you do to bring these into a more equitable situation?

ANSWER: As stated above, if confirmed, I plan to review all funding allocation formulas and work tribes to ensure these allocation formulas are up-to-date and fair. I will also ensure that they have measures in place to determine whether the funding allocations resulted in the anticipated improvements or outcomes, and whether adjustments need to be made.

In addition, increasing overall resources available to IHS will help the agency distribute funding more equitably. The President's proposed increase for IHS is a step in the right direction, but we need to do more. If confirmed, I look forward to working with Congress to do whatever we can to make more resources available to the Indian Health Service.

5) **Some tribes currently provide services through contract health services, but are looking to transition to becoming direct providers rather than contracting with private providers. The potential savings from providing services internally, and having the ability to collect from third party payers like Medicare, Medicaid and private insurers, would allow more services to be provided with the same investment from IHS.**

   Do you believe that IHS can help tribes transition away from contract health services, at least for some services, in an effort to make dollars go further and provide more services than they are able to now?

ANSWER: If confirmed, I look forward to working with tribes to explore options for reducing their dependence on contract health services. In addition, I am always open to discussing ideas that will lead to greater efficiency and improved performance at IHS.

6) **Contract health services are provided by non-Indian Health Service (or Tribal) healthcare providers and facilities when the IHS is unable to provide in its own facilities. There has been concern that there is both a lack the resources as well as administrative constraints in trying to build partnerships between area Indian healthcare systems and the private sector for "sharing" specialty care providers. In addition, transportation usually becomes a Tribal obligation as**

the IHS budget does not provide for it nor can the individual Tribal member afford the expense.

Do you believe by giving tribes more flexibility and funding to enter into partnerships with private sector entities as well as the federal government contributing towards transportation costs that this could help reduce the disparities?

ANSWER: Yes, I believe that giving more flexibility and funding to tribes to enter into partnerships with the private sector and the federal government could have the potential to help reduce costs and disparities. If confirmed, I look forward to working with tribes to explore the details of these options.

7) **Tribes in the nation are developing chronic disease at a younger age. Severe health problems/treatments related to chronic disease i.e. cardiovascular disease, gastrointestinal disease, cancer and diabetes take a toll on the annual CHS budgets. The tribes are asking, "What stress will this add to our strained healthcare system knowing we may be supporting, at greater costs, an individual at a younger age for a potentially longer time?"**

   Do you believe an "ultra" emergency plan needs to be developed when catastrophic health emergency fund dollars and IHS/Tribal CHS funding are depleted? Should there also be additional funding opportunities created for a tribal health system redesign to develop a more effective and meaningful healthcare system?

ANSWER: The increasing burden of chronic disease is absolutely placing greater stress on the Indian health system and challenging the ability to provide services for a growing population. I believe that IHS can decrease the burden of illness in our communities and the cost of illness and disability in our system through improved prevention and management of chronic conditions. IHS's experience over the past 30 years in improving diabetes care, and for the past decade with IHS, Tribal and Urban Indian health programs that make up the Special Diabetes Program for Indians, have shown that a comprehensive approach with strong community and clinical partnerships can make a difference.

In order to handle chronic diseases in the AIAN population over the long term, IHS will have to increase its prevention strategies and expertise. It is absolutely necessary that we make fundamental change in the way we care for and prevent chronic conditions, including by finding ways to provide care around the needs of the patient and family, to prioritize prevention of illness, and to coordinate proactive team care to support management of chronic conditions. As part of this effort, it will be important to reach beyond the clinic and hospital to develop the partnerships that promote health in the community.

IHS will also need to explore ways to transition to a health care system that is capable of truly supporting individuals and communities in a healthy lifestyle. I believe that IHS is capable of making this investment while at the same time meeting its obligation to provide care to those who are ill.

8) **IHS funds approximately 1% of its budget for 34 urban Indian health projects (UIHPs) with operations at 41 locations. In 2000, UIHPs served an estimated 669,970 urban Indian s living in IHS's urban service areas.**

   Past bills before Congress have authorized HHS to study the feasibility of federal direct or guaranteed loans for urban Indian organization facilities construction, and require that IHS consult or confer with such organizations. What are your concerns for urban Indian facilities and the prospect of construction and/or remodeling?

ANSWER: As you know, American Indians and Alaska Natives (AIANs) living in urban areas comprise a significant percentage of the total AIAN population - today, over half of all AIANs live in urban areas. I strongly support urban Indian health programs, which provide culturally competent care that is not available from other health providers for this growing population.

I understand that many urban Indian health programs are underfunded, and that many also have facility construction and renovation needs. If confirmed, as part of my overall approach to facility construction and renovation within IHS, I look forward on working with Congress to develop a timely approach to adequately funding the well-documented need for new and replacement health care facilities, including with respect to urban Indian health programs.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. JEFF BINGAMAN TO YVETTE ROUBIDEAUX, M.D., M.P.H.

The Indian Health Service contract health program allows Native Americans to utilize non-IHS facilities when Indian facilities do no not have the capacity or ability to provide treatment. This program serves as a lifeline for Native Americans. Unfortunately, contract health services are significantly underfunded - some experts estimate by as much as 50 percent. As a result, GAO and others have found that Native Americans are left without access to critical care.

In large part, the recent low funding levels were the result of very low funding requests from President Bush. For example, in FY 2009 President Bush requested only $570 million for contract health services, which represents only about 50 percent of need.

Some headway on funding was made in the Omnibus that was just signed into law - and contract health services received $634 million, about a 21 percent increase from the FY 2008.

1) **Do you support a much more significant budget request for contract health services from the President to ensure that the contract health service program meets the needs of Native Americans?**

ANSWER: I am aware of the serious shortfalls we face in funding for contract health services. I have heard the stories of so many patients who have waited months and even years for referrals, and how limited funding for these services has resulted in a priority system that only pays for "life or limb" care. Given the severity of the situation, this is consistently a top priority in tribal consultation.

If confirmed, I will make it a priority to review how IHS is handling these referrals to determine how to improve the process, and to ensure that the rules in this area are clear and well-understood by both our patients and our referral partners.

However, while the President and I both understand that more money is not the whole answer, a significant increase in resources for these services is essential for the agency to be able to effectively fulfill its mission.

2) **What other steps will you take as Director of the Indian Health Service to address the needs of Indians that receive services at your facility?**

ANSWER: Both the President and I support passage of IHCIA as an important first step to update and modernize the IHS. While I understand that formal legislation has not yet been introduced this Congress, if confirmed, I look forward to working with you and members of the Senate Indian Affairs Committee and others in Congress to pass that important legislation, and to working together in other ways to further improve the health of American Indian and Alaska Natives. In addition, I believe it must be a top legislative priority to make more resources available to IHS in an effort to begin addressing the significant gap between available funding and need.

With respect to reform, as I mentioned in my testimony, if confirmed, I intend to review and improve the tribal consultation process; ensure that IHS participates in, and benefits from, the broader effort to reform our health system; make the quality of and access to health care an agency-wide priority; and work to promote transparency, accountability, and fairness. With these general priorities in mind, I look forward to working members of Congress, tribes, Indian health experts, and IHS staff to develop ideas for reform, ensure those ideas are part of the broader health reform discussion, and implement them at IHS.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. BARBARA BOXER TO YVETTE ROUBIDEAUX, M.D., M.P.H.

1) **Of the four Contract Health Service (CHS) dependent areas, California has the second lowest Level of Need Funded, the second lowest CHS allocation per active user, and the absolutely lowest Catastrophic Health Emergency Fund utilization rate of the entire IHS system. The consequent funding shortfalls leave $18 million in bad debt at California hospitals according to CRIHB research. What steps will you take to address this ongoing problem?**

ANSWER: I am aware of the serious shortfalls we face in funding for contract health services. I have heard the stories of so many patients who have waited months and even years for referrals, and how limited funding for these services has resulted in a priority system that only pays for "life or limb" care. Given the severity of the situation, this is consistently a top priority in tribal consultation.

If confirmed, I will make it a priority to review how IHS is handling these referrals to determine how to improve the process, and to ensure that the rules in this area are clear and well-understood by both our patients and our referral partners.

However, while the President and I both understand that more money is not the whole answer, a significant increase in resources for these services is essential for the agency to be able to effectively fulfill its mission. If confirmed, in consultation with tribes, I will review the funding issues that are particular to California as I review the overall funding allocation systems and priorities, and I look forward to working with you to address these issues.

2) **Are you willing to review the current funding distribution formula for Urban Indian health programs and reconsider allocations based on the level of services provided and service area eligible beneficiaries?**

ANSWER: As you know, American Indians and Alaska Natives (AIANs) living in urban areas comprise a significant percentage of the total AIAN population - today, over half of all AIANs live in urban areas. I strongly support urban Indian health programs, which provide culturally competent care that is not available from other health providers for this growing population.

If confirmed, I would be willing to review the current funding formula for urban Indian health programs to determine whether it is up-to-date and fair, and I look forward to working with you to find a solution to address your concerns in this area.

3) **As you are aware, California has very few Indian Health Services Facilities, how can we be assured that some of the ARRA funding for Indian health care will come into California?**

ANSWER: I understand that the California Area, in partnership with California tribes and tribal organizations, identified 30 Recovery Act-eligible projects valued at approximately $3 million. If confirmed, I will review the status of IHS's efforts to allocate the funds it received under ARRA, and work to ensure those funds are distributed as effectively and as fairly as possible.

April 27, 2009

The Honorable Byron Dorgan
322 Hart Senate Office Building
Washington, DC 20510

The Honorable John Barrasso
307 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Dorgan and Vice Chairman Barrasso,

On behalf of the American Diabetes Association, it is my great honor and pleasure to write in support of the nomination of Yvette Roubideaux, MD, MPH for Director of the Indian Health Service. Dr. Roubideaux is an exceptional medical professional who has made outstanding contributions to the Association through her efforts on behalf of people with diabetes.

Dr. Roubideaux has demonstrated extraordinary leadership for the Americans most adversely impacted by diabetes, American Indian and Alaska Natives (AIAN). As a physician, Dr. Roubideaux has witnessed the destruction that diabetes has brought to this community. As a professor, she has led the way in research and education about diabetes in the AIAN population. Her passion for improving diabetes care led her to an additional role as Chair of the Association's Awakening the Spirit Project team in 2008.

Within the epidemic of diabetes in the United States, the disease it is four to eight times more common in American Indians and Alaska Natives. Moreover, the prevalence is growing in the AIAN population, particularly among children. American Indians and Alaska Natives suffer higher rates of complications, and it is the fourth leading cause of death.

In sum, Dr. Roubideaux is an exceptional candidate for Director of the Indian Health Service. If you have questions or would like more information, please contact Katie Murray, Manager, Federal Government Affairs at kmurray@diabetes.org or by phone at (703) 299-2087.

Sincerely,

Shereen Arent

Shereen Arent
Executive Vice President, Government Affairs and Advocacy
American Diabetes Association

OFFICE OF THE GOVERNOR
The Chickasaw Nation
Post Office Box 1548 • Ada, Oklahoma 74821

BILL ANOATUBBY
GOVERNOR

April 23, 2009

Honorable Byron Dorgan, Chairman
Honorable John Barrasso, Vice Chairman
Senate Committee on Indian Affairs
SH 838 Hart Senate Office Building
Washington, DC 20510-6450

Dear Chairman Dorgan and Vice Chairman Barrasso:

Please allow me this opportunity to express support for Dr. Yvette Roubideaux as director of the Indian Health Service. Dr. Roubideaux has been a strong supporter in advancing the health-care status of American Indian/Alaska Native people both academically and as assistant professor in the department of family and community medicine at the University of Arizona College of Medicine, and clinically while serving three years as the clinical director and medical officer at the San Carlos Indian Hospital. In addition, she has worked on many national committees which address specific health care needs of our indigenous population. Dr. Roubideaux is also a great advocate for the reauthorization of the Indian Health Care Improvement Act.

Dr. Roubideaux has already proven that she is sincere in working with tribal leaders to meet the health care needs of Indian country. She is a citizen of the Rosebud Sioux tribe, and she understands the complex issues involved in Indian health issues.

Your consideration of Dr. Yvette Roubideaus ad director of the Indian Health Service will be very much appreciated.

Sincerely,

Bill Anoatubby

Bill Anoatubby, Governor
The Chickasaw Nation

Fort Belknap Indian Community

R.R. 1, Box 66
Fort Belknap Agency
Harlem, Montana 59526

Fort Belknap Indian Community
(Tribal Gov.)
Fort Belknap Indian Community
(Elected to administer the affairs of the community and to represent the Assiniboine and the Gros Ventre Tribes of the Fort Belknap Indian Reservation)

April 17, 2009

Byron Dorgan, Chairman
Committee on Indian Affairs
United States Senate
838 Hart Office Building
Washington, DC 20510

RE: Appointment of Yvette Roubideaux for Director the Indian Health Service, U.S. Department of health and Human Services

Dear Mr. Chairman and Committee Members

The Fort Belknap Indian Community is extremely honored to support the nomination of Dr. Yvette Roubideaux as the Director of the Indian Health Services, US dept of Health and Human Services. The Fort Belknap Indian Community is well aware of Dr. Roubideaux's long standing effort and advocacy in seeking better health care for Native Americans.

Having worked directly with, and as a member of an Indian Nation, Dr. Roubideaux has demonstrated a true understanding of health issues that Native Americans face, particularly the dramatic and traumatic affect diabetes has had on the Native American population. A truer advocate cannot be found.

Dr. Roubideaux, in understanding the medical needs and health deficiencies of Native Americans, is quick to encourage Native youth to enter into health professions. Her actions not only give youth a sense of direction and purpose, but also serve to increase the number of qualified, trained Native American health professionals who can then be in a better position to help their own people.

The Fort Belknap Indian Community feels a sense of comfort and relief in knowing that Native American health issues will be accurately understood and addressed through the appointment of Dr. Roubideux.

Thank you for your time and attention to this very important matter.

THE FORT BELKNAP INDIAN COMMUNITY

Julia dOney

JULIA dONEY
President

NATIVE RESEARCH NETWORK, INC.
P.O. BOX 1448
BLANCHARD, OKLAHOMA 73010

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April 10, 2009

The Honorable Byron L. Dorgan, Chairman
Committee on Indian Affairs
United States Senate
838 Hart Office Building
Washington, DC 20510

The Honorable Bryon L. Dorgan:

On behalf of the Native Research Network, Inc (NRN), it is an honor and pleasure to endorse Dr. Yvette Roubideaux as Director of the Indian Health Service. Founded in 1997, the NRN membership consists of 257 American Indian, Alaska Native, Kanaka Maoli, Canadian Aboriginals and non-Native colleagues nation-wide who promote and advocate for high quality research that is collaborative, supportive and builds capacity on the principles of integrity, respect, trust, ethics, cooperation and open communication in multidisciplinary fields.

Dr. Roubideaux is a distinguished member and a founder of the NRN. Her work on behalf of American Indians and Alaska Natives is highly regarded and crosses many health disciplines. Although her expertise is in diabetes, she is well versed in many health and disease issues affecting the American Indian and Alaska Native (AI/AN) population, and in multiple disciplines including health policy, research, program implementation and clinical medicine. She is by far one of the most recognized Native professionals and experts on issues that contribute to health disparities in AI/AN communities.

Dr. Roubideaux is very passionate about her work and has made a significant impression on the national level. We can say with certainty that Dr. Roubideaux is bright, hard working, and highly committed to improving heath care for Native people. Our organization has very high regard for Dr. Roubideaux's integrity, ability to perform under demanding conditions, and determination to accomplish anything put in front of her. Dr. Roubideaux is a special person whose character, values, and dedication will greatly benefit our Native communities in this new capacity.

President Barack Obama could not have made a better choice.

Sincerely,

Lisa Rey Thomas, Ph.D.
Co-Chair

Alison J. Boyd-Ball, Ph.D.
Co-Chair

Promoting Integrity and Excellence in Research

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Tlingit

NCAI HEADQUARTERS
1301 Connecticut Avenue, NW
Suite 200

April 23, 2009

Chairman Dorgan
Senate Committee on Indian Affairs

Vice Chairman Barasso
Senate Committee on Indian Affairs

Dear Chairmen,

On behalf of the National Congress of American Indians (NCAI), we are pleased to present a letter of support to the Senate Committee on Indian Affairs towards the nomination of Dr. Yvette Roubideaux for the position of Director of the Indian Health Service.

Dr. Roubideaux is a long-time advocate for the improved health and well-being of Indian people. From her work as a physician in the Indian Health Service to her experience working on health campaigns across Indian Country, Dr. Roubideaux has a strong understanding of the health needs and challenges facing our communities. More importantly, she has also shown that she has the dedication and commitment necessary to find solutions.

As Director of the Indian Health Service, Dr. Roubideaux has stated she will place tribal consultation and the inclusion of the Indian Health Service in the national conversation of health care reform as two of her top priorities. NCAI's membership has overwhelmingly supported both of these issues and we look forward to working with Dr. Roubideaux to accomplish and fulfill these priorities.

Thank you for the opportunity to provide our comments and support for Dr. Roubideaux. We look forward to continuing this productive and valuable relationship.

Sincerely,

Joe Garcia
President, NCAI

Bemidji Area Representative
National Indian
Health Board

Wisconsin–Minnesota-Michigan-Indiana-Illinois
Representing the Nation and Peoples of the:
Ojibwe-Chippewa-Ottawa-Odawa-Potawatomi-Menominee
Ho-Chunk- Oneida- Sioux-Stockbridge-Munsee

April 23, 2009

The Honorable Byron Dorgan, Chairman
The Honorable John Barrasso, Vice-Chairman
Senate Committee on Indian Affairs
838 Hart Office Building
Washington, D. C. 20510

Dear Senators Dorgan and Barrasso:

It is my privilege on behalf of the Bemidji Area Tribal Nations to endorse the nomination of Yvette Roubideaux, MD, MPH, for the Director of the Indian Health Service (IHS).

Dr. Roubideaux is well known across Indian Country for her dedication and advocacy of American Indian and Alaska Native health care issues. She brings to the office direct experience as a practicing physician in Indian Country within the IHS system, which provides the office a unique insight into the mechanisms required to improve health care delivery within the IHS; this discussion will be in the forefront of a new directors responsibilities in the broader national health reform discussions. Her leadership capacity was well demonstrated during the Tribal Health Listening Sessions for the Presidential Transition Team. It was largely though her efforts that Tribes were directly involved with Transition Team discussions regarding health needs in Indian Country; she understands that Tribes are best able to provide direction in creating solutions to the health care challenges we face in our home communities.

It is well documented that Indian Country faces the worst health disparities in the Nation; in the Bemidji Area, our Tribes are leading the IHS delivery system in disease process statistics with the lowest life expectancy in Indian Country at 65.3 years of age, compared to all of IHS at 70.6 years. Bemidji also suffers the greatest funding disparity with a total level of need funded at 37% of the cost to adequately provide needed treatment. We have confidence that Dr. Roubideaux's experience as a provider to Indian people, and her knowledge of navigating the intricacies of the Contract Health Services system will assist in addressing these disparity issues that continue to plague Bemidji and

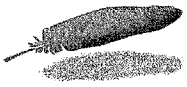
all of Indian Country. We recommend Dr. Roubideaux and her abilities to examine the budgetary and policy challenges at the agency level, to make meaningful and lasting changes in a system that is in dire need of establishing a better way of doing business in health care delivery.

I appreciate the opportunity to offer this letter of support for the confirmation of Dr. Yvette Roubideaux as the Director of Indian Health Service on behalf of the Tribal Nations of the Bemidji Area. If you have further questions or require additional information, please do not hesitate to contact me .

Sincerely,

Jessica L. Burger, RN – Health Director
Bemidji Area Representative
NIHB Member-at-Large
310 9th Street
Manistee, MI 49660

National Indian Health Board



April 20, 2009

The Honorable Byron Dorgan, Chairman
The Honorable John Barrasso, Vice-Chairman
Senate Committee on Indian Affairs
838 Hart Office Building
Washington, DC 20510

Dear Senators Dorgan and Barrasso:

On behalf of the National Indian Health Board (NIHB), I am pleased to support the nomination of Yvette Roubideaux, MD, MPH for the Director of the Indian Health Service (IHS). Tribes across the nation recognize Dr. Roubideaux to be a very dedicated and respected advocate for American Indian and Alaska Native health care. We look forward to working with Dr. Roubideaux and urge the Senate Committee on Indian Affairs to swiftly approve her nomination.

The well-accomplished Dr. Roubideaux has many extensive skills and experiences that will be invaluable assets for leadership of IHS. From her years as a practicing physician in Indian Country and program administrator to her years of research and teaching, Dr. Roubideaux brings a well-rounded perspective and in-depth knowledge of the Indian health care system that will serve both IHS and Indian Country well. Most recently, we appreciated her work as the lead for the Tribal Health Listening Session for the Presidential Transition Team last December. Her approach of ensuring that Tribes were included in the transition discussion demonstrates how she will reach out as IHS director to work with Tribes. In addition, NIHB has had the privilege of working closely with Dr. Roubideaux on the Tribal Public Health Accreditation project through which the Tribes created a strategic plan to improve the quality of public health services throughout Indian Country. As we all move forward to improve the health status of Indian people, we expect that Dr. Roubideaux continue to work diligently for the health needs of all American Indians and Alaska Natives.

Service as IHS Director will not be easy. As we all know, with some of the worst health disparities in the Nation, Indian Country experiences the shortfall of budgetary constraints for health care on a daily basis. For example, American Indians and Alaska Natives have the highest prevalence of diabetes among all U.S. racial and ethnic groups. The complications of diabetes can be averted or delayed with proper care but programs to help curtail this preventable illness require reauthorization and continuous funding. Last year, Dr. Roubideaxu chaired the American Diabetes Association Awaking the Spirit Team, which led national efforts for Congressional

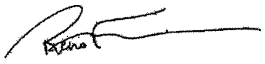
926 Pennsylvania Avenue, SE | Washington, DC 20003

The Red Feather of Hope and Healing

reauthorization of the Special Diabetes Program for Indians. Similarly, NIHB trusts that Dr. Roubideaux will take the steps necessary to make significant improvements to contract health service, health facilities construction and recruitment and retention of health professionals in Indian Country. We recommend Dr. Roubideaux to undertake these budgetary and policy challenges at the agency level on behalf of all of Indian Country.

I appreciate the opportunity to offer this letter of support for the confirmation of Dr. Roubideaux's nomination as the Director of IHS. Should you have questions or need additional information, please do not hesitate to contact me or NIHB's Executive Director, Stacy Bohlen at (202) 507-4070.

Sincerely,



Reno Keoni Franklin
Chairman

National Council of Urban Indian Health
924 Pennsylvania Ave. SE
Washington, DC 20003

Excellence, Equity, Effectiveness

April 21, 2009

Senator Byron Dorgan
Chairman
Senate Committee on Indian Affairs
Senate Hart Building, Room 838
Washington DC, 20001

Senator John Barrasso
Ranking Member
Senate Committee on Indian Affairs
Senate Hart Building, Room 838
Washington DC, 20001

Dear Chairman Dorgan and Ranking Member Barrasso,

I am writing to express my strong support of Dr. Yvette Roubideaux for the position of Director of Indian Health Services (IHS). I express individual support but also extend support on behalf of the National Council of Urban Indian Health, our 36 member programs and the 150,000 patients that our programs serve annually.

We feel that Dr. Roubideaux not only has the experience and passion to be a dynamic Director, but that she is also deeply innovative at a time where innovation and the ability to think creatively are desperately needed. As health care reform moves forward all American Indians and Alaska Natives, particularly those living in urban centers, need a Director at IHS that is able to fully exploit the opportunities opening at this time. The Indian Health Service must be flexible at this time. Dr. Roubideaux is a person who understands the need to re-imagine not just what the Indian Health Service is currently doing, but what it *could* be doing.

Dr. Roubideaux's publications, research, and—indeed—the entire history of her career speaks to her commitment to Indian health. She has a long history of thinking critically and comprehensively about the health needs of all Indian people and proposing creative, practical solutions to reach those needs.

Her work during the Transition Planning for the Obama Administration was especially encouraging to NCUIH. She reached out to all of the Indian organizations working on health care issues in a respectful, thoughtful manner. We know that Dr. Roubideaux will continue to work with all stakeholders in a considerate fashion that not only respect tribal sovereignty, but also the trust responsibility to those Indians who live in non-reservation settings.

Dr. Roubideaux has NCUIH's full support and we look forward to working with her in building healthier Native communities. We also would like to thank acting IHS Director, Robert McSwain, for his leadership through this time of transition.

Sincerely,

Geoffrey Roth
Executive Director

Senator Bryan L. Dorgan
Senate Committee on Indian Affairs
838 Hart Senate Office Building
Washington, D.C. 20510

April 5, 2009

Re: Support of nomination of Dr. Yvette Robideaux

Dear Chairman Dorgan and Honorable Committee Members:

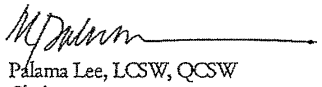
On behalf of the American Indian, Alaska Native, Native Hawaiian Caucus of the American Public Health Association, we support the nomination of Dr. Yvette Robideaux as Director of the Indian Health Services (IHS) of the Department of Health and Human Services.

Dr. Robideaux has extensive experience in tribal health. As a Rosebud Sioux tribal member, Dr. Robideaux understands the unique cultural needs within healthcare. Dr. Robideaux often recalls her childhood memories as a recipient of IHS services and the long waits to see a physician, and how all physicians were non-Indian. These memories have left lifelong impressions upon her. As a physician who has worked for IHS, educational institutions, and other community-based settings, she has a comprehensive and systemic understanding of healthcare and the inherent challenges within IHS. We believe she is position well to address these issues while closing the gap in health disparities experienced by American Indians.

The American Public Health Association is the oldest, largest, and most diverse public health organization in the world. Dr. Robideaux has contributed significantly to the American Public Health Association and we expect her contributions to continue, especially in the areas of Indian and Native health.

In closing, the American Indian, Alaska Native, Native Hawaiian Caucus of the American Public Health Association strongly encourages your support of Dr. Yvette Robideaux as Director of the Indian Health Services.

Sincerely,



Palama Lee, LCSW, QCSW
Chair,
American Indian, Alaska Native, Native Hawaiian Caucus
American Public Health Association

ASSOCIATION OF AMERICAN INDIAN PHYSICIANS
1225 Sovereign Row, Suite 103
Oklahoma City, OK 73108

EXECUTIVE BOARD
Gerald Hill, M.D. *(Klamath/Paiute)*
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Member at Large
LeeAnna Muzquiz, M.D. *(Salish / Kootenai)*
Member at Large

ASSOCIATION OF AMERICAN INDIAN PHYSICIANS, INC
BOARD RESOLUTION

WHEREAS the Association of American Indian Physicians (AAIP) was founded in 1971 by American Indian physicians to support efforts to improve health status and conditions of American Indian and Alaska Native people and;

WHEREAS the AAIP membership is made up exclusively of American Indian and Alaska Native physicians who are licensed to practice medicine in the United States and whose mission is to pursue excellence in Native American health care by promoting education in the medical disciplines, honoring traditional healing principles and restoring the balance of mind, body and spirit, and;

WHEREAS the American Indian and Alaska Natives continue to experience unacceptable health disparities such as death rates that are 1.5 times that of the US population and over twice as high for age groups 1 to 4 and 15 through 54. Death due to diabetes is 3.9 times higher than US all races; 3 times higher from injury and poisonings; and 20% higher from heart disease and;

WHEREAS behavioral health is a critical need in American Indian and Alaska Natives communities; suicide is 91% higher; homicide related deaths are 80% higher; alcohol and drug related deaths is 7 times higher than US all races and;

WHEREAS the Indian Health Service needs to continue to be the leading health care provider for American Indians and Alaska Natives and demonstrate leadership in the provision of quality health care and;

WHEREAS DR. YVETTE ROUBIDEAUX, an enrolled member of the Rosebud Sioux Tribe, has the academic qualifications, demonstrated experience, leadership skills, and administrative capabilities to meet the challenges confronting the health status and conditions of American Indians and Alaska Natives as outlined above, and

WHEREAS, DR. YVETTE ROUBIDEAUX has served her peers with honor and distinction, is a leading force in the fight against diabetes in Indian Country through her work with the National Diabetes Education Program, and was recognized by the AAIP as the "Physician of the Year" in 2004, served as President of AAIP in 1999-2000, is an active member of AAIP and has received many national honors.

NOW THEREFORE BE IT RESOLVED that the Association of American Indian Physicians' Board of Directors do hereby respectfully support and fully endorse DR. YVETTE ROUBIDEAUX as the Director of the Indian Health Service.

Gerald Hill MD

Gerald Hill, M.D., President
Board of Directors
AAIP

CERTIFICATION

I hereby certify that the above Board Resolution was duly enacted on the 15th day of April 2009 during a meeting of the AAIP Board of Directors in which a quorum was present.

Phillip Smith, MD

Phillip Smith, M.D., Secretary
Board of Director
AAIP

American
Public Health
Association

800 I Street, N.W. • Washington, DC 20001-3710

Protect, Prevent, Live Well

April 17, 2009

The Honorable Byron Dorgan
Chairman
U.S. Senate Committee on Indian Affairs
838 Hart Senate Office Building
Washington, DC 20510

The Honorable John Barrasso
Vice Chair
U.S. Senate Committee on Indian Affairs
307 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Dorgan and Senator Barrasso:

On behalf of the American Public Health Association (APHA), the oldest and most diverse organization of public health professionals and advocates in the world dedicated to promoting and protecting the health of the public and our communities, I write in support of Dr. Yvette Roubideaux's nomination to Director of the Indian Health Service (IHS) within the U.S. Department of Health and Human Services. Dr. Roubideaux is a long-standing member of APHA and has dedicated her career to improving the health of American Indians and Alaskan Natives.

As a member of the American Indian community, a physician, public health professional and academician, Dr. Roubideaux is uniquely qualified to provide IHS the necessary leadership to improve the health and wellbeing of the approximately 1.9 million American Indians and Alaskan Natives the IHS serves among more than 562 federally recognized tribes in 35 states. Throughout her distinguished career, Dr. Roubideaux has demonstrated her commitment to improving the health of this especially vulnerable population and to eliminating disparities in health status and health services that result in a lower life expectancy, higher infant mortality rate and a disproportionate disease burden.

APHA has a long history of supporting and advocating on behalf of the public health needs of American Indians and Alaskan Natives. We look forward to working with the Committee and the Administration to increase and enhance the health services and facilities of IHS programs and to eliminate the long-standing health disparities experienced by American Indians and Alaskan Natives. Please feel free to contact me if you have any questions regarding our support for Dr. Roubideaux's nomination.

Sincerely,

Georges C. Benjamin, MD, FACP, FACEP (Emeritus)
Executive Director

April 22, 2009

To: Allison Binney
Committee on Indian Affairs
United States Senate
838 Hart Office Building
Washington, DC 20510

Fr: Bijiibaa' Garrison
Association of Native American Medical Students and
The Indians Into Medicine Program at the University of Arizona
University of Arizona College of Medicine
Tucson, Arizona

Re: President Obama Nomination for Department of Health & Human Services, Indian Health Service Director: Yvette Roubideaux, MD/MPH

Dear Allison Binney:

It is with tremendous excitement and honor that we, the University of Arizona Association of Native American Medical Students, support President Barrack Obama's nomination of Yvette Roubideaux MD/MPH as Director of the Indian Health Service, Department of Health and Human Services. Dr. Roubideaux is a role model to American Indian medical students both professionally and personally.

Dr. Roubideaux pioneered the University of Arizona's Indians Into Medicine (INMED) Program. The INMED Program is a statewide collaboration between the University of Arizona and Intertribal Council of Arizona that has expanded opportunities for aspiring American Indian healthcare professionals.

- INMED targets high school, college, and graduate students whom seek careers in medicine, dentistry, pharmacy, public health, nursing careers, physical therapy and other allied health positions.
- INMED funds students for travel to present scientific research at national conferences, such as the Association of American Indian Physicians.
- INMED networks with local and national programs to withhold American Indian students accountable for maintenance of traditional values and cultural while proceeding professionally.
- INMED provides workshops which further develop professionalism to students in presentation, approach and awareness of clinical and policy research.
- As one student stated, "INMED provided a home-away-from-home as [we] were challenged with the rigors of balancing academics, cultural identity, and homesickness while working towards a professional health degree." – Bijiibaa' Garrison, Harvard Medical School

Dr. Roubideaux also challenges her students on an individual basis. Students mentored by Dr. Roubideaux are currently pursuing degrees that include: Doctorate of Medicine (both allopathic

and osteopathic), Masters in Public Health/Health Policy, and physiological graduate studies.

- She encourages students to network with programs like the Kaiser Family Foundation in Washington, DC. Dr. Roubideaux is a mentor for the Barbara Jordan Health Policy Scholars Program, which is a Congressional Summer Internship in Washington, DC whose mission is to eliminate health disparities through legislative affairs. A number of University of Arizona graduates, with the support of Dr. Roubideaux, have participated in this program.
- She encourages students to apply to post-graduate fellowships in biomedical research. An increasing number of students, through Dr. Roubideaux's recommendation, have participated in the National Institutes of Health Academy Program in Bethesda, Maryland. The NIH Academy mission is to eliminate health disparities through clinical research.

As American Indian medical students, with respect to American Indian healthcare, we believe there are challenges that have been surpassed by our mentors, yet many challenges remain in our future. The mentoring of Dr. Roubideaux has provided students insight to the biomedical, clinical, and political future of American Indian Health.

The mission of the Indian Health Service is "to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level." As both tribal members of the American Indian/Alaskan Native communities and future physicians of the Indian Health Service, we feel Dr. Yvette Roubideaux is an ideal nomination for the next Indian Health Service Director.

Sincerely,

Bijiibaa' Garrison
Harvard Medical School, Class of 2011

Association of Native American Medical Students
The University of Arizona College of Medicine
Tucson, Arizona

ROSEBUD SIOUX TRIBE
RESOLUTION NO. 2009-81

WHEREAS, the Rosebud Sioux Tribe is a federally recognized Indian Tribe organized pursuant to the Indian Reorganization Act of 1934 and all pertinent amendments thereof; and

WHEREAS, the Rosebud Sioux Tribe is governed by a Tribal Council made up of elected representatives who act in accordance with the powers granted to it by its Constitution and By-Laws; and

WHEREAS, the Rosebud Sioux Tribe is authorized to promulgate and enforce ordinances for the maintenance of law and order, and to safeguard the peace and morals, and general welfare of the Tribe, pursuant to the Rosebud Sioux Tribal Constitution and bylaws Article IV Section 1 (k) and (m); and

WHEREAS, Yvette Roubideaux, M.D., a member of the Rosebud Sioux tribe, is an assistant professor in both the College of Public Health and College of Medicine at the University of Arizona in Tucson. Whose commitment for her people, is demonstrated by dedicating her career to improving American Indian health care through teaching and research, focusing on diabetes as a pervasive chronic disease, has been nominated by President Obama's as the Director of Indian Health Service, Department of Health and Human Services and will appear before the United States Senate for a confirmation hearing; and

WHEREAS, Yvette Roubideaux, M.D., co-edited a book on Indian health policy with Mim Dixon, Ph.D., entitled *Promises to Keep: Public Health Policy for American Indians and Alaska Natives in the 21st Century* in 2001, and she completed her M.D. at Harvard Medical School in 1989 and received her M.P.H. at Harvard School of Public Health in 1997. After completing the Commonwealth Fund/Harvard University Fellowship in Minority Health Policy, she decided to shift her career in the direction of teaching, research, and service related to Indian health issues and Indian health program development. Dr. Roubideaux also completed a faculty development fellowship at the Native American Center of Excellence, the University of Washington School of Medicine in 1998; and

WHEREAS, Yvette Roubideaux, M.D., has worked on a number of national committees related to diabetes, including the National Diabetes Education Program Steering Committee, and American Indian Campaign, and the Awakening the Spirit Team for the American Diabetes Association. She has also worked with tribal leaders on a number of initiatives, including the Tribal Leader Diabetes Committee Technical Workgroup and the Blue Ribbon Panel for Navajo Health Care. In 1999-2000 she was president of the Association of American Indian Physicians.

WHEREAS, Yvette Roubideaux, M.D., is a consultant and medical epidemiologist for the Division of Diabetes Translation at the Centers for Disease Control and Prevention, and for the Indian Health Service National Diabetes Program. She is also a consultant to the Henry J. Kaiser Native American Health Policy Fellowship Program and is a faculty mentor and former participant in the University of Colorado native Elder Resource Center Native Investigator Program.

WHEREAS, Dr. Roubideaux has provided testimony on the Indian Health Care Improvement Act reauthorization for the Senate Committee on Indian Affairs, and in 2000 advised the Centers for Disease Control and Prevention on health funding priorities for its first meeting of American Indian Governments and Organizations Budget Planning and Priorities. She was a consultant to the National Indian Health Board and was an author of the national survey of tribes, "Tribal Perspectives on Indian Self-Determination and Self-Governance in Health Care Management" and is a member of the Department of Health and Human Services Secretary's Advisory Committee on Minority Health.

WHEREAS, Dr. Yvette Roubideaux, as an enrolled member of the Rosebud Sioux Tribe, has given inspiration, hope and an exemplary example of a roll model to the children of the Rosebud Sioux tribe, and we the people of the Rosebud Sioux Tribe have the honor to support Dr. Yvette Roubideaux, in her nomination as the Director of Indian Health Service, Department of Health and Human Services, and strongly supports her appointment as the next as the Director of Indian Health Service, Department of Health and Human Services.

THEREFORE BE IT RESOLVED, the Rosebud Sioux Tribe respectfully requests the Honorable United States Senators Tim Johnson and John Thune recommend and support Dr. Yvette Roubideaux's conformation to their fellow United States Senators and vote affirmatively to confirm her nomination as the next Director of Indian Health Service, Department of Health and Human Services.

Darrell Herman — District 1 3-26-09 Date

Steve DeNoyer, Jr. — District 2 3-26-09 Date

Robert D. Moore — District 3 3-26-09 Date

Shawn Bordeaux — District 3 3-26-09 Date

Trent Poignee	District 3 3-30-09 Date
Scott Herman	District 3 3-26-09 Date
Norman Running, Sr.	District 4 3-28-09 Date
James Henry, Sr.	District 5 Date
Michael Boltz	District 5 3/26/09 Date
Michael J. Valandra	District 5 3-27-09 Date
Donna Hollow Horn Bear	District 6 3-30-09 Date
Claudette Arcoren	District 7 Date
Anthony Castaway	District 8 Date
Robert Shot	District 9 3-16-09 Date
Stephanie Sully	District 10 3-26-09 Date
William Long, III	District 10 3-26-09 Date
Lenard Wright	District 10 3-30-09 Date
Russell Eagle Bear	District 11 Date

_____ District 12_____
Lewis Good Voice Eagle Date

_____ District 13_____
Byron Andrews Date

CERTIFICATION

This is to certify that the above petition Resolution No. 2009-81 was duly circulated and signed by members of the Rosebud Sioux Tribal Council. Said petition was duly passed, as signed by a majority of the Rosebud Sioux Tribal Council.

ATTEST:

for Gerri Night Pipe, Secretary
Rosebud Sioux Tribe

Rodney M. Bordeaux, President
Rosebud Sioux Tribe

Quinault Indian Nation

POST OFFICE BOX 189 □ TAHOLAH, WASHINGTON 98587 □ TELEPHONE (206) 276-8211

April 20, 2009

The Honorable Byron Dorgan, Chairman
Senate Committee on Indian Affairs
838 Hart Senate Office Building
Washington, DC 20510

The Honorable John Barrasso, Vice-Chairman
Senate Committee on Indian Affairs
838 Hart Senate Office Building
Washington, DC 20510

Re: SCIA Nomination Hearing for Dr. Yvette Roubideaux, Indian Health Service

Dear Chairman Dorgan and Vice-Chairman Barrasso:

The Quinault Indian Nation (QIN) supports the Presidential nomination of Yvette Roubideaux, M.D., M.P.H., to serve as the Director of the Indian Health Service (IHS). As an IHS Self-Governance Tribe, the QIN compliments Dr. Roubideaux on her forthcoming term as the Director and looks forward to working with her to support issues that are of great concern not only to Self-Governance Tribes, but to the overall health care system and delivery of services to all of Indian Country.

Dr. Roubideaux has been instrumental in fostering programs to help teach and research on Indian health issues, with focus on the quality of diabetes and Indian health policies. Her medical background and firsthand knowledge of the struggle Native Americans face in Indian Country is invaluable and we will be honored to support her on her journey as the Director of the Indian Health Service.

On behalf of the Quinault Indian Nation, thank you for this opportunity to participate in this process.

Sincerely,

Fawn Sharp

Fawn Sharp, President
Quinault Indian Nation

cc: Senate Committee on Indian Affairs

Choctaw Nation of Oklahoma

P.O. Box 1210 • Durant, OK 74702-1210

Gregory E. Pyle
Chief

Gary Batton
Assistant Chief

April 21, 2009

The Honorable Byron Dorgan, Chairman
Senate Committee on Indian Affairs
838 Hart Senate Office Building
Washington, DC 20510

The Honorable John Barrasso, Vice-Chairman
Senate Committée on Indian Affairs
838 Hart Senate Office Building
Washington, DC 20510

Re: Dr. Yvette Roubideaux, Nominee for Director of the Indian Health Service

Dear Chairman Dorgan and Vice-Chairman Barrasso:

The Choctaw Nation of Oklahoma is proud to support the Administration's nomination of Yvette Roubideaux, M.D., M. P.H., as the Director of the Indian Health Service (IHS). We are confident that her nomination as the Director of IHS will pave the way for greater career advancement for Dr. Roubideax.

The Choctaw Nation has designed and implemented a health care network that exceeds most in a rural setting, but many Tribes have not been so fortunate. We all have needs, some are greater than others. There is a funding shortfall disparity thourghout Indian Country to build and repair facilities, to adequately fund contract health services that are available at Tribal or IHS facilities to Tribal beneficiaries. Worse of all is the lack of due diligence by the Administration and Congress to fully fund contract support costs for programs, services, functions and activities contracted or compacted by Tribes.

We ask the Senate Committee on Indian Affairs to support Dr. Roubideaux in this quest as the first female Director of the IHS. We ask that you and your fellow colleagues use every means available to remain stellar in supporting her work to remove the funding health disparities that no longer register on the chart of equity, parity and fair. If we can count on you to stand with her than we can certainly guarantee you that we will stand with you to champion your work.

I hope that this message will resonate throughout the Chamber during the confirmation proceedings. Thank you for allowing the Choctaw Nation of Oklahoma to share these comments with you.

Sincerely,

Chief Gregory E. Pyle

cc: Senate Committee on Indian Affairs

April 20, 2009

The Honorable Byron Dorgan, Chairman
Senate Committee on Indian Affairs
838 Hart Senate Office Building
Washington, DC 20510

The Honorable John Barrasso, Vice-Chairman
Senate Committee on Indian Affairs
838 Hart Senate Office Building
Washington, DC 20510

Re: SCIA Nomination Hearing for Dr. Yvette Roubideaux, Indian Health Service

Dear Chairman Dorgan and Vice-Chairman Barrasso:

I am writing on behalf of the Lummi Nation to inform you that we support the nomination of Dr. Yvette Roubideaux as the Director of the Indian Health Service (IHS).

The Lummi Nation and most other Tribes have suffered from the lack of adequate Indian Health Care appropriations. Almost all of the discretionary income available to the Lummi Nation membership is consumed by the rising health care needs and costs of our members. IHS appropriations have not kept pace with population growth, medical inflation and certainly not with the treaty based obligation of the United States to provide for the health care needs of the Lummi Nation membership.

The Indian Health Care Improvement Act legislation has languished in Congress for more than a decade of needless wrangling. Senators Dorgan, McCain and Inouye, as well as other distinguished members of the Committee, have looked at the Department as a block to legislative initiatives supported by the Tribes. We ask that Dr. Roubideaux continue to champion the IHCIA and find mechanisms to help fund and fully support the health needs of Tribes.

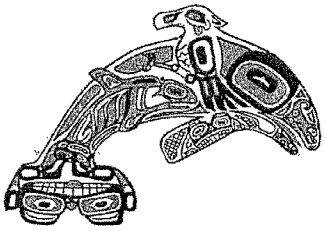
Dr. Yvette Roubideaux would truly be an asset in this position. We ask that the Senate Committee on Indian Affairs expedite the nomination and confirmation process.

Hy'shqe Siam.

Sincerely,

Henry Cagey, Chairman
Lummi Nation

cc: Senate Committee on Indian Affairs



SQUAXIN ISLAND TRIBE

April 21, 2009

The Honorable Byron Dorgan, Chairman
Senate Committee on Indian Affairs
838 Hart Senate Office Building
Washington, DC 20510

The Honorable John Barrasso, Vice-Chairman
Senate Committee on Indian Affairs
838 Hart Senate Office Building
Washington, DC 20510

Re: Dr. Yvette Roubideaux, Nominee for Director of the Indian Health Service

Dear Chairman Dorgan and Vice-Chairman Barrasso:

The Squaxin Island Tribe encourages the Senate Committee on Indian Affairs to expedite the nomination process of Dr. Yvette Roubideaux as the Director of the Indian Health Service. Dr. Roubideaux would truly be an asset in this position given her extensive background in management and business administration.

Dr. Roubideaux has exhibited leadership qualities by working on a number of national committees related to Indian Health issues, in addition to having the work experience as President of the Association of American Indian Physicians, that will certainly compliment and qualify her for the job requirements of this position.

We look forward to working with her in addressing the health issues and needs in Indian Country. Dr. Roubideaux personifies the type of Administrative representative who strives to put forth what it takes to yield positive results. Most importantly, Dr. Roubideaux is committed to bringing improvements to the Indian health care system in a manner that recognizes and upholds the sovereign status of American Indian and Alaska Native tribal governments.

Thank you for considering this letter of recommendation.

Sincerely,

Dave Lopeman

Dave Lopeman, Chairman
Squaxin Island Tribe

cc: Senate Committee on Indian Affairs

LOWER ELWHA KLALLAM TRIBE

ʔəʔɬx̌ʷə nəxʷsƛ̓ay̓əm "Strong People"

2851 Lower Elwha Road
Port Angeles WA 98363

April 21, 2009

The Honorable Byron Dorgan, Chairman
United States Senate
Senate Committee on Indian Affairs
838 Hart Senate Office Building
Washington, DC 20510
ATTN: Erin Bailey, Health Fellow

The Honorable John Barrasso, Vice-Chairman
United States Senate
Senate Committee on Indian Affairs
838 Hart Senate Office Building
Washington, DC 20510
ATTN: Rhonda Harjo, Deputy Chief Counsel

Dear Chairman Dorgan and Vice-Chairman Barrasso:

The Lower Elwha Klallam Tribe supports the nomination of Dr. Yvette Roubideaux for Director of the Indian Health Service in the Department of Health and Human Services. Dr. Roubideaux has been a strong advocate to improve the quality of the health care delivery system in Indian Country throughout her career. With a background in business and administration, and her continued involvement in the health issues most affecting Native people, she is qualified to be at the helm of the agency with the responsibility for Indian Health.

We hope that the confirmation of Dr. Roubideaux will generate more visibility and widespread support to pass the Indian Health Care Improvement Act.

As a member of President Obama's Transition Team, Dr. Roubideaux has expanded her reach to all Tribes to listen to our concerns and become engaged in an all too familiar topic about our struggle to provide adequate health care to our Tribal members.

We applaud the Administration for this choice and we encourage the Senate Committee to expedite the confirmation process.

Sincerely,

Frances Charles

Frances Charles
Tribal Chairwoman

Cc: Senate Committee on Indian Affairs

1033 Old Blyn Highway, Sequim, WA 98382

April 21, 2009

The Honorable Byron Dorgan, Chairman
United States Senate
Senate Committee on Indian Affairs
838 Hart Senate Office Building
Washington, DC 20510
ATTN: Erin Bailey, Health Fellow

The Honorable John Barrasso, Vice-Chairman
United States Senate
Senate Committee on Indian Affairs
838 Hart Senate Office Building
Washington, DC 20510
ATTN: Rhonda Harjo, Deputy Chief Counsel

Dear Chairman Dorgan and Vice-Chairman Barrasso:

The Jamestown S'Klallam Tribe has been an active advocate in the campaign for improved health care delivery to Native people. As a first tier Self-Governance Tribe, we have been involved on the policy, program and legislative levels of the health agenda of Tribes for nearly 30 years. I am the Chairman for the Department of the Interior Self-Governance Advisory Committee and the Primary Representative from Portland for the Indian Health Service Tribal Self-Governance Advisory Committee representing approximately 330 Federally-recognized Tribes. I offer the support of the Self-Governance Tribes to assist Dr. Roubideaux, if confirmed, as the new Director and first female of this agency, as she addresses the many challenges that confront Indian Health in the new Obama Administration.

In addition, on behalf of Jamestown, I will work with Dr. Roubideaux, this Committee and the Secretary of the Department of Health and Human Services to develop a long and short-term plan to eliminate the funding disparities that exist for Indian health and to work on the long-overdue Indian Health Care Improvement Act.

I encourage the Senate Committee on Indian Affairs to expedite this confirmation process so that we can begin the work at hand.

Sincerely,

W. Ron Allen

W. Ron Allen
Tribal Chairman/CEO, Jamestown S'Klallam Tribe

Cc: Senate Committee on Indian Affairs

SHOALWATER BAY INDIAN TRIBE
P.O. Box 130 • Tokeland, Washington 98590

April 21, 2009

The Honorable Byron Dorgan, Chairman
United States Senate
Senate Committee on Indian Affairs
838 Hart Senate Office Building
Washington, DC 20510
ATTN: Erin Bailey, Health Fellow

The Honorable John Barrasso, Vice-Chairman
United States Senate
Senate Committee on Indian Affairs
838 Hart Senate Office Building
Washington, DC 20510
ATTN: Rhonda Harjo, Deputy Chief Counsel

Dear Chairman Dorgan and Vice-Chairman Barrasso:

I have had the pleasure of working with Dr. Yvette Roubideaux on various workgroups for more than a decade and on behalf of the Shoalwater Bay Indian Tribe I applaud her nomination as the next Director of the Indian Health Service (IHS).

Dr. Roubideaux, in addition to being the first woman Director of the IHS, will eliminate barriers, both funding and service delivery as compared to the quality of care enjoyed by other citizens of this country, in a new agenda that is aligned with the President's directives on collaboration, unity and outreach that was embraced during his campaign, which was so brilliantly executed. As a member of the Obama Team we are optimistic that Dr. Roubideaux will work to address the lack of adequate funding that has hindered the quality of services provided to American Indian and Alaska Native people.

I offer our support for this nomination.

Sincerely,

Charlene Nelson
Tribal Chairwoman

Cc: Senate Committee on Indian Affairs

GWY.9 DBP
CHEROKEE NATION™
P.O. Box 948 • Tahlequah, OK 74465-0948

ᎠᏂᏏᏳᏍᏗ
Chad "Corntassel" Smith
Principal Chief

ᏗᏓᏍᏚ ᏗᏥᏍᏚ
Joe Grayson, Jr.
Deputy Principal Chief

April 21, 2009

Senator Byron Dorgan, Chairman
U.S. Senate Committee on Indian Affairs
838 Hart Office Building
Washington, DC 20510

Senator John Barrasso, Vice-Chairman
U.S. Senate Committee on Indian Affairs
838 Hart Office Building
Washington, DC 20510

Dear Chairman Dorgan and Vice-Chairman Barrasso:

On behalf of the Cherokee Nation, please accept this correspondence in support of the confirmation of Dr. Yvette Roubideaux, M.D., MPH, as Director of the Indian Health Service. Dr. Roubideaux, a member of the Rosebud Sioux Tribe, has a long and distinguished career in Indian health care that has prepared her to direct the agency responsible for administering health services to over 1.8 million American Indians and Alaska Natives throughout the United States.

Dr. Roubideaux currently serves as the Co-Director of the Coordinating Center for the Special Diabetes Program for Indians Competitive Demonstration Projects. Her efforts with the Special Diabetes Program for Indians have had a profound impact on the health and well being of countless Native Americans afflicted with Diabetes. Dr. Roubideaux has contributed further to Indian Country as the Director of the University of Arizona-Inter Tribal Council of Arizona's programs: Indians into Medicine (INMED) and Student Development Core of the American Indian Research Center for Health. Her efforts with these programs have invariably increased attraction and career retention of Native Americans and Alaska Natives into the health and research professions.

Dr. Roubideaux has demonstrated an exceptional level of commitment to improving the quality of care and efficiency of service throughout the Indian health care system. Her collective experience has amply prepared her to undertake the responsibility of the office and to serve as the first Native Woman Director of Indian Health Service.

The Cherokee Nation is supportive and stands ready to assist to ensure an expedient confirmation process for Dr. Roubideaux as Director of Indian Health Service. Should you require additional information, please contact Paula Ragsdale at the Cherokee Nation Washington Office at (202) 393-7007, or by e-mail at paula-ragsdale@cherokee.org.

Sincerely,

Chad Smith
Principal Chief
Cherokee Nation

UNITED SOUTH AND EASTERN TRIBES, INC.
711 Stewarts Ferry Pike • Suite 100 • Nashville, TN 37214

April 23, 2009

Honorable Byron Dorgan
Chairman
Senate Committee on Indian Affairs
Hart Senate Office Building, RM 838
Washington, DC 20510

RE: Support for Nomination of Dr. Yvette Roubideaux

Dear Senator Dorgan:

The United South and Eastern Tribes, Inc. (USET) is a non-profit inter-tribal organization representing twenty-five (25) federally recognized Tribal Governments. I write to you today conveying our support for the nomination of Dr. Yvette Roubideaux for Director of the Indian Health Service.

Dr. Roubideaux has been a commendable advocate for American Indian/Alaska Native people and their healthcare needs for a number of years. With her familiarity and background with the Indian Health Service, having served as Medical Officer and Clinical Director with the San Carlos Indian Hospital in San Carlos, Arizona, as well as the Hu Hu Kam Memorial Hospital on the Gila River reservation in Sacaton, Arizona, USET believes she will be a great asset to the Indian Health Service.

On behalf of USET and its member Tribes I encourage Senate confirmation of Dr. Roubideaux for Director of the Indian Health Service. Please contact myself or Mr. Michael Cook, Executive Director should you have questions at (615) 872-8700.

Sincerely,

Brian Patterson
USET President

Cc: Tribal Health Directors
Michael Cook, Executive Director
Byron Jasper, Deputy Director of Public Health
Dee Sabattus, Health Policy Analyst
File

"Because there is strength in Unity"

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