



**Indian Health Service  
Direct Service Tribes 10th Annual National Meeting  
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*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 a real pleasure to be here with you today at the Direct Service Tribes 10th Annual National Meeting.

Thank you to the Direct Service Tribes Advisory Committee for your vision for this meeting. And of course thanks to all the IHS staff who have worked hard to make this meeting possible. We have an innovative format – some of you are here in person, and some of you are joining by webinar. This is a first time we have done a combined meeting, so thank you for your patience in case we have a few bumps along the way.

I am grateful that you have joined us, even with the travel and conference restriction, since this is one of our most important meetings of the year. We take our responsibility to provide health care services to our direct service Tribes very seriously. I hope we can have discussions during this meeting on how we can continue to change and improve the IHS.

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 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.

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

The 46% increase in CHS funding has helped many of our service units provide much needed care for our patients that used to be denied or deferred. 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 Shawnee Service Unit. In 2011, the deferred referrals for

*The text is the basis of Dr. Roubideaux's oral remarks at the Direct Service Tribes meeting on July 23, 2013. It should be used with the understanding that some material may have been added or omitted during presentation.*

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 4 major and 211 minor orthopedic referrals. So the funding increases are making a difference, but we know we have more to do.

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. This means IHS has a total of \$228 million in across-the-board budget cuts that are being made in the allocation of funds for the remainder of the fiscal year.

IHS is engaged in extensive implementation efforts to absorb the cuts associated with sequestration on the federal side. I know we are all doing what we can to protect our core mission to the greatest extent possible.

IHS posted its operating plan for how the across-the-board cuts impact the budget and each line item. 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 have been holding many virtual meetings to help reduce travel and training costs. We're noticing that by holding conferences virtually, more Tribes and individuals can participate who otherwise were not able to travel, especially given the travel restrictions. So we are actually reaching more people while we are reducing costs.

We are 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 of approximately:

- \$35 million for the CHS program, which is under proposal to be called the Purchased/Referred Care program;
- \$77.3 million for staffing at new and replacement facilities, which we believe will help us catch up on almost all the new staffing needs in FY 2014;
- \$6 million for pay increases for federal and tribal staff; and
- \$5.8 million to partially address the shortfall in Contract Support Costs.

If the proposed budget is enacted, the IHS discretionary budget will have increased 32% since FY 2008. I am so grateful that the Department of Health and Human Services (HHS) makes the IHS budget a priority.

In preparation for the FY 2015 budget, we held our FY 2015 national Tribal Budget Work Session in February, and the tribal workgroup presented their national recommendations at the HHS Tribal Budget Consultation that was held in March in Washington, D.C. Tribes presented a needs-based budget, requested a significant increase in funding, and discussed budget priorities.

The workgroup submitted their final FY 2015 national recommendations to HHS on May 31, 2013, after consideration of the final FY 2013 budget and the FY 2014 President's budget proposal. IHS is now working with HHS on the budget formulation process towards the FY 2015 budget.

The FY 2016 budget process should start in October with Area budget meetings. I encourage you to participate in the budget formulation sessions – we need your input as the budget climate continues to be difficult.

In February, we held the Tribal Budget Formulation Workgroup meeting. We had a great turnout, and I use the recommendations in our budget formulation process. Thank you to the workgroup for their very helpful report document with the recommendations. I use it all the time to advocate for the IHS budget.

Now I'd like to provide a progress update on our agency priorities.

Our first priority is to renew and strengthen our partnership with Tribes. 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. I appreciate our partnership with the Direct Service Tribes Advisory Committee (DSTAC); thank you all for your support and assistance.

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, such as this one. We are planning to focus more on improving consultation at the local levels. At this point, you should be hearing regularly from your Area Director and your local CEO; if not, let me know.

The direct service Tribes are an important part of the IHS. We need and appreciate our partnership with you as we work together to change and improve the IHS. Our Office of Direct Service and Contracting Tribes is in the Office of the Director. We have finally selected a permanent Director for that office, CAPT Chris Buchanan, and we are meeting regularly with the DSTAC.

I also value meeting with the national organizations, such as our recent meetings with the National Indian Health Board. Area listening sessions are also an important venue for me to hear about Area and local issues. And I routinely meet with various tribal advisory groups such as the Tribal Self-Governance Advisory Committee, which focuses on Tribes that manage their own health programs, and of course DSTAC. Both groups are discussing how they can work together on common issues.

And of course individual Tribal Delegation Meetings are a vital part of our efforts to partner with Tribes in addressing health issues in Indian Country. You can request a phone or an in-person Tribal Delegation Meeting from IHS headquarters at any time.

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 four of them today.

The first is the consultation since 2010 on improving the CHS program, which is how we pay for referrals for services in the private sector.

I recently sent out a letter with the Tribal CHS Workgroup's third set of recommendations, which included a recommendation to keep the funding distribution formula for new CHS increases the same, and to protect the base CHS funding. I have heard from many Tribes to "hold the base funding harmless."

We also have 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 members have 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. Thank you to those of you who are helping with this important effort.

The second consultation is on Health Care Facility Construction – we have such a great need for new facilities. We initiated a consultation last July, and issued a call for nominations for the new Facilities Appropriations Advisory Board. We have finally selected members and will hold our first meeting soon.

The third consultation is the consultation 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. Through this agreement, VA can reimburse IHS for direct care services to eligible American Indian and Alaska Native veterans. The agreement implements Section 405 of the Indian Health Care Improvement Act, and serves as the agreement for all IHS federal facilities.

The VA announced in August 2012 that tribally-managed facilities can negotiate agreements with the VA directly, and this new national VA-IHS Reimbursement Agreement can be used by tribally-managed programs as well.

We are making progress in improving coordination of care for veterans eligible for IHS and VA under the MOU. In terms of the VA-IHS National Reimbursement Agreement, tribal input was critical to ensuring that the final agreement contained the Office of Management and Budget all-inclusive rate for outpatient services, which helps so many of our programs. 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. We are proceeding with setting up the billing process for all other federal sites.

And the fourth consultation that has been ongoing since last year is the consultation on Contract Support Costs (CSC). I appreciate that this conference includes a session on CSC funding; this issue is of importance to both Self-Governance Tribes and the Direct Service Tribes.

The consultation on this issue started last year with a request to review the CSC policy; then the Supreme Court ruled last June in the Salazar vs. Ramah Navajo Chapter case. The decision impacts two areas – past CSC claims, and future appropriations.

In terms of past CSC claims, the IHS goal is to resolve all claims for CSC as quickly as possible and through settlement wherever possible. We are making progress.

The usual process is that Tribes submit claims to IHS for unpaid CSC; we deny them; the Tribe appeals; and then a settlement is reached, which is paid out of the Judgment Fund. This is the process defined by the Contract Disputes Act. We do not have a class action like the Bureau of Indian Affairs (BIA).

While there are some differences between how tribal lawyers and how the Administration interpret the Ramah decision, the Office of General Council (OGC) has worked with tribal lawyers to develop a case management plan for appealed claims that prioritizes settlement

discussions. This plan was approved by the Judge on April 16, 2013. We are working with the Department of Justice to establish a similar plan for cases appealed to federal court.

My tribal leader letter in March indicated a decision to extend the time for discussion of claims before the agency denies them, and even before they have been appealed, as was requested by tribal lawyers.

We have recently developed two options for settlements. This is based on input that each Tribe should have the right to decide for themselves how to settle their claims. Some Tribes, for instance, may decide that the paperwork involved is too burdensome and they just want to put these claims in the past.

So the first option, the traditional approach, is what we are already doing – having in-depth discussions and exchanging documentation to reach a number that we can agree upon for settlement

The second option, which is new, is a simpler or alternative approach. Upon request, we will offer a non-negotiable, lump sum for settlement based on our paperwork alone. If the Tribe likes it, we are done. If they don't, then we return to the in-depth discussions.

We are hoping this simple approach helps us get through some of the claims in a more efficient manner. We can try this for a few months and see how it goes.

Again, if a Tribe is interested in exploring their options, they can contact our OGC through their lawyer, or schedule a headquarters level Tribal Delegation Meeting. We hope this progress is good news and demonstrates our goal to resolve these claims quickly and efficiently, through settlement if possible. You can read the latest update on CSC in my June 12 tribal leader letter, which is posted on the IHS website.

In terms of CSC appropriations, we have heard that Tribes are upset with the administration's proposal on new appropriations language. The administration considers this a short-term solution, and the BIA and IHS are consulting with Tribes to determine a more long-term solution, in the context of the difficult budget climate we face and multiple competing budget priorities. Your input is welcomed.

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 (IHCA). The second part is about internal IHS reform.

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.

And of course, we are thrilled that the IHCA, our authorizing legislation, was made permanent by the ACA. These are all important issues for Indian Country, so I appreciate this conference offering sessions on 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.

Right now, about 22% 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 40% 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 one third of our patients – have no health coverage other than IHS. This is the group that may benefit the most from the ACA.

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 70 days from now.

The Health Insurance Marketplaces, whether run by the state or the federal government for your situation, will be a way for individuals to purchase more affordable insurance if they are interested and/or don’t have employer sponsored insurance, or will be a way that individuals can enroll in the Medicaid expansion. 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, and if they are eligible for Medicaid.

There will be people to help – there are various ways that groups or individuals can assist people during enrollment. We are working to help our local staff, including those in the business office, to assist our patients.

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

We are also 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.

I also have some good news on the ACA related to the definition of “Indian.” This is the definition of “Indian” that relates to benefits of the ACA. IHS eligibility is not affected and will remain the same.

The definition of “Indian” in the ACA impacts three areas of benefits – access to monthly enrollment for those purchasing insurance, access to cost-sharing waivers (which is not having to pay copays for those who have insurance), and the minimum responsibility payment, or penalty, for not having health coverage.

The challenge is that the ACA law was written with definitions of “Indian” that are narrower than IHS eligibility, and that include only members of Tribes. IHS eligibility is broader, and includes members and descendants of Tribes.

During tribal consultation on this issue, Tribes in general have said that they want the definition of “Indian” in the law to be equal to IHS eligibility criteria. However, since the definitions are in the law, it will take Congress to fix it. HHS has been giving technical assistance to Congress on this issue.

The good news is that HHS has announced that all American Indians and Alaska Natives who are eligible to receive services from IHS will receive an exemption from the minimum responsibility payment under the ACA. Prior to this exemption, based on the specific definition of “Indian” in the ACA, only tribal members would have been exempt from the requirement to maintain minimum essential coverage under the law. This announcement means that all American Indians and Alaska Natives eligible for IHS services are exempt from the minimum responsibility payment. Our tribal partners were essential in reaching this point, because this decision reflects the comments and feedback received from Indian Country.

While this is great news, we do still need to work with Congress on corrections to the definition of “Indian” as written in the law related to access to monthly enrollment and cost-sharing waivers. Again, it doesn’t change IHS eligibility; it just makes sense that the same people who are eligible for IHS should also benefit from the ACA provisions specific to Indians. Overall, I encourage you to learn more about the ACA.

We are also continuing to work on implementation of the IHCA. Of course there are many self-implementing provisions already in place. For example, health care professionals in tribal facilities are now allowed to work under a license from any State, and outside providers can’t go after patients for referral charges if the referral is authorized for payment by the CHS program. And third-party reimbursements must remain at the Service Unit where they were received.

We continue consultation on implementation. You can submit input at any time at [consultation@ihs.gov](mailto:consultation@ihs.gov), and visit <https://www.healthcare.gov/> and my Director’s blog for general information and updates on the ACA.

We are also working with national and regional tribal organizations to conduct outreach and education on the benefits of the ACA. For instance, 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 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 are 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.

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. At an upcoming meeting of our IHS Area Directors, we are going to review our progress on our Agency's response to the Senate Committee on Indian Affairs investigation of the Aberdeen Area and our 12 Area Oversight Reviews that we just completed in December.

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.

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

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 with other racial and ethnic groups in the U.S. Between 1995 and 2006, the incident rate of ESRD in American Indian and Alaska Native people with diabetes fell by 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 Medicare, IHS, 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 have a recommendation from the National Tribal Advisory Committee on Behavioral Health to keep the distribution the same for one more year and then consult on whether it should be changed for FY 2014 funding. It only goes to some Tribes now, but there are others that want to have a chance for this funding in the future.

I am glad we are also discussing Prescription Drug Abuse at this meeting – it is a growing problem in our communities.

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 are 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.

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.

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 is how to find health care. You can 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 now.

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. Again, I am thrilled that the focus of the meeting is on the priorities of the DSTAC that we set at the meeting last year.

I know that many of you are concerned about the budget and the care in your community. I also know that the ACA has the potential to help improve health care options and services for all of our patients.

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 can ensure that our patients get the health care that they need and deserve.

Thank you, and I hope you have a great meeting.