



## Indian Health Service

### **IHS National Combined Councils 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). I'm really pleased to be here today for the IHS National Combined Councils (NCC) Meeting and the Improving Patient Care (IPC) IPC5 Meeting. It's so good to see everyone in person for once! As you know, many of our meetings are now virtual due to travel and conference restrictions, but I am glad that we can all meet in person this week.

The theme of this conference, "Access to Care . . . Achieving Equity in Health," reminds us of our mission and commitment to ending health disparities among American Indian and Alaska Native people. We need and appreciate all your continued hard work, dedication, and expertise as we work together to improve our ability to provide quality health care services to American Indian and Alaska Native people. Today I will provide an update on the work we are all doing to change and improve the IHS.

It seems like just yesterday, well actually 2 years ago, since we have met in person at an NCC conference. We have had a rough time the last three years, with a minimal funding increase in 2011, travel reductions and conference limits, and sequestration and rescission cuts in fiscal year (FY) 2013. We have actually reduced travel expenditures by about half since 2010, and conference spending by about a third.

This has meant that we have had to have fewer meetings or have more meetings through webinars, such as last year's Virtual Tribal Consultation Summit. Fortunately, we have the technology to connect when we cannot travel. But I know how important it is for our team to get together in person. We're going to see if we might be able to bring back some of the in-person meetings; if not every year, at least every other year.

*The text is the basis of Dr. Roubideaux's oral remarks at the IHS National Combined Councils Meeting on June 24, 2014. It should be used with the understanding that some material may have been added or omitted during presentation.*

I really enjoyed meeting with the Councils yesterday, and I hope this conference provides you with some renewal and a chance to network with your colleagues. And for those of you on the webinar today, we're glad you have joined us, and we hope to see you in person sometime soon!

For my update today, I first would like to talk about some recent changes. As you know, we have a new Secretary of the Department of Health and Human Services (HHS). Secretary Sebelius left HHS recently, and we were sad to see her go since she has been such a huge supporter of IHS. She helped us get the increases to our budget in the past few years and supported us in many other ways. So we are grateful to her and wish her well as she moves on.

Secretary Burwell has been on the job for about two weeks, and I have to say that I am impressed and excited to work with her. In meetings with her, she has indicated that her biggest focus is "impact" and that all that we do should be focused on the impact or outcomes for those we serve. I am glad her focus is on the impact of what we do, because, as I have said before, we might think we are providing the best care and doing the right thing, but if the people we serve do not feel the positive impact of our efforts, then we have more to do.

I know that all of you are focused on providing health care that makes a difference for all of those we serve, and we have lots of evidence that we're making a positive impact as we work to implement our agency priorities. But as we all know, there is much more to do.

As I provide an update today, I will talk about the impact we have had, and mention areas where we have more to do and where we might do more to gather feedback from those we serve to ensure we're making progress from their perspective. The people we're serving are counting on us to constantly be working to make improvements in the care that we deliver.

And of course, the IHS budget is a huge factor in how we are able to provide services, make an impact, and work to improve the IHS. Thanks in large part to tribal input and support, we have made a lot of progress on increasing the IHS budget. Compared to the FY 2008 level, the IHS budget has increased every year during the Obama Administration except in FY 2013, which is the year we were subject to an across-the-board rescission and sequestration. However, the FY 2014 budget included an increase to \$4.4 billion, getting us up over the FY 2012 amount. And the FY 2015 President's Budget Request that was recently released proposed to increase the IHS budget to the \$4.6 billion level. If this Budget Request is enacted, the IHS budget will have increased 38% compared to the 2008 level.

So there has definitely been progress on the IHS budget over the last few years. One question I get from staff is: "With all these increases, why does it seem like our budgets are tighter than ever?" Here is why you may not be seeing the full impact of the increases in the budget at the local level.

We have had significant increases in certain line items – Purchased and Referred Care (PRC), formerly known as Contract Health Services, has increased 52% compared to the level in FY 2008, which helped almost half of all federal PRC programs fund more than Medical Priority 1 referrals in FY 2012. So it's likely you have seen the positive impact of these increases.

You may have heard about Contract Support Costs (CSC) – this part of the budget has increased by 120%, with the big news being full funding for CSC in FY 2014. Tribes are very happy about the Administration’s decision to fully fund these costs associated with their contracts and compacts.

And health care facility construction funding has increased by 132 percent, meaning several facilities have been constructed to provide better services in their communities. But there are still many more facilities waiting on the Health Care Facility Construction Priority List.

However, if you look at the other line items in the budget, there have been increases, but they mainly have gone towards staffing and operating costs for new facilities. There have been some increases for medical inflation, so local facilities benefit from those increases. But then we had sequestration and the rescission cuts last year, which made our budgets even tighter.

So even though our budget has grown significantly over the past few years, we do realize that not everyone has seen the full impact of the large increases, and in fact, many sites continue to struggle to meet the need with available resources. I know that means many of you. And third party reimbursements or collections have become a more important part of our budget.

So our efforts will continue as we work to get more funding for IHS. In the meantime its up to all of us to do what we can to use our resources in the most effective and efficient manner.

We know that the Tribes we serve are working with us to get more resources for the IHS budget. Here are a few of their other budget priorities.

Funding for PRC is a top priority for Tribes. Even though our overall budget is about \$900 million, our better way of accounting for denied and deferred referrals is showing that there is still \$785 million in need above the current budget. So increases in PRC will continue to be a budget priority.

We have also heard that Tribes are advocating for Advanced Appropriations. A bill was introduced by the Senate Committee on Indian Affairs to give IHS authority for Advanced Appropriations, and the administration is reviewing this issue. This would be getting our budget authority a year in advance so that we would have funding available even if there was a continuing resolution or a shutdown. We know how disruptive both of those can be and that it’s especially disruptive for Tribes who depend on cash flow to operate.

We also have heard that Tribes want IHS to be exempt from sequestration. The Administration is working with Congress to avoid sequestration next year, which will require Congress finding a way to meet its overall budget levels agreed upon last year.

Another tribal priority that impacts the budget is our work to implement the VA-IHS MOU and the 2012 VA-IHS National Reimbursement Agreement. Tribes helped advocate to get these agreements in place. The VA-IHS MOU is helping us better coordinate care for our veterans. And so far, the VA-IHS reimbursement agreement has resulted in tribal and IHS facilities having collected approximately \$5 million in reimbursements from the VA so far. These collections are returned to the facility that provided the care, to support their health care delivery system, and it

helps with the local budgets. IHS has implemented the agreement in all its federal sites, and the VA is working to enter into agreements with tribal sites.

Tribes are also advocating for requiring Medicare participating providers to accept payment for referred care from IHS at “Medicare-Like Rates,” which are in general lower than full-billed charges. Already, when we refer patients out to hospitals, they are required to accept payments from IHS at Medicare-Like Rates, and in general that saves PRC funding so we can pay for more referrals. The problem is that the law currently only applies to hospital services. Tribes are now advocating for extending these rates to non-hospital and physician services. A bill was just introduced in Congress, so we know there will be more work on this issue. The GAO reported in 2013 that capping payment rates for nonhospital services could save millions of dollars for PRC. Recently we looked at one Area and overall we would pay about a third less to outside providers, so that means savings in PRC that can go towards more referrals being paid, which would be great for our patients.

Although a lot of good work is happening with the support of our tribal partners towards obtaining more resources, funding is not the only answer. At IHS, we must remain committed to continuing our work to change and improve the IHS, guided by our four agency priorities. And partnering with the Tribes we serve is essential to our progress.

Our first priority is to renew and strengthen our partnership with Tribes. We’ve made a number of improvements in how we consult with Tribes, and we want to continue to strengthen that partnership. So we’re working on more opportunities to consult in various forums, and to improve our responsiveness and follow-up.

While we’ve been making improvements in our partnership with Tribes at the headquarters, Area Office, and local Service Unit levels, the travel reductions and conference limits have resulted in less time together in person. That’s why I recently sent a letter to Tribes announcing that I would attend and conduct listening sessions in all IHS Areas this year. It’s a chance to meet in person, especially with those Tribes that are unable to travel to Washington, D.C. We need to hear the concerns and issues of all the Tribes we serve so that we can focus our improvements on tribal priorities.

We’re also connecting with Tribes through tribal delegation meetings and conferences, and are holding more conference calls and webinars to extend our reach. And I rely a lot on our Tribal Advisory Groups to help us work on tribal priority recommendations.

I am hearing that while Tribes have seen improvements in consultation at the national and Area levels, we need more improvements in tribal consultation and communication at the local facility levels. So this year, we are going to ask our CEOs to do more to reach out and meet with Tribes. And I hope you can do more to communicate and education the community on how to best access quality care at your facility and on what you are doing to improve care locally.

Area listening sessions are an important venue for me to hear about Area and local issues. So far this year, I’ve met with the California, Billings, Nashville, and Phoenix IHS Areas, and we’ve set dates for all the other IHS Area Listening Sessions.

And individual Tribal Delegation Meetings are a vital part of our efforts to partner with Tribes in addressing health issues in Indian Country. Tribes can schedule these meetings in person or by phone. It helps to hear local concerns so we can develop action steps together to resolve them.

Again, we really need your help at the local levels to increase our efforts to reach out to the Tribes we serve. We talk about providing patient-centered care, but we cannot possibly be doing that if we are not regularly meeting with the Tribes and communities we serve. By now, local Service Units should be regularly meeting with Tribes and sharing information on the budget and improvements made to date, and patients should be able to understand how to access services at the facility and to see some of the improvements you're making. So please help us increase our local consultation activities this year.

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 Indian Health Care Improvement Act. The second part is about internal IHS reform.

In terms of the Affordable Care Act, we want every American Indian and Alaska Native to see what benefits are available to them. So even though the Marketplace deadline for open enrollment for 2014 coverage was March 31 for most Americans, we still need your help with three things:

- Continuing to help tribal members who can enroll monthly as a special benefit of the Affordable Care Act;
- Helping with Medicaid and CHIP enrollment throughout the year; and
- Helping tribal members and those eligible for IHS with the application for an exemption or waiver from the tax penalty.

So we still have more work to do.

And there will be another open enrollment for everyone starting this fall, on November 15, for 2015 coverage. So we will continue to need your help in keeping our patients informed about their benefits and how to get coverage or an exemption.

The potential for the Affordable Care Act to improve options and coverage for our patients is great, and even greater is the possibility of us seeing more revenues from the third-party reimbursements so that we can provide more care for everyone. But if we don't pay attention here, we could lose patients and resources. So we need everyone's help.

The Affordable Care Act is about options for health coverage in addition to access to the IHS health care system. Patients who are eligible can still come to IHS. And they might find out that they can access affordable coverage. Right now, about 23% of our patients have private insurance; about 38% of IHS patients are currently on Medicaid; and less than 10% of our patients have Medicare and VA, so that leaves approximately 30% of our patients with no coverage other than IHS. This is the group that may benefit the most from the Affordable Care Act.

We estimated that we could see millions more in third-party collections, especially from the Medicaid expansion. So making sure our patients understand their choices related to these new benefits is critical. If more people who go to IHS are also covered by insurance, that will help stretch our limited dollars and help us provide more services.

I was pleased to learn in a recent meeting with the urban Indian health programs in Montana that at least one of the programs has already seen increased reimbursements from patients newly enrolled in insurance as a result of the Affordable Care Act and was able to purchase a new piece of equipment.

Having more of our patients covered can really make a difference for all of our patients. That's why we're continuing to encourage outreach and enrollment activities at all of our facilities, and to work with our National Indian Health Outreach and Education initiative tribal partners on outreach, education, and enrollment in tribal communities. We need all of you to help with outreach and education efforts.

We're also continuing our focus on business planning around the Affordable Care Act at our Service Units, and using the Business Office as a central point for information. We've recently worked on guidance for the business office, local contracting with Qualified Health Plans from the Marketplace, and training on how to incorporate the new plans and their requirements into our Purchased/Referred Care program.

You may have also heard about the "definition of Indian" issues related to specific benefits of the Affordable Care Act, such as access to monthly enrollment and reduced cost sharing. We're still providing technical assistance to Congress on a legislative fix to broaden the definition of Indian to be similar to IHS eligibility, which includes members and descendants. In the meantime, HHS has created an IHS eligibility exemption/waiver to ensure that anyone who is eligible to receive services from IHS can also be exempt from the shared responsibility payment.

An exemption application is available on [healthcare.gov](http://healthcare.gov) for use by both tribal members and those eligible for IHS. And tribal members can also apply for the exemption on their 2014 tax forms. It's a one-time exemption, so it doesn't hurt to apply even if our patients have coverage.

But even though this exemption is available, we still want American Indians and Alaska Natives to understand their potential benefits on the Marketplace because they might be newly eligible for Medicaid, or might find that insurance is now very affordable. And we continue to hope that the Medicaid Expansion will be adopted in more states.

If you have any questions about IHS and the Affordable Care Act, you can email [acainformation@ihs.gov](mailto:acainformation@ihs.gov) or go to our website at <http://www.ihs.gov/aca/>.

I also want to mention a new resource – on [marketplace.cms.gov](http://marketplace.cms.gov) – called "From Coverage to Care." There are materials available to help patients learn more about what to do with the new coverage they may have if they purchased a Qualified Health Plan under the Affordable Care Act Marketplaces. As you know, many of our patients do not have experience with insurance. So take

a look at these materials – they might be very helpful to our patients, especially if they have new coverage. That’s at <http://marketplace.cms.gov> .

We’re also continuing our work on internal reform efforts to change and improve the IHS, based on the input we received from staff like you. Our internal reform efforts are focused on improving the way we do business and how we lead and manage our staff. This is so important since we are in the business of healthcare, and with all the changes in the U.S. healthcare system, and our limited resources, we can no longer act like we are a service or different from the private sector.

All of us have to be involved in reforming and improve how we operate. We have to succeed at the business of healthcare in all of our facilities. 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. We’re also working to make our business practices more consistent and effective throughout the system.

These may sound like simple things, but they are fundamental to our efforts to improve as an organization in order to better serve our patients. IHS is changing its orientation to run more like a business in many ways, since we’re in the business of healthcare, and we need all of our Service Units to transition to that orientation.

To improve how we lead and manage staff, we’re using the new HHS supervisory training for our managers, and improving our performance management process. 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. This includes working on specific activities to make the hiring process more efficient and proactive, and less time-consuming. I know that Lisa Reyes, Headquarters Division of Human Resources, has been meeting with some of the Councils by phone this week.

Some key changes you can make are working on understanding how you can help shorten and improve the hiring process by being more involved in it, and by offering more competitive salaries for providers under Title 38. It’s getting more competitive in the market for providers, and we have to offer more competitive salaries.

We’re also working under the recently announced IHS Veterans Hiring Initiative to increase the number of veterans we employ at the IHS. Our goal is to increase the percent of new hires that are veterans in IHS from 6 percent to 9 percent in 2 years. I will be sending an IHS-All email with more information on the goals of the initiative and to send a clear message that hiring officials should work to fully consider qualified veterans whenever the opportunity arises.

Our work on IHS reforms must take into account the trends in staff over the past two decades. When Tribes take over the management of health care programs from IHS, they often take their “share” of funding from headquarters and from Areas.

Since the 1990s, the number of staff in headquarters and the Area offices has reduced by about half. That means that we cannot do as much of the technical assistance and oversight as we have done in the past. However, our overall full-time staffing counts have stayed the same since collections have allowed our Service Units to increase their staff.

So our system is changing, and this means that as the headquarters and Area offices are further reduced as more Tribes contract or compact, we need our local service units to be a greater focus of change and improvement for our system. But this means a more business oriented approach, better customer service, maximizing revenues, and using resources in the most efficient manner so that we are improving the care we provide to patients. So we need everyone's help to adapt to our changing system and to help us implement reforms.

Our third priority is to improve the quality of and access to care. This is what our patients want us to focus on. We're 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, which is our patient-centered medical home initiative that is designed to improve the coordination of care for patients.

The patient-centered medical home is a big focus of the changing health care system in the U.S. and the Affordable Care Act. We plan to expand this initiative throughout the entire IHS system – currently we have 174 sites. I remember when I first started in 2009 we only had 38 sites, so that's some significant progress! We're encouraging our sites to become accredited as Patient-Centered Medical Homes. That's an extra way we can show that we provide quality care.

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. This initiative is making the improvements that our patients have requested. And our IPC Quality and Innovation Learning Network will be the ongoing way to connect IPC programs and share best practices.

I want to continue to remind everyone that it's the outcomes that matter with IPC – it's not just enough to implement it – the outcomes for patients have to get better, and we have to be measuring those outcomes. And the patients have to be noticing that things are getting better.

Many of our programs are seeing results. For example, I have mentioned that 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.

The Claremore Indian Hospital is also actively involved in the IPC collaborative. Their Family Medicine Clinic has improved access to care by reducing appointment availability delays from an average of 140 days to 1.5 days, and decreasing 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. So we hope all of our sites can make these types of improvements.

Please send me a slide with the evidence of your improvements so I can show examples of how IPC is improving care for the patients we serve. Yuma and Claremore are getting all the attention!

We've also have worked with the Centers for Medicare and Medicaid Services (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. This will help us with more consistent practices and better care that can adapt to the changing requirements for health care systems.

IHS also supports the CMS initiative for Meaningful Use of Electronic Health Records (EHR), and Indian country has benefited from nearly \$90 million in incentive payments to date. We've been working very hard on the 2014 certification requirements and expect to receive that certification soon. We're also continuing to focus on preparations for ICD-10, even though the deadline has been extended for a year by CMS. We know that the transition to EHR has been a challenge, but that's true for the private sector as well. Please continue to work with IT on making sure we are fully utilizing the system we have.

We've also heard from Tribes that prevention is important. One important focus area for IHS is obesity prevention and healthy weight promotion. Since obesity is a major cause of chronic diseases and mortality in our patient population, we want to do everything we can to prevent and address it. So we have our Healthy Weight for Life initiative to unify all our efforts to promote a healthy weight among American Indians and Alaska Natives. This includes a website with information on evidence-based, proven approaches to fighting the obesity epidemic that is threatening the health and well-being of Indian people.

And we've joined the First Lady's *Let's Move! in Indian Country* initiative, which includes our IHS Baby-Friendly Hospital initiative. We're actively promoting breastfeeding in all IHS hospitals with obstetric services because it has been shown that breastfeeding can help reduce childhood obesity. We're also encouraging all tribally-managed hospitals to join us in this effort. So far, 9 of 13 IHS federal hospitals with obstetric services have achieved national designation as Baby Friendly. This means that nearly 70% percent of all IHS obstetric hospitals currently performing births are Baby-Friendly. We expect to have all these facilities designated as Baby-Friendly by the end of 2014.

I am so proud of all the hospitals that have done what people thought was impossible – most of our obstetric hospitals are now nationally designated as Baby-Friendly and promote breastfeeding to reduce childhood obesity. IHS is actually a national leader in this area. Last week we visited the Zuni Comprehensive Health Center, and saw firsthand how they are actively promoting breastfeeding, and helped celebrate their recent national designation as a Baby-Friendly Hospital. Thank you all for making IHS proud!

We also recently began collaborating with the Notah Begay III Foundation on activities aimed at preventing childhood obesity in American Indian and Alaska Native youth. The partnership will include sharing best practices in implementation of community-based activities directed at addressing childhood obesity in Indian Country.

And we're also so grateful that the Special Diabetes Program for Indians (SDPI) is reauthorized for another year! Even though we would have preferred a multi-year reauthorization, we are glad now that our programs don't have to worry for another year about whether the funding will be available.

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. Our recent Report to Congress showed outcomes and improvements in diabetes care throughout our system. And our recent outcomes paper for the SDPI Diabetes Prevention Program show that these programs can reduce new cases of diabetes through lifestyle changes. So this is a successful program that needs to continue.

We also have updated data on one of the most important potential impacts of the SDPI's combined and sustained clinical improvements over time. Based on national data, between 1995 and 2011, the number of new cases of ESRD, or kidney failure, in American Indian and Alaska Native people with diabetes fell by nearly 39% – a greater decline than for any other racial or ethnic group.

This data gives us hope that our efforts are making a difference. At a recent conference, a nephrologist who works with the U.S. Renal Data System told me that we had every right to claim that our efforts have contributed to this successful outcome. So great job SDPI!

Since they are top tribal priorities, we're also focusing on behavioral health issues by making progress on our National Behavioral Health Strategic Plan and our National Suicide Prevention Plan. For example, IHS funded over 180 federal, tribal, and urban Indian projects to participate in the Methamphetamine and Suicide Prevention and the Domestic Violence Prevention Initiatives in 2013.

And the evaluation data from these initiatives are very promising. The results showed an increase in access to care through the provision of over 17,600 direct service encounters for domestic or sexual violence; over 7,500 individuals entering treatment for substance abuse; and over 10,000 community members trained in suicide crisis response. And in 2013 alone, 176 health care providers were trained to conduct sexual assault examinations and 46 IHS and tribal facilities received equipment to photo-document sexual assault examinations.

The currently funded projects will continue through a 1-year extension to promote evidence-based and practice-based models created and managed by tribal communities, and then we will have a new 5-year project period. We're currently consulting with Tribes on how to move forward with these initiatives.

We've accomplished a great deal as we work to meet our priorities, and this is reflected in our Government Performance and Results Act, or GPRA, measures. In FY 2011, for the first time ever, we met all of our clinical GPRA measurement goals. In FY 2012, we did great again. And the results are in for 2013, and once again, we did great!

We're very proud of all the IHS and tribal sites that worked so hard to make improvements in the quality of healthcare that we deliver. 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 much 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, and we're

also emphasizing accountability, fairness, and inclusiveness in the way we do business and in our decision-making. We want a greater focus on this priority at the local levels this year.

This priority is particularly important as the Affordable Care Act is implemented. Our ability to show that we're improving and providing quality care will help encourage our patients to continue using our facilities, even if they take advantage of the health coverage options offered by the Affordable Care Act. This could mean more third-party resources that will help improve access to services for everyone we serve.

I cannot emphasize enough how important it is to communicate with the Tribes you serve and the local community – they need to know about the improvements you're making and that you're working hard to make improvements. It's essential for our system to grow and change as we move forward.

I hope you've noticed the new format for our IHS website, which is much more customer friendly. So one of the first things you see now on the website homepage is how to find health care and how to find a job in IHS. You can also see a link to my Director's blog. I want to remind you that 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. So I hope you can check it regularly for updates.

I just posted some pictures from the President's recent visit to the Standing Rock Indian Reservation in North Dakota, where he and First Lady Michelle Obama attended the annual Cannon Ball Flag Day Celebration. This administration has been so supportive of tribal issues, and IHS has been a priority for the budget, even with all the challenges of the past few years.

The President actually focused his visit on youth – he met with a group of youth to talk about their struggles and how they are determined to overcome them. At the Pow Wow, he spent most of the time interacting with the youth who had the honor of dancing for him.

As our new Secretary is emphasizing focusing on impact, it's clear how important the work is that we do each and every day. The care that we provide is helping us create healthier communities for the future generations.

I mentioned before that I visited the Zuni Pueblo Community last week. It was such an inspiring trip because of the strong relationships and partnership between the IHS and the Tribe that have resulted in so many activities to promote health and wellness in the community. Seeing the youth learning how to garden and having fun engaging in many different fitness activities, including a delightful Kids Zumba class, was so great to see.

And speaking of impact – there were two Youth Speakers named Kaleia and Kaitlin who did an outstanding job of sharing how and why they stay physically active and healthy. The longstanding partnership between the Tribe and the IHS in the Zuni Pueblo has resulted in activities and services that are helping kids like these have a chance at a healthy future.

So even with all the challenges we face, I so much appreciate all your efforts and expertise as we work to change and improve the IHS. I would like to thank all of you for what you do every day to

help IHS meet its mission. I appreciate your dedication as we work together to ensure that all American Indian and Alaska Native people get the health care they need and deserve. We are making progress, and with your help, I know we can continue changing and improving the IHS.

Thank you and I hope you enjoy the rest of the meeting!