



Indian Health Service
Association of American Indian Physicians Annual Meeting
August 2, 2013

Indian Health Service Update

by

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Good morning. I am Dr. Yvette Roubideaux, Acting Director of the Indian Health Service (IHS). It is great to be here with you today at the Association of American Indian Physicians (AAIP) Annual Conference. Thank you to Dr. Stern and the AAIP Board for the invitation to speak today. Congratulations to Margaret Knight for 25 years with AAIP!

Today I will provide an update on what we are doing to change and improve the IHS. But first let me say how much we need and deeply appreciate all the talented, committed American Indian and Alaska Native health professionals who are a part of our agency. We especially welcome your valuable support and unique contributions as we work together to improve the health status of American Indian and Alaska Native people.

The last time I was at an AAIP event was at the National Native American Youth Initiative meeting in Washington, D.C., this past June. It was so great to see all the young students interested in health professions! Congratulations to AAIP for a wonderful program for students.

We have so many American Indian and Alaska Native physicians and health professionals working in IHS; for instance, Dr. Susan Karol, who is our IHS Chief Medical Officer (CMO). She was instrumental in the signing of an IHS/Dartmouth Partnership Memorandum of Understanding last November. This new partnership allows Dartmouth, Dartmouth-Hitchcock Medical Center, and the IHS to pursue common goals, including developing leaders in the Native American community. And many of you probably know Dr. Charlene Avery, the Director of the IHS Office of Clinical and Prevention Services. She is doing a great job helping us make improvements. You may also know Dr. Lyle Ignace, the Director of the Improving Patient Care Initiative at Headquarters. I will tell you some more about this important initiative later in my presentation. And you know Dr. Dawn Wyllie, CMO of the IHS Bemidji Area, who is now Admiral Wyllie. She is one of three Flag Promotions we had for IHS Officers this past year.

One of the great parts of my job is seeing American Indian and Alaska Native physicians and health professionals making their contributions to improving the Indian health system. I am so glad to have American Indian physicians in leadership positions to help us improve care for the patients we serve.

And of course, there are many notable Indian health physicians and professionals who served in the IHS in the past, such as Dr. Everett Rhoades, who founded the AAIP in 1971 and was also the first Native Director of the IHS. I recently presented him with the Carol Anne Heart Spirit Award at the 10th Annual Direct Service Tribes Conference.

I know that there are some present and future leaders in this room as well today. It is quite likely that someone in this room will be the Director of the IHS someday.

I want to start with an update on the IHS budget, which is a huge factor in our ability to improve the IHS and address health disparities in Indian Country. I know many of you are concerned about the IHS budget. It is clear that a lack of adequate resources is a huge barrier to fully meeting the mission of the IHS. Many of the challenges and issues we struggle with at the IHS relate to the lack of resources. So advocating for more funding has been a top priority of mine. And fortunately, IHS is a top priority of President Obama and Department of Health and Human Services (HHS) Secretary Kathleen Sebelius.

It seemed like we were on a roll prior to this year. We've received increases in the IHS budget each of the last 4 years. Overall, the IHS budget authority has increased 29% since fiscal year (FY) 2008. Within this increase, there have been some significant targeted increases; for example, the 46% increase in Contract Health Service (CHS) funding has made a difference. More funding means more patients are getting the referrals they need. In fact, at some facilities, patients are having referrals paid for beyond Priority 1 – life or limb.

For example, this increase in funds, along with concentrated efforts to improve the CHS program, has resulted in an increase in orthopedic care for patients in the IHS Shawnee Service Unit. In 2011, the deferred referrals for orthopedic care were more than the approved referrals. However, with the increased CHS funding in FY 2012, the number of CHS referrals increased, and the approved orthopedic referrals were much higher. The Service Unit did not have to defer even one major orthopedic referral, and only had to defer 50 low-priority orthopedic medical referrals. This is contrast to a previous year deferral rate of 64 major and 211 minor orthopedic referrals. So the funding increases are making a difference, but we know we have more to do as the need continues.

However, the FY 2013 budget is a different story. We're working on implementing the IHS FY 2013 final budget authority of \$4.1 billion, which is lower than the FY 2012 budget of \$4.3 billion. The FY 2013 budget does include an increase of \$53 million for additional staffing for new health care facilities that have been constructed, which is great.

But it also includes rescission cuts of \$8 million and sequester cuts of \$220 million. IHS is engaged in extensive implementation efforts to absorb the cuts associated with sequestration on the federal side. However, the impact is significant – reduced services, denied referrals, and a significant change in the way we are doing business to protect the IHS mission. We have already implemented a number of cost-saving changes to the way we carry out our work, including many reductions in administrative functions such as travel reductions, new restrictions on conferences, delayed or reduced purchasing and contracting, hiring delays and lapsing of positions, and enhancing third-party collections.

You may have also heard about the efficiency in spending initiatives that require federal reductions in travel and strict conference approvals and oversight.

We are doing everything we can to protect our agency mission to the greatest extent possible. We have been holding many virtual meetings to help reduce travel and training costs. We're holding meetings with hundreds of participants using webinar technology so that we can continue the important work of the agency.

We're doing everything we can to eliminate the need for sequestration and to get the IHS budget back on track. That's why we are supporting the FY 2014 President's Budget Request,

which was released on April 10. It has enough deficit reduction to replace sequestration entirely, but still protects important priorities such as IHS.

The FY 2014 President's Budget proposed a 2.9% increase in budget authority for the IHS from the FY 2012 enacted level, with a total budget request of \$4.4 billion, which helps get us back to where we need to be – continuing the upward trend of the IHS budget. This adds \$124 million to the IHS appropriation compared to FY 2012, and includes increases for the CHS program, staffing for new facilities, pay costs, and contract support costs for tribal programs.

The next step is that Congress has to pass a budget for FY 2014, but given the budget climate, we are likely to be on a Continuing Resolution starting October 1. I am so grateful that HHS makes the IHS budget a priority.

IHS has a Tribal Budget Formulation process, and that's when Tribes can learn about the budget and propose funding levels. At the annual HHS Tribal Budget and Policy Consultation, the Tribal Budget Formulation Workgroup presents their recommendations for the IHS budget, and has the opportunity to discuss their budget and policy priorities with Secretary Sebelius.

Even with all the uncertainty with the budget, we are committed to continuing our efforts to change and improve the IHS. Now I would like to update you on our progress on our agency priorities. These are what guide improvements throughout the IHS.

Our first priority is to renew and strengthen our partnership with Tribes. The only way we are going to improve the health of our communities is to work in partnership with them. You can provide the best quality of care as a physician, but if the community is not healthy, those efforts will face challenges.

Working to improve tribal consultation is an important part of this priority. We've seen evidence throughout our system that we accomplish more when we work in partnership with our communities. Being both patient-centered and partners with the communities we serve is our goal.

We have done a lot to improve consultation at the national, Area, and local levels. We have held Area listening sessions with all 12 IHS Areas each year since I became Director, either in person or by phone or videoconference. We have also held many tribal delegation meetings, regularly meet with tribal workgroups and advisory groups, and attend tribal meetings and conferences. The input during these meetings helps us focus our efforts on tribal priorities.

President Obama has asked all federal agencies to consult with Tribes. He spoke before an audience of tribal leaders at the last White House Tribal Nations Conference. This week, I attended the inaugural meeting of the White House Council on Native American Affairs, which was recently established by Presidential Executive Order to convene agencies to better collaborate on tribal issues. The meeting was held in the Indian Treaty Room in the Eisenhower Executive Office Building at the White House and included several Cabinet Secretaries, including HHS Secretary Sebelius and Secretary Jewel, who serves as the Chair. This Council will now give attention to tribal priorities at the highest level of government. And health is one of those priorities.

Secretary Sebelius is also committed to helping to improve the IHS. She has signed an updated HHS Tribal Consultation Policy with her Tribal Advisory Committee, which was the first Cabinet-level Tribal Advisory Group.

Tribal consultation is a major activity for IHS because we need to understand the priorities and issues of the communities we serve. National tribal listening sessions are an important forum for mutual understanding and hearing about tribal priorities. Area listening sessions are also an important venue for me to hear about Area and local issues. I also value meeting with the national organizations, such as our recent meetings with the National Indian Health Board.

And I routinely meet with various tribal advisory groups such as the Tribal Self-Governance Advisory Committee (TSGAC), which focuses on Tribes that manage their own health programs under the Indian Self Determination and Educational Assistance Act. Many Tribes have chosen this option, and overall they are doing a great job. I also recently met with the Direct Service Tribes Advisory Committee (DSTAC), which advises the agency on issues related to the facilities that IHS continues to directly manage. I'm glad that the DSTAC and TSGAC leadership are starting to meet together to discuss common issues.

And of course we continue to hold individual Tribal Delegation Meetings, such as the recent one with the Redding Rancheria delegation from California.

We have conducted a number of tribal consultations in the past few years, and we have concluded or made decisions on many of these. I would like to highlight three of them today.

The first is the consultation that began in 2010 on improving the CHS program, which is how we pay for referrals for services in the private sector. We've consulted with Tribes on how to improve the business and process for referrals. We've also made significant progress on gathering better data on CHS denials and deferrals. For FY 2012, the shortfall for CHS was \$973 million – almost a billion dollars of need beyond our funding. That's why CHS is a priority in budget formulation, since this impacts all Tribes.

The CHS workgroup has made some very key recommendations to improve our CHS business practices. More referrals are being made; we are tracking deferred and denied referrals more accurately; and we are working with outside providers to improve the referral and billing process. We appreciate the work of all those who are helping with this important effort.

The second consultation is on Health Care Facility Construction – the total need for new facilities construction is approximately \$7 billion. Those of you work in IHS know the challenges of working in old facilities

The third consultation is on the memorandum of understanding (MOU) between the IHS and the Department of Veterans Affairs (VA) that was signed in 2010, and the recently signed VA-IHS National Reimbursement Agreement. We are making progress in improving coordination of care for veterans eligible for IHS and VA under the MOU and can now bill the VA for direct care services provided to American Indian and Alaska Native veterans. The initial 10 federal sites are now billing the VA, and I understand that several of them have actually received payments! That's more dollars for services for everyone served by the facility.

Our second IHS priority is “to bring reform to the IHS.” This priority has two parts – the first part involves the Affordable Care Act (ACA) and the Indian Health Care Improvement Act (IHCIA). The second part is about internal IHS reform.

The purpose of the ACA is to increase access to quality health coverage for all Americans, including our First Americans. I hope you already know that the benefits of the ACA for American Indians and Alaska Natives are significant. They can benefit from all the reforms, whether they have insurance now, want to purchase affordable insurance through the “Health Insurance Marketplace,” or can take advantage of the Medicaid expansion starting in 2014. Indian elders will benefit from how Medicare is being strengthened with more affordable prescriptions and free preventive services. We know that some states are not choosing to expand Medicaid, but we hope they change their minds soon. The expansion means that more low income adults can get health coverage.

And of course, we are thrilled that the IHCIA, our authorizing legislation, was made permanent by the ACA.

Sometimes Tribes ask me why they should care about the ACA – since they already get their healthcare through IHS. The answer is that while IHS is here to stay and will remain the health care system that our patients can access, the ACA is about options for additional health

coverage. It is another way the government meets its responsibility for health care for American Indians and Alaska Natives.

Right now, about 23% of our patients have private insurance; that means when they come to us for a visit, we can bill their insurance. That means more resources at the local level for services for all our patients.

The same is true for other coverage. About 38% of IHS patients are currently on Medicaid. With the ACA, many more of our patients may be eligible with the Medicaid expansion. Medicare and the VA account for a smaller portion (less than 10 percent) of the health coverage that our patients have, but they also bring in more resources. However, a good proportion – approximately 30% of our patients – have no health coverage other than IHS. This is the group that may benefit the most from the ACA. In fact, we estimated that we could see an additional \$95 million in third-party collections in FY 2014. So making sure our patients understand their choices related to these new benefits is critical.

An important date is coming up soon – October 1, 2013 – that's when enrollment begins for the ACA Health Insurance Marketplaces and the Medicaid Expansion. It is especially important that everyone understand now what new benefits will be available in about 60 days from now.

The key thing that you need to know is that the Health Insurance Marketplaces, whether run by the state or the federal government, will be a way for individuals to purchase more affordable insurance if they are interested and/or don't have employer-sponsored insurance. Or they can enroll in the Medicaid expansion in the Marketplaces. While enrollment starts on October 1, the coverage will start January 1, 2014. So this means starting October 1, our patients will have more choices related to health coverage.

Individuals can apply or enroll through a number of different ways – by phone or mail, online, or in person. They can submit an application to the Marketplace that will determine their eligibility to purchase insurance; whether they qualify for premium tax credits or cost-sharing reductions, so that they don't have to pay copays or deductibles; and if they are eligible for Medicaid.

Since the potential to impact our bottom line is significant, IHS has developed a business planning template to help ensure our facilities have the opportunity to benefit from their patients' increased access to affordable health coverage, as this could mean more resources through third-party collections and more services for everyone we serve. However, we have to plan, because patients may get more coverage and then decide to go elsewhere for their care.

The template covers understanding the local health insurance market and the potential patients who might enroll; assessing the workload for the facility, including the business office and the CHS program; and looking at marketing for staff and patients to ensure they know what to do and that they want to continue to receive their care at the facility.

A copy of the planning template was sent to all IHS Service Units – it's required for federal sites, and recommended for tribal and urban Indian health programs.

We're also planning our 2013 Indian Health Partnerships Conference to be held August 13-15, 2013, where we will have more ACA training.

And we're working with the Qualified Health Plans (QHP) that will offer insurance for purchase in the Health Insurance Marketplaces in 2014; they are establishing networks and should be working with our local sites. The IHS, tribal, and urban Indian health program QHP Addendum is now available to help explain the special authorities for working with these facilities.

We are also working on Contracting Guidance for Service Units when they enter into agreements with QHPs, and we will share this guidance when it's completed.

A major focus over the next few weeks to months is training for our staff and Tribes on the ACA. We are working with HHS and the Center for Consumer Information and Insurance Oversight on training for our staff. In addition, the national tribal organizations are helping us with outreach and awareness training. We also have a number of other resources for training. Our goal is that all staff will be able to respond to questions our patients have about the ACA, or will know where to refer the patients for further information.

Our National Indian Outreach and Education initiative, which includes partners from all IHS Areas, has conducted over 330 ACA training sessions so far, and plan to do many more this year. They are also developing helpful materials on the ACA, including a tribal website – <http://tribalhealthcare.org/>. I encourage you to take a look at some of the helpful tools and information on this site. We appreciate all their help in getting information out to Indian Country on this very important health legislation.

You can also go to <https://www.healthcare.gov/> to learn more about your options related to the ACA. This is where you can go on October 1 to see if you are eligible for the Medicaid expansion, or to compare rates for purchasing health insurance in your state.

For those of you on the technical side, you can go to <http://marketplace.cms.gov/> to get more information on training and resources to help you learn more about the ACA.

And the IHS has developed a slide show, tailored to the American Indian and Alaska Native population, to help with outreach and education efforts in Indian communities. We need all of your help to make sure all American Indians and Alaska Natives know what benefits are going to be available starting in 2014.

We're also working on internal reform efforts in our federal programs. Our internal reform efforts are focused on improving the way we do business and how we lead and manage our staff, with an emphasis on customer service, ethics, professionalism, and performance management.

To improve the way we do business, we're working with HHS and our Area Directors to improve how we manage our budgets and to improve our financial management.

And we're working to make our business practices more consistent and effective throughout the Indian healthcare system. To improve how we lead and manage staff, we're working on specific activities to make the hiring process more efficient and proactive, and less time-consuming. We're using the new HHS supervisory training for our managers, and improving our performance management process to praise top performing employees and to better hold accountable those employees who are not performing well.

We're also working on improvements in pay systems and strategies to improve recruitment and retention. We know that recruitment and retention are a big issue in all of our sites. We're working on specific activities to make the hiring process more efficient and proactive, and less time-consuming.

We're also using the National Health Service Corps to recruit more providers; all our sites are now eligible for National Health Service Corps placement. We currently have approximately 311 full-time providers employed at our Indian health program sites, which is a substantial increase from the 260 providers we had at this time in 2012.

We're working to specifically address the shortage of physicians and health professionals in the Indian health system through mechanisms such as our scholarship and loan repayment programs. We are currently in the process of making loan repayment awards for FY 2013 and have awarded 62 LRP awards so far; 14 of which were awarded to American Indian and Alaska Native physicians.

These recruitment and retention activities are extremely important, given the looming shortage of primary care providers

All these reforms are ongoing and are helping us change and improve the agency's business practices, which is fundamental to our reform efforts. We are constantly working on activities to change and improve the IHS. To ensure continued progress, I meet regularly with our IHS senior leadership team and our Area Directors, who are leading the efforts to improve our business practices and reform the organization.

Our third priority is to improve the quality of and access to care. We have emphasized the importance of customer service, and I am now starting to see and hear about activities to improve customer service throughout the system. Customer service is even more important now that the ACA is going to give our patients more choices. I tell our staff that even if you think you are providing the highest quality of care, patients won't see that if someone treats them poorly in the clinic.

We're also working on a number of initiatives to help improve the quality of care and promote healthy Indian communities. One of the most important of these is our Improving Patient Care (IPC) program.

The IPC is our patient-centered medical home initiative that is designed to improve the coordination of care for patients. This is about making changes that will result in measurable improvements in patient-centered care. The patient-centered medical home is a big focus of the changing health care system in the U.S. So if our sites get recognition as a "medical home," they might be able to get better reimbursements in the future. We plan to expand this initiative throughout the entire IHS system – currently we have 127 sites.

Many of these sites are doing really outstanding work, including reducing waiting times, improving no-show rates, and arranging the system so that patients can see the same providers each time they come to the clinic, which results in better coordination of care.

Many of our programs are seeing results. For example, the Fort Yuma Health Center has implemented ambulatory clinic care teams that have worked to reduce no-show rates from about 20% to 9%; thereby increasing the number of provider-to-patient opportunities. They have also formed patient-centered task teams to improve patient outcomes, including successfully lowering A1C levels in patients identified with very high levels.

Claremore Indian Hospital is also actively involved in the IPC collaborative through their Internal Improvement Team, which is charged with spreading the Indian Health Medical Home concepts throughout all departments of their facility. Their Family Medicine Clinic was the first department of focus. Using IPC-inspired changes, they have improved access to care by reducing appointment availability delays from an average of 140 days to 1.5 days, and decreased no-show rates from an average of 30% to 10% of scheduled appointments. They are also improving continuity of care by establishing Patient Care Teams so patients see the same providers over time.

And the Warm Springs Health and Wellness Center Patient-Centered Primary Care Home has achieved several improvements in health care provision. With the use of the Electronic Health Record and IPC Collaboration, the service unit is able to deliver a more comprehensive and patient-focused care. As a result, the service unit received recognition as a Tier-3 Patient-Centered Primary Care Home with the highest possible rating from the State of Oregon in 2012. Using the electronic health record (EHR) reminder component allows the service unit to track each patient's health screening and maintenance needs. For example, with the implementation of colon cancer screening clinic reminders, the screening rates have increased from 38.3% in 2007 to 81.7% in 2012. Since launching the HIV screening reminder, the service unit has achieved the highest HIV screening rate in the IHS.

And the Wewoka Indian Health Center reports that their implementation of IPC concepts has helped them streamline processes, decrease inefficiencies, maximize productivity, and

increase patient satisfaction. This includes decreasing wait times from over 3½ hours to an average of 67 minutes, and reducing appointment availability delays from an average of 135 days to just one day.

The IHS IPC initiative is making a difference, and we're working to have it implemented in all of our direct care sites and are encouraging our tribal programs to implement it as well.

A few other initiatives are also helping us improve the quality of care. One of the most important of these is the Special Diabetes Program for Indians (SDPI). I noticed there are a couple of presentations on diabetes and the SDPI on the agenda for this meeting. This program has shown that, in partnership with our communities, we can prevent and treat diabetes in Indian country with innovative and culturally appropriate activities. So we're very pleased that this program was recently reauthorized through 2014.

Last September I attended the SDPI Diabetes Prevention and Healthy Heart Initiatives Meeting in Denver, Colorado. I viewed posters from the grant programs that documented their successful prevention activities through photos, activity summaries, and client testimonials. It was very inspiring to see the innovation, enthusiasm, and expertise of our grant program activities.

Our 2011 SDPI Report to Congress clearly shows that the SDPI programs have done an incredible job of implementing activities to prevent and treat diabetes in the communities we serve. And we just published our evaluation of the SDPI Diabetes Prevention Program, which showed that we can reduce new cases of diabetes through prevention activities!

I hope you have seen the dramatic drop in the rate of end stage renal disease (ESRD) in American Indian and Alaska Native people with diabetes when compared to other racial and ethnic groups in the U.S. Between 1995 and 2006, the incident rate of ESRD in American Indian and Alaska Native people with diabetes fell by 28% – a greater decline than for any other racial or ethnic group. Given that the Medicare cost per year for one patient on hemodialysis was \$82,285 in 2009, this reduction in the rate of new cases of ESRD means a decrease in the number of patients who would have required dialysis – translating into millions of dollars in cost savings for IHS, Medicare, and other third-party payers.

All of this occurred while SDPI I has been implemented. While we cannot say this is cause and effect, I believe these efforts are making a difference. But the SDPI needs to be reauthorized by Congress after FY 2014.

We're also focusing on behavioral health issues, which are a top tribal priority. We're making progress on our National Behavioral Health Strategic Plan and our National Suicide Prevention Plan. And the evaluation data from the Methamphetamine and Suicide Prevention and the Domestic Violence Prevention initiatives are very promising.

I recently sent out a letter to tribal leaders about our completed consultation on the FY 2013 funding distribution for both of these initiatives.

We're also working on plans to help address the growing problem of prescription drug abuse through a workgroup in our National Combined Councils.

There are a few other quality initiatives we are working on to address health promotion and disease prevention in Indian communities. The IHS Healthy Weight for Life initiative unifies all our efforts to promote a healthy weight among American Indians and Alaska Natives. And our IHS Baby-Friendly Hospital Initiative, which is our contribution to the First Lady's *Let's Move! In Indian Country* initiative, is promoting breastfeeding to reduce childhood obesity. Congratulations to Rosebud, Pine Ridge, Belcourt, Phoenix Indian Medical Center, and Claremore Service Units for achieving the Baby Friendly national designation!

Another initiative we are participating in is the national Million Hearts Campaign, with its goal of preventing a million heart attacks and strokes over the next 5 years, by focusing on

improvements in “ABCS” – aspirin, blood pressure, cholesterol, and smoking cessation. And the new Partnership for Patients that was launched by HHS will help improve the quality of care by focusing on reducing harm and improving patient safety in our hospitals. And we’re working under an agreement with the Centers for Medicare and Medicaid to establish a new hospital consortium to work on improving quality and meeting accreditation requirements in our hospitals. We plan to establish a system-wide business approach to accreditation.

We’re also implementing Meaningful Use with our electronic health record, and are now receiving incentive payments throughout the system. The IHS was the first federal government health system to develop a certified EHR that met Meaningful Use Stage 1 requirements, such as electronically capturing health information and computerized provider order entry. The IHS is now focused on maintaining and further developing its certified EHR to meet Meaningful Use Stage 2 requirements.

I also wanted to mention our recent trip to the Navajo Nation with HHS Secretary Sebelius. We got to see several tribal health programs, including their behavioral health program that incorporates Native culture and traditions into its services. We also got to visit the Gallup Indian Medical Center, where Traditional Healers work together with the medical providers to promote the health and wellness of our patients. The role of traditional medicine in our system is something that we continue to define, and there are best practices to share in this area.

Congratulations to the Emergency Department at Gallup Indian Medical Center for being the first federal IHS facility to achieve the Level III Trauma Designation.

Our fourth priority is to make all our work transparent, accountable, fair, and inclusive. We’ve worked hard to improve transparency and communication about the work of the agency. This includes working with the media, sending more email messages and letters to tribal leaders, and holding regular internal meetings.

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

Inclusiveness is a part of these priorities because the IHS has to ensure that our decisions consider the impact on all our patients, whether they are served in an IHS, tribal, or urban Indian health facility. One area of interest here is that we are working on our final new urban confer policy. Instead of consultation, the IHCIA authorizes IHS to “confer” with urban Indian organizations.

In terms of accountability, we are seeing that our efforts over the past few years are resulting in improvements. When you look at Government Performance and Results Act trends over the past several years, you can see significant improvements in many of the measures, such as an increase in the percent of mammography screenings, the percent of tobacco cessation intervention received, the percent screened for depression, and the percent screened for colorectal cancer. So the increased funding we have received, along with more accountability and a focus on improving the quality of care, are making a difference. But we know we still have more to do.

We are working to communicate more about our agency reform efforts. We just launched a new IHS website, and I hope you can take some time to go there and learn about all we are doing at the IHS. We actually realized that our website needed to be more customer friendly for our patients, and not just focused on what our staff need. So the first thing you see on the homepage now is how to find health care. You will also see a link there to my Director’s blog.

I use the Director’s Blog on the IHS website to post brief updates on our activities and the latest IHS news at least weekly. This is one of many efforts to be more transparent about what we’re doing as an agency. I regularly post updates to my blog, so this is a good place to find the

latest information on Indian health issues. You can also subscribe for updates and search the blog.

I will close now by just saying once again how I appreciate all your support as we work together to reform and improve the IHS. As American Indian and Alaska Native physicians, you bring a valuable combination of both exceptional professional skills and Native perspective to the challenge of ending health disparities in Indian Country. For those of you who are students, we hope you will serve a part or all of your careers as a health professional in the IHS.

Despite all the challenges we face, I am confident that by working together in partnership, we can ensure a healthier future for all American Indian and Alaska Native people, and ensure that they get the health care that they need and deserve.

Thank you, and I hope you enjoy the rest of the meeting.