



Indian Health Service

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Indian Health Service Update

by

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Good morning. This is Dr. Yvette Roubideaux, Acting Director of the Indian Health Service (IHS). I'm really excited to be holding our 4th IHS Tribal Consultation Summit and our first virtual summit!

We're trying out this virtual format in response to travel restrictions and the uncertainty about the budget. Thank you for your patience with the technology!

Today I will provide an update on the IHS with a focus on our current consultation activities, and then we will have time for questions.

The tribal consultation summit concept was based on recommendations from the IHS Director's Workgroup on Tribal Consultation. They envisioned the summit as a "one-stop shop" for information on IHS consultation activities. And with the travel demands on tribal leadership, they wanted a more efficient way to get updates and information about IHS consultation activities. There are usually several consultations occurring at once at these summits, not just with IHS but also with other federal agencies. We've held three Tribal Consultation Summits so far; this is the fourth one, which is being held virtually for the first time. So I am glad you could join us today.

We've made some other improvements in tribal consultation related to the recommendations of the Director's Workgroup. We now have a dedicated website for tribal consultation that lists all the events and workgroups; we have an email address for consultation input; we have a site for all the tribal leader letters for your reference; and we have improved our process for the Area consultation sessions and our tribal delegation meetings, holding both in person or on the phone

The text is the basis of Dr. Roubideaux's oral remarks at the IHS Virtual Tribal Consultation Summit on Nov. 4, 2013. It should be used with the understanding that some material may have been added or omitted during presentation.

to ensure greater access. We are always interested in your comments on how to improve the tribal consultation process.

I would like to start by talking about the IHS budget, which we all know is a huge factor in our ability to provide the services our patients need. I know we'll spend more time on it tomorrow, but it's a major tribal consultation topic every year, so I wanted to say a few things today.

It seemed like we were on a roll for a while. We received increases in the IHS budget each year from 2009 to 2012. Overall, the IHS budget authority had increased 29% since fiscal year (FY) 2008. The IHS budget in FY 2012 was \$4.3 billion. Within this increase, there were some significant targeted increases; for example, the 46% increase in Contract Health Service (CHS) funding made a difference, allowing for more referrals for care in the private sector. In fact, almost half of all federal CHS programs were able to fund more than Medical Priority 1, or life or limb referrals.

However, the FY 2013 budget was a different story. The final IHS FY 2013 budget authority was \$4.1 billion, which was lower than the FY 2012 budget of \$4.3 billion. The FY 2013 budget included an increase of \$53 million for additional staffing for new health care facilities that have been constructed, which is great. But it also included across-the-board rescission cuts of \$8 million and sequester cuts of \$220 million.

IHS engaged in extensive implementation efforts to absorb the cuts associated with sequestration on the federal side. However, the impact was significant: reduced services, denied referrals, and a significant change in the way we are conducting business. In order to protect the IHS mission, we implemented a number of cost-saving 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 enhanced 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've been doing everything we can to protect our agency mission to the greatest extent possible, but there is no doubt the impact has been significant.

For FY 2014, as you well know, we ended up in a government shutdown due to a lapse in appropriations that lasted 16 days. Even though our facilities were considered "excepted" from the lapse in appropriations and staff continued to work, it was still difficult due to all the uncertainty for our facilities and the communities we serve.

We're now on a Continuing Resolution until January 15, 2014, and Congress is due to report on progress on the budget by December 13. We are certainly hopeful that they'll be able to reduce the deficit enough to avoid sequestration in FY 2014, which would automatically start in January if funding levels are not met.

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

released in April. It has enough deficit reduction overall to replace sequestration entirely, but still protects important priorities such as IHS and other tribal programs.

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 would help get us back to where we need to be – continuing the upward trend of the IHS budget. If enacted, it would add \$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.

We know that IHS has support in Congress and with the administration; we are hoping we can have a good outcome with the budget, but we don't yet know the level of our final FY 2014 budget, which of course makes it difficult to plan. But we have to wait and see the outcome of the appropriations process.

For FY 2015, the administration is working on its budget formulation process right now. And we will soon start our FY 2016 Area budget formulation discussions – you will hear more about them tomorrow. I encourage you to attend and take part in the discussions about budget priorities.

The Department of Health and Human Services (HHS) held its FY 2014 President's Budget Rollout in April with Secretary Sebelius and all the Operating Division leaders. I am so grateful that HHS makes the IHS budget a priority. The President has made the IHS budget a priority as well.

The HHS Tribal Consultation Meeting was held last March; this is where the national IHS budget recommendations are presented and tribal leaders have the opportunity to meet with Secretary Sebelius. We value our partnership with Tribes on the budget. We do consider the recommendations of Tribes to be extremely important and helpful as we formulate the IHS and HHS budgets.

But even with all of this support for the IHS, it's still a difficult budget climate.

At the IHS, we are continuing our efforts to change and improve the IHS, guided by our four agency priorities. These priorities were based on tribal consultation input. We know there is much more to do, and we are working to continue progress.

Our first priority, and the one that is most important to us, is to renew and strengthen our partnership with Tribes. The only way we're going to improve the health of our communities is to work in partnership with them. 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.

We've done a lot to improve consultation at the national, Area, and local levels. We hold Area listening sessions with all 12 Areas each year, either in person or by phone or videoconference. We've also held many tribal delegation meetings, regularly meet with tribal workgroups and advisory groups, and attend tribal meetings and conferences. And of course these tribal

consultations summits have been an important part of our consultation efforts. The input from these meetings helps us focus our efforts on tribal priorities.

I recently attended the inaugural meeting of the White House Council on Native American Affairs, which was established by Presidential Executive Order to convene federal 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 DOI Secretary Jewel, who serves as the Chair. This Council now will give attention to tribal priorities at the highest level of government. It is focused on implementation through collaborations among the agencies.

Tribal consultation is a major activity for IHS because we need to understand the priorities and issues of the communities we serve. Area listening sessions are an important venue for me to hear about Area and local issues. And of course our Tribal Consultation Summits, which began in 2011, are a forum for Tribes to get updates on new and ongoing consultations.

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 in person Tribal Delegation Meeting from IHS headquarters at any time. I value the time we take to discuss issues, share information, and consider options to make progress. As partners, your advocacy along with ours within the administration has resulted in many improvements over the past few years. And given all the challenges we're still facing, our partnership has never been more important.

These are the agenda topics that were covered at the last Tribal Consultation Summit in August 2012 in the workshop sessions; discussions and consultations on many of these issues are still ongoing, so we welcome your input at any time:

- Health Care Facilities Construction
- CHS
- Budget formulation
- Prescription Drug Abuse
- Recruitment/Retention
- Data Sharing
- Long-Term Care
- Traditional Medicine
- Suicide Prevention
- Special Diabetes Program for Indians (SDPI)
- Department of Veterans Affairs (VA)-IHS Memorandum of Understanding (MOU)

I would like to highlight a few of those consultation topics and some of the outcomes from the 2012 summit discussions.

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. We have consulted with Tribes on how to improve the

referral process. One of those improvements has been making online CHS training available on the IHS website.

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.

We also made a decision on a recommendation from the workgroup to keep the CHS funding distribution formula the same. A Tribal Leader Letter was sent on May 6, 2013, informing Tribes that for now the existing formula will remain the same.

We appreciate all the work and input of the CHS workgroup. They've made some very key recommendations for improving our CHS business practices. More referrals are being made; we're tracking deferred and denied referrals more accurately; and we're 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 increase in CHS funding over the past few years really has made a difference in trying to address the significant need. For example, this increase in funds, along with concentrated efforts to improve their CHS program, resulted in an increase in orthopedic care for patients at the Shawnee Service Unit. In 2011, their deferred referrals for orthopedic care were more than the approved referrals. However, with the increased CHS funding in FY 2012, their number of CHS referrals increased, and the approved orthopedic referrals were much higher. So more resources, along with improved business practices, really do make a difference.

The next consultation update today 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. We are continuing to try to make progress on the IHS health care facility construction priority list with available appropriations. However, we have received approximately \$80-85 million in funding each year for health care facility construction. I want you to know that we have selected members of the new Facility Appropriations Advisory Board (FAAB), and I think we are finally scheduling the first conference call for later this month.

Appropriations for health care facility construction are allowing us to make progress. For example, a beautiful new hospital in Barrow, Alaska, opened in September. It was constructed under a great partnership effort, with IHS providing the appropriations and the Arctic Slope Native Corporation completing the construction.

We've also begun work on the growing, nation-wide problem of prescription drug abuse. I've heard Tribes indicate their concern on this issue in multiple forums. So we've convened a multidisciplinary workgroup of physicians, pharmacists, and behavioral health professionals to help address this difficult issue. The workgroup has identified four main objectives:

- Education;
- Tracking and monitoring of prescription drugs;

- Proper medication storage and disposal; and
- Development of a national policy that outlines IHS protocols, treatment, and standard of care for IHS facilities and health care providers.

We plan to conduct more consultation on this issue in the coming year.

I also want to mention our ongoing consultations on the VA-IHS MOU that was signed in 2010, and the recently signed VA-IHS National Reimbursement Agreement. I also want to clarify that these are two related but different agreements.

The VA-IHS MOU was signed in October 2010, and its purpose is to improve coordination of services for veterans eligible for both VA and IHS. We're working on sharing facilities and services, including telehealth and behavioral health services, and efforts to improve veteran enrollment and outreach.

The VA-IHS National Reimbursement Agreement was signed in December 2012. 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.

Tribal consultation was critical to the completion of the final agreement, which includes their recommendation to use the Office of Management and Budget all-inclusive rate for outpatient services provided to Indian veterans who are eligible for IHS and the VA.

We can now bill the VA for direct care services provided to Native veterans. The initial 10 federal sites are now billing the VA and receiving payments from the VA! That's more dollars for services for everyone served by the facility. We're implementing the billing process in all our federal sites, and I know that the tribal sites are also entering into agreements with the VA and receiving reimbursements.

Another consultation that has been ongoing since last year is the consultation on Contract Support Costs (CSC). It started in 2012 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. I will talk about that in a minute.

In terms of past CSC claims, the IHS goal is to resolve all these claims as quickly as possible and through settlement wherever possible. We are making progress – we have about 60 settlement offers on the table that are being informally or formally discussed, and many more are in progress.

The usual process is that Tribes submit claims to IHS for unpaid CSC; we deny them; the Tribe appeals; and then hopefully a settlement is reached, which is paid out of the Judgment Fund. This is the process defined by the Contract Disputes Act. We also have claims in litigation in federal court.

The HHS Office of General Counsel has worked with tribal lawyers to develop a case management plan for appealed claims that prioritizes settlement discussions. 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.

My tribal leader letter in June discussed how there are now two options for settlements – the traditional approach and the alternative approach. The traditional approach involves in-depth discussions and exchange of documents. However, with the alternative approach, which can be requested by Tribes, IHS will generate a one-time, non-negotiable settlement offer that Tribes can compare with their original claim, and if they like it, they can accept it and we can put the claim in the past. The alternative approach idea came from discussions with tribal leaders. We recently came to agreement to settle in our first alternative approach claim, which only took about 4 months from request to agreement to settle.

I wanted to provide an update related to my most recent letter to Tribes dated September 9, 2013. It indicated that IHS has recently committed funding for additional staff and resources dedicated to generating settlement offers for claims under both the traditional and alternative processes.

I also indicated that we would initiate a discussion on calculating CSC estimates in the pre-award phase or at the time of negotiations. Better agreement on these initial estimates would be very helpful throughout the entire CSC process. The first step was to start the discussion with tribal leaders in two of our IHS advisory committees – the IHS Tribal Self-Governance Advisory Committee (TSGAC) and the IHS Direct Service Tribes Advisory Committee (DSTAC). I recently met with the TSGAC and we had a productive discussion that resulted in recommendations to move forward. I also agreed with their recommendation to convene the CSC workgroup to make recommendations on this topic. Later this week I will have a similar discussion with the DSTAC and then we can proceed with convening the CSC workgroup for this task. The goal is to find areas of agreement.

In terms of CSC appropriations, we've heard that Tribes are very upset with the administration's FY 2014 President's budget proposal that has new appropriations language related to CSC. The administration considers this a short-term solution, and the Bureau of Indian Affairs and the IHS are consulting with Tribes to determine a more long-term solution, in the context of a difficult budget climate and multiple competing budget priorities.

Your input is welcomed and the budget formulation process is another forum in which we can discuss this issue. I also want to assure you that I have frequently informed the administration about the input we've received from Tribes on this issue.

There are other consultation activities in process that I won't mention in detail here, but I did want to let us know that we are still working together on them:

- We're due to consult on the Methamphetamine and Suicide Prevention and the Domestic Violence Prevention Initiatives funding distribution, and I'll be sending a letter to Tribes soon.

- The National Tribal Advisory Committee on Behavioral Health has been helping us with this activity. We've reviewed comments about the draft urban confer policy and are finalizing the policy.
- We need to hear from Tribes about the SDPI funding distribution beyond 2014 if it gets reauthorized. The Tribal Leaders Diabetes Committee will help with that consultation.
- I sent a letter to Tribes requesting input on Community Health Representative training, and we're reviewing those comments.
- We've initiated a consultation on how to better collaborate on traditional medicine. We only received a few letters on this topic, so we realize that we might need to discuss this issue in a different format. We'll let you know when that will occur.
- And the Information Systems Advisory Committee is helping us implement the Tribal Shares Improvement Plan, and they are meeting regularly.

These consultation activities are in addition to the work of the CHS workgroup, the FAAB, and the CSC workgroup that will help us continue progress. I also value the input of the TSGAC and the DSTAC, which helps ensure that we're hearing the perspectives and unique priorities of all Tribes.

Moving forward, our goal is to continue to strengthen our partnership with Tribes, and we value your input on our consultations.

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. The second part is about internal IHS reform.

We've been consulting on the ACA since it was passed in 2010, and tribal input has been extremely important. 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 Marketplaces," or can take advantage of the Medicaid expansion. 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're thrilled that the Indian Healthcare Improvement Act, our authorizing legislation, was made permanent by the ACA. So IHS is here to stay.

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

The same is true for other coverage. About 38% of IHS patients are currently covered by Medicaid. With the ACA and Medicaid expansion, many more of our patients may be eligible for Medicaid. 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 estimate that we could see an additional \$95 million in third-party collections in FY 2014. So making sure all American Indians and Alaska Natives understand their choices related to these new benefits is critical.

You may have also heard about the “definition of Indian” issues related to specific benefits of the ACA. First, let me make it clear that IHS eligibility is not affected by this and will remain the same.

The definition of Indian in the ACA impacts three areas of benefits – for those who purchase insurance through the Marketplaces, it affects who gets access to monthly enrollment and to waivers for cost-sharing, or co-pays. For those without insurance, it relates to the shared responsibility payment, or penalty, for not having minimum essential health coverage.

The challenge is that the ACA definitions of Indian are mostly based on membership in a federally recognized tribe, which is a narrower definition than for IHS eligibility, which includes members and descendants of Tribes. During tribal consultation on this issue, Tribes in general have said they want the definition of Indian in the law to be equal to IHS eligibility. However, since the definitions are in the law, it will take Congress to fix it.

And I’m happy to report that this process has begun; Senators Begich, Baucus, Schatz, and Udall have introduced a bill in the US Senate - S.1575 - that would streamline the definition of Indian in the ACA. This is an important first step in ensuring that all American Indians and Alaska Natives receive the benefits and protections intended for them in the ACA. And it just makes sense that the same people who are eligible for IHS should also benefit from the ACA provisions specific to Indians. We’ll continue to monitor the progress of the bill and provide technical assistance as needed.

While we await the outcome of this bill, HHS has created an IHS eligibility exemption to ensure that anyone who is eligible to receive services from IHS is exempt from the shared responsibility payment. Prior to this exemption, based on the definition of Indian in the ACA, only tribal members would have been exempt from the requirement to maintain minimum essential coverage. Tribal consultation was essential in reaching this point, since this decision reflects the feedback received from Indian Country. Individuals will be able to apply for these exemptions later this year as the application has been open for comments in the Federal Register.

We're encouraging every uninsured American Indian and Alaska Native to learn what benefits are available to them and to consider enrolling in the Marketplaces.

As you may know, open enrollment for the ACA Health Insurance Marketplaces and the Medicaid Expansion began on October 1. It's very important that everyone understand what new benefits are available to them. Even though the healthcare.gov website has had some challenges, it is fixable and the administration is working to get it working for the vast majority of users by the end of November.

The key things that you need to know are that the Health Insurance Marketplace, whether run by the state or the federal government, is a way for individuals who are interested to purchase more affordable insurance. Individuals who are uninsured and not eligible for Medicare or Medicaid may be interested in enrolling in the Marketplace insurance plan.

The initial open enrollment period will continue until March 31, 2014, and if you enroll by December 15, 2013, coverage can begin as soon as January 1, 2014. And monthly enrollment is available even after that for eligible American Indians and Alaska Natives. So there is plenty of time.

We realize there have been connectivity failures and other issues with the healthcare.gov website performance, but I assure you that these issues are being addressed and corrected even as I speak. I also want to assure you, and all our patients, that HHS is working diligently and continuously to improve the HealthCare.gov marketplace website. Please know that the website is just one place to enroll; patients can enroll by phone, mail, or in person.

IHS has been working hard to ensure our staff and patients are aware of their options. We've been offering weekly ACA question and answer sessions; responding to inquiries received through the ihs.gov website; sending messages via social media, including the Director's blog; and holding leadership briefings on important topics.

We're also working with our colleagues at the Centers for Medicare and Medicaid Services (CMS) to resolve issues that our staff and patients have encountered. If you have any questions or concerns, I encourage you to submit an email to acainformation@ihs.gov.

The HHS tech team has put fixes into place to address the performance and functionality of www.healthcare.gov and will continue to make progress. This nerve center for technical operations is diagnosing problems and making quick decisions with developers and vendors to identify and resolve issues in real time. They've also improved responsiveness and performance across the site. For example, the process for viewing and filtering health plans now takes seconds instead of minutes. And they've resolved issues with how eligibility notices are presented to consumers so that those now display properly at the completion of the application process.

Since the potential for the ACA to impact our bottom line is significant, IHS has been working hard to provide education and technical assistance for our patients to see if they are interested in enrolling.

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. 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. Our sites are now implementing the business practices they identified to ensure patients can enroll and that our collections can be maximized. And the IHS, tribal, and urban Indian (I/T/U) health programs Qualified Health Plan Addendum is now available to help explain the special authorities for working with I/T/U facilities. We're also working on contracting guidance for our facilities as they work with the qualified health plans to ensure reimbursement.

A major focus over the last few months has been training for our staff and Tribes on the ACA. We held our Indian Health Partnerships Conference in August and focused a lot on training related to the ACA. We've also worked with HHS and the Center for Consumer Information and Insurance Oversight on training for our staff and have made the Certified Application Counselor online interactive training available. In addition, the national tribal organizations are helping us with outreach and awareness training.

We completed a round of training for all of our IHS Areas, and now are conducting technical assistance calls and leadership calls on the ACA on a regular basis. And there are also many educational resources available on the various websites. Our goal is that all staff will be able to respond to questions that patients have about the ACA, or will know where to refer the patients for further information.

We held our Indian Health Partnerships Conference in August. Over 500 IHS, tribal, and urban Indian health program participants were in attendance at the various sessions, many of which focused on the ACA.

Our National Indian Outreach and Education initiative, with partners from all IHS Areas, has conducted over 350 ACA training sessions so far, and plan to do many more this year. They even conducted the ACA 101 sessions at the Partnership conference. They're also developing helpful materials on the ACA, including a tribal website – <http://tribalhealthcare>. I encourage you to take a look at some of the helpful tools and information on this website. We appreciate all their help in getting information out to Indian Country on this very important program.

IHS has launched a user-friendly webpage on our www.IHS.gov website to help American Indians and Alaska Native better understand and take advantage of the potential benefits of the ACA and the Health Marketplaces. The webpage addresses issues such as eligibility determination, dependents coverage, cost-sharing exemptions, and the Marketplace application process. It also has links to important additional resources for American Indian and Alaska

native individuals about the ACA. We hope this new webpage will help make this process easier and more understandable.

All of our hospitals and other sites are working hard to educate our patients on the ACA, including helping with enrollment and navigation of the healthcare.gov website.

We're also working on internal reform efforts to change and improve the IHS. 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. These are all things we heard you wanted as improvements.

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 health care 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. And we're working on improvements in pay systems and other strategies to improve recruitment and retention, which are big issues at all of our sites. We're also 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.

Many of these improvements were suggested by Tribes during consultation sessions, and some were a part of the recommendations from the Senate Committee on Indian Affairs investigation of the Aberdeen Area and the Area Reviews that we've completed. We've made improvements, but we're continuing to work on additional improvements.

Our IHS senior leadership team and Area Directors are leading the way in our efforts to change and improve the IHS and to work more closely in partnership with the Tribes and communities we serve. I'm glad to hear that our Area Directors are reaching out, communicating more and sharing more information with Tribes.

Our third priority is to improve the quality of and access to care. We've started by emphasizing the importance of customer service, and I'm hearing 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, or 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 more reimbursements in the future. There is a transition occurring in reimbursement payments that is moving away from paying for the number of services toward paying more for the quality of services. I think IHS is well-suited to adapt to this change because of our involvement in the IPC.

We plan to expand this initiative throughout the entire IHS system – currently we have 127 sites. We are now beginning the IPC 5 cohort, and hope all the rest of our facilities will join. 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’ve also formed patient-centered task teams to improve patient outcomes, including successfully lowering A1C levels in patients identified with very high levels.

A few other initiatives are also helping us improve the quality of care. One of the most important of these programs is the Special Diabetes Program for Indians, which is also another of our ongoing consultation topics. 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 program is currently authorized through the end of this year (2014).

The case for continuing this program is strong. I hope you’ve seen the dramatic drop in the rate of new cases 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.

All of this occurred while the SDPI has been implemented. Although we cannot say cause and effect, I believe these efforts are making a difference.

We’re also focusing on behavioral health issues, which are a top tribal priority and consultative topic. 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, and as I mentioned before, I’ll be sending out another letter requesting input on the distribution in FY 2014.

And as I also mentioned earlier, we’re also working on plans to help address the growing problem of prescription drug abuse.

There are a few other quality initiatives we're working on to improve the quality of and access to care for our patients. Our 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 is promoting breastfeeding to reduce childhood obesity. It's a part of the First Lady's *Let's Move! And Let's Move in Indian Country* initiatives. Five sites have already achieved the Baby Friendly designation.

Another initiative we're participating in is the national Million Hearts Campaign, with its goal of preventing a million heart attacks and strokes over the next 5 years. We're doing that by focusing on four things – ABCS – aspirin use, controlling blood pressure, reducing cholesterol, and stopping smoking.

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. We're also working under an agreement with CMS 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.

Great news for FY 2013 – we met all of our Government Performance Results Act (GPRA) clinical targets! This is one way of demonstrating that we are making improvements. We're seeing that our efforts over the past few years are resulting in improvements in care at the overall national level. When you look at national GPRA 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, which is increasing at a faster pace since 2010. And the percent of tobacco cessation intervention received is increasing, as is the percent screened for depression and for colorectal cancer.

So the increased funding we've received in the past few years, 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.

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 sending more messages and letters to tribal leaders, creating a new website, and posting regular announcements/updates through the Director's blog.

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 Indian health facility.

One area of interest here is that we're working on our final new urban confer policy as I briefly mentioned before. Instead of consultation, the Indian Health Care Improvement Act authorizes IHS to “confer” with urban Indian organizations. We appreciate all the input and hope to get the final policy out soon. We recently held a listening session on the Draft Urban Confer Policy that was published in the [Federal Register](#) for comment.

We recently launched a new IHS website, and I hope you can take some time to look at the new format. We realized that our website needed to be more customer friendly for our patients, and not just focused on what our staff need. So one of the first things you see now on the website homepage is how to find health care. You can also see a link 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, including updates on the ACA. This is one of many efforts to be more transparent about what we're doing as an agency. I post regular updates to my blog, so I encourage you to keep checking them for the latest information on Indian health issues. You can also subscribe for updates, and search the blog. We’re a little behind due to the shutdown, but should get the caught up soon.

I will close now by just saying once again how very important this summit and all our tribal consultations are as we work to change and improve the IHS. We also value your input as we implement the ACA with all its potential benefits for the people we serve.

We appreciate all your support; despite all the challenges we face, I am confident that by working together, we can ensure that all American Indian and Alaska Native people get the health care they need and deserve. Thank you.