Indian Health Service

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Indian Health Service Update

by

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Good afternoon, I am Dr. Yvette Roubideaux, Director of the Indian Health Service (IHS). Thank you all for joining us at this virtual National Combined Councils (NCC) meeting. I am grateful that even with the travel restrictions and sequestration, we are still able to hold this important conference, thanks to technology.

I'll be giving you a brief update today on what we're doing to change and improve the IHS in partnership with the Tribes we serve. I want you to know that we need and appreciate all your input and support as we work together to provide quality health care to the patients we serve.

I want to start with an update on the IHS budget, which is a huge factor in our ability to improve the IHS. We've received increases in the IHS budget each of the last 4 years. Overall, the IHS budget has increased 29% since fiscal year (FY) 2008. Within this increase, there have been some significant targeted increases, including a 46% increase in Contract Health Service (CHS) funding. The increases in CHS funding have made a real difference; more patients are getting the referrals they need. In fact, at almost of half of our federal CHS programs, 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.

However, the FY 2013 budget is a different story. The IHS is now working on implementing the FY 2013 final budget of $4.1 billion, which is reduced from our FY 2012 level of $4.3 billion. It does include an increase of $53 million for additional staffing for new health care facilities. But it also

The text is the basis of Dr. Roubideaux's oral remarks at the IHS national Combined Councils Meeting on April 22, 2013. It should be used with the understanding that some material may have been added or omitted during presentation.

includes rescission cuts of $8 million and sequestration cuts of $220 million. This means IHS has a total of $228 million in across-the-board budget cuts that will have to be made in the allocation of funds for the remainder of the fiscal year.

IHS is engaged in extensive planning and implementation efforts to absorb the cuts associated with the sequestration. We have already implemented a number of cost-saving changes to the way we carry out our work, including travel reductions, new restrictions on conferences, delayed or reduced purchasing and contracting, hiring delays and lapsing of positions, and enhanced third-party collections activities, which are a key element in our Service Units budgets.

Although there is much budget uncertainty, IHS operating plans will focus on protecting our ability to provide quality health care and preserve the core mission of the agency in all budget planning.

I know that the final budget for FY 2013 is disappointing, but the sequestration cut is across the board, and is a result of the Congressional Super Committee not being able to come to an agreement on how to reduce the budget deficit last August. Thank you for your understanding as we implement the FY 2013 final funding level.

Unless Congress enacts a plan for reducing the deficit, sequestration will continue. We are facing a new reality. That's why the FY 2014 President's budget is so important for the IHS. The FY 2014 President's Budget Request has been released, and it proposed a 2.9% increase for the IHS from the FY 2012 enacted level, with a total budget request of $4.4 billion. The President's budget includes a $124 million increase to the IHS appropriation. This includes increases of approximately $35 million for the CHS program, now proposed to be called the Purchased/Referred Care program; $77.3 million for staffing at new and replacement facilities; $6 million for pay increases for federal and tribal staff; and $5.8 million to partially address the shortfall in Contract Support Costs (CSC).

If the proposed budget is enacted, the IHS discretionary budget will have increased 32% since FY 2008. This gets us back on track. And most importantly, if the President's FY 2014 budget is enacted by Congress, there is no need for sequestration, because it reduces the deficit while protecting important priorities. So the FY 2014 President's Budget is good news for IHS, and it demonstrates the continued commitment of the Administration to improving health care for American Indians and Alaska Natives.

In preparation for the FY 2015 budget, we recently held our FY 2015 national budget work session, and the tribal workgroup presented their national recommendations at the Department of Health and Human Services (HHS) Tribal Budget Consultation last month in Washington, D.C. Those included an estimate of the total need for the IHS budget, and a proposed 19.75% increase.

The President and this administration have made IHS a priority, and we are grateful for the funding increases we have received. I am also grateful for the support of HHS Secretary Kathleen Sebelius – she makes improving IHS a priority in the HHS budget.

Now, I would like to review our progress on our agency priorities. These are not just the "Director Priorities" – these priorities serve as our strategic framework for how we all are changing and improving the IHS. These priorities are what we use to focus our efforts and to measure our

progress. They are a focused, simple, and common way to discuss how we are changing and improving the IHS. Tribal leaders are now using them in our discussions and consultations, which can help keep us focused on these priorities.

I am hearing from tribal leaders that they are seeing improvements, and I see the efforts we are making on these priorities. So we are making progress, but it's clear we also have much more to do.

Our first priority is to renew and strengthen our partnership with Tribes, and tribal consultation is an important part of this priority. We know the only way we're going to improve the health of our communities is to work in partnership with them. We've seen evidence throughout our system that we accomplish more when we work in partnership with our communities.

We have done a lot to improve consultation at the national level. We have held Area listening sessions with all 12 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. I know that Service Units are reaching out more to Tribes and sharing more about their progress and accomplishments.

I attend many meetings with Tribes and tribal groups to hear their input, concerns, and recommendations. One such meeting was the recent National Congress of American Indians Executive Winter Session Conference. I also recently met with the National Indian Health Board. We value our partnership with them.

Area listening sessions are also an important venue for me to hear about Area and local issues. For instance, I recently attended the California Area Listening Session and the impact week for the Midwest Alliance of Sovereign Tribes. Meetings with individual Tribes are also very important for our partnership. For instance, I recently met with the new Bemidji Area Health Board. The input we receive from Tribes is helping us change and improve. I hope that your facility is working to develop a stronger partnership with Tribes. That's our goal as an agency.

We have implemented many improvements in the tribal consultation process, and have consulted with Tribes on many topics. Current and recent consultation topics include:

- Improving the tribal consultation process;
- Improving our CHS program;
- Priorities for the Affordable Care Act and implementation of the Indian Healthcare Improvement Act (IHCIA);
- Budget formulation;
- Information Technology Shares–this is important for our P.L. 93-638 (Indian Self-Determination and Education Assistance Act) negotiations;
- Evaluation of the 2007 CSC Policy;
- Implementation of the Federal Advisory Committee Act;
- Improving our Indian Healthcare Improvement Fund allocation;
- The Tribal Epidemiology Centers Data Sharing Agreement;
- Long-term care;
- Behavioral health issues and suicide prevention;

- Health Care Facility Construction;
- Traditional Medicine; and
- Implementation of provisions for Indian veterans care in the IHCIA, such as the Department of Veterans Affairs (VA)-IHS reimbursement agreement, which I am pleased to say was signed on December 5, 2012.

While some issues have been resolved, others are still in progress. These consultations have helped us make important improvements in the agency. For example, tribal consultation was critical to the consultations on CHS and the VA-IHS Reimbursement Agreement. Tribes have provided input on how we have been improving agency business practices around the referrals that we make in the CHS program.

And Tribes played a critical role in advocating for specific provisions in the VA-IHS Reimbursement Agreement, including reimbursement rates, eliminating copays for veterans, and handling reimbursements. Through this agreement, the VA can reimburse IHS for direct care services to eligible American Indian and Alaska Native veterans. The agreement implements Section 405 of the IHCIA, 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.

Our second IHS priority is "to bring reform to the IHS." This priority has two parts – the first part involves the Affordable Care Act and the IHCIA. The second part is about internal IHS reform.

I want to call your attention to the need for everyone to participate in our Agency's preparation for and implementation of the Affordable Care Act in the next year.

The benefits of the Affordable Care Act 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 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.

And of course, we are thrilled that the IHCIA, our authorizing legislation, was made permanent by the Affordable Care Act. Currently, we are focusing on implementation for our Service Units. We convened a workgroup of IHS, tribal, and urban Indian program leaders to develop a "business planning template" for all our Service Units to use in developing their own business plan for implementation of the Affordable Care Act at each facility. The template provides some important overall factors to consider, but planning within individual facilities will vary, given the differences in our facilities in general and the differences in their respective health markets.

Your local CEO has received a copy of the template. We are requiring all our federal sites to work on these elements, and it is recommended for tribal and urban sites. Everyone at the local facilities needs to participate in this planning process.

For example, right now the most important thing our facilities should be doing is reaching out to the health plans to ensure that they are a part of their network. This will help optimize access for our patients who choose those insurance plans and will help ensure that we get the best reimbursement rates. This is a part of the implementation of the Essential Community Provider provision, Section 206 of the IHCIA. It is also about establishing partnerships with the Qualified Health Plans that will offer insurance in the state or federal Health Insurance Marketplaces.

All of our facilities need to focus on making sure that when our patients have access to affordable insurance or more access to enrollment in Medicaid, they will still come to us for health care. If they stay with us, we can bill their coverage and have more resources available for services for all of our patients. So each facility must come up with a plan to ensure that their user population stays stable or increases, that their third-party collections increase, and that we continue to provide quality, efficient, and effective health care.

My Director's blog includes a posting with a table that summarizes progress on implementation of the IHCIA, and we hope to post an update soon. 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 cannot 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.

Tribes are submitting input at consultation@ihs.gov, and you can visit http://www.healthcare.gov/ and my Director's blog for general information and updates on the Affordable Care Act. I hope you are learning about the Affordable Care Act and are considering how it is going to change how we do business and practice medicine in the agency. Every IHS employee needs to understand the benefits of the Affordable Care Act and how it impacts our agency.

We are also working with national and regional tribal organizations to conduct outreach and education on the benefits of the Affordable Care Act. And we have a slide show, tailored to the American Indian and Alaska Native population, to help with outreach and education efforts in Indian communities. We recently distributed it and posted it on our website so everyone can use it. And the national Indian organizations have developed a website – http://tribalhealthcare.org/. I encourage you to take a look at it.

Our internal reform efforts are focused on improving the way we do business and how we lead and manage our staff. Overall, we've implemented many improvements based on input from our staff. Four years ago, we heard complaints about human resources, accountability, UFMS, etc. We have made progress on these issues, but we also understand there is more to do.

We have set a strong tone at the top for how we will conduct business, 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 our budget management and overall financial management system. We have significantly improved results on our annual audit. And we're working to make our business practices more consistent and effective throughout the system.

To improve how we lead and manage staff, we're working on specific activities to improve the hiring process by making it 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. This allows us to praise top performing employees and to better hold accountable those employees who are not performing well. We also have established a Labor Management Council that is helping with our partnership with the unions.

We're working on improvements in pay systems and on strategies to improve recruitment and retention, including making health provider and health professional salaries more competitive. We're also using the National Health Service Corps (NHSC) to recruit more providers, and now all our sites are eligible for NHSC placement.

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. I am glad we are focusing on customer service at this meeting.

We're also working on a number of initiatives to help improve the quality of care. 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 quality improvement, and making changes that will result in measurable improvements in care that is focused on the needs of the patient.

We plan to expand this initiative throughout the entire IHS system – so far we have 93 sites. Many of these sites have been able to reduce waiting times, improve no-show rates, and arrange the system so that patients can see the same providers each time they come to the clinic, resulting in better coordination of care.

I have been sharing success stories and best practices from our IPC sites – thank you for submitting them – we really are making great progress in implementing the patient-centered medical home concept in the IHS. 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. The Ft Yuma Health Center has also formed patient-centered task teams to improve patient outcomes, including successfully lowering A1C levels in patients identified with very high levels.

If you are not implementing the patient-centered medical home in your facility, you should be – it is the future of medicine, primary care, and the U.S. health care system.

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. The SDPI Disease Prevention and Healthy Heart initiatives have shown that we can prevent diabetes and cardiovascular disease in our communities. So we're very pleased that the SDPI was recently reauthorized through 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. We’re also beginning to focus on addressing the problem of Prescription Drug Abuse in Indian Country. I am looking forward to hearing about the progress of our NCC workgroup.

We’ve also launched the Healthy Weight for Life initiative to unify all our efforts to promote a healthy weight among American Indians and Alaska Natives. And we’ve joined the First Lady’s *Let’s Move! in Indian Country* initiative, which includes our IHS Baby-Friendly Hospital initiative to promote breastfeeding in all IHS hospitals – three hospitals have already achieved the national designation. We are planning to do more with the First Lady’s initiative.

We’re also participating in the national Million Hearts Campaign, with its goal of preventing a million heart attacks and strokes over the next 5 years. Make sure you are 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. These improvements will be a focus of reimbursements in the future, so we all have to work on them now.

And we just signed 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 implementing Meaningful Use with our Electronic Health Record, and are now receiving incentive payments throughout the system. Don’t worry if you registered and attested for those payments and received a 1099 MISC form; we have a letter you can submit to the IRS to show that you did not personally benefit from those incentive payments.

We have accomplished a great deal as we work to meet our priorities, and this is reflected in our recent Government Performance and Results Act (GPRA) measures. Thank you for your efforts in helping us meet these measures. We have seen significant increases in the past few years, and that has been very helpful in showing Congress that we are effectively using our funding.

You may remember that in FY 2011, for the first time ever, we met all of our clinical GPRA measurement goals, including all our applicable measurement goals for diabetes. We are proud of all the IHS and tribal sites that have worked so hard to make improvements in the quality of healthcare that we deliver.

The results are now in for 2012, and we did great again! We met all but three indicators, and two of those had a change in clinical practice (so the new baseline won’t be established until next year) and the other one is being discontinued in favor of a better measure. So congratulations to all our IHS and tribal sites for a great showing again this year on GPRA.

When you look at GRPA trends over the past several years, you can see significant improvements in many of the measures, such as increases in the rates of mammography screenings, tobacco cessation interventions, depression screenings, and colorectal cancer screenings.

There are so many innovative efforts underway to improve health care services, and they are happening due to your great work in our system. For instance, the California Area Office team was recently named one of the top six finalists for the HHSInnovates program.

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've also enhanced our website with the IHS Reform Page, Director's Corner, and Director's Blog, which contain important updates and information on reform activities.

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 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 health facility. We will soon be releasing our new urban confer policy, which will guide our implementation of a new process to confer with urban Indian organizations.

I use the Director's Blog on the IHS website to post brief updates on our activities and the latest IHS news. 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 I encourage you to keep checking them for the latest information on Indian health issues.

IHS is making progress on agency reforms, and everyone needs to help us change and improve. The Affordable Care Act implementation will be critical in the coming months as we get ready for October 1, when open enrollment starts.

The IHS budget is an important part of our ability to change and improve. Our partnership with Tribes is also fundamental to our success – every facility should be working with the local community on improvements.

Thank you for all you have done to change and improve the IHS – despite the challenges we are facing, we need to keep our focus on making sure patients get the care they need and deserve.

Thank you.