



**QUALITY AND SERVICE IMPROVEMENTS AT THE INDIAN HEALTH SERVICE:**  
**Calendar Year 2016**

***The Indian Health Service (IHS or Agency) is committed to its mission to provide health care to 2.2 million American Indian and Alaska Native people.***

The IHS strives to use its limited resources as effectively as possible as the Agency explores new and innovative ways to improve access and the delivery of quality care to its patients. The IHS is laser-focused on solving its considerable, long-standing systemic challenges, through immediate and longer-term solutions. The Agency is focused on performance improvement, from the staff level – across the IHS system – to Agency management and leadership.

While its budget appropriation has increased in recent years, there are significant demands on this funding. For example, the IHS service population continues to grow, nearly 20 percent since 2001. Per capita spending for IHS patients is approximately \$4,000, compared to \$8,500 per capita spending for the rest of the U.S. population. In addition, many IHS facilities are significantly outdated and in need of renovation or replacement. IHS hospitals average 40 years of age, nearly four times older than the average age of U.S. hospitals at 10.6 years. The age of IHS facilities contributes to steep operational and quality of care challenges and adversely impacts the ability to attract and retain qualified medical staff necessary to meet the needs of the Agency's service population.

***Throughout 2016, the IHS has undertaken a number of actions to strengthen and sustain the delivery of quality health care, including improving operational practices and deploying new tools in an effort to decrease staff recruitment and retention challenges.***

The IHS is building on prior investments, and leveraging available resources – including expertise across the U.S. Department of Health and Human Services (HHS or Department) through the Executive Council on Quality Care – with a focus on implementing improvements that can be sustained over time. Specifically, the IHS has focused on the following: assessing and surfacing problems to strengthen service delivery, area management, and staff accountability; infusing quality expertise at the executive and staff levels; addressing behavioral health; using telehealth and other innovative practices to reach patients in remote areas; and engaging local resources to fulfill its mission.

## **QUALITY IMPROVEMENT**

**HHS Executive Council on Quality Care to Improve IHS Care:** Health and Human Services Secretary Burwell established the Executive Council on Quality Care (Council) with the aim of supporting the delivery of quality care consistently across IHS facilities. Through the Council, some of the Department's top managers, clinicians, and program experts have been taking a fresh look at long-standing obstacles that directly impact the quality of care. In addition, the Council addresses key operations issues that hinder the IHS from consistently meeting the health needs of the American Indian and Alaska Native patients. Throughout 2016, the Council has leveraged significant expertise from across HHS to deploy specific actions in support of the mission and goals of the IHS. Some examples of this collaboration include members of the Council working individually with local hospital leaders in the IHS Great Plains Area (GPA) to help guide and support improvement. As a result, IHS offers quarterly system-wide Webinars on quality topics, to ensure leadership receive timely updates and feedback on survey findings and corrective actions occurring in any part of the system, which fosters opportunities to learn. Two Webinars have occurred to date, with a third planned for January 2017.

**New Quality Framework Developed to Guide Delivery of Care at IHS:** The 2016-2017 Quality Framework (Framework) outlines how the IHS will develop, implement, and sustain an effective quality program that improves patient experience and outcomes, strengthens organizational capacity, and ensures the delivery of reliable, safe, high quality health care at Direct IHS-operated facilities. The Framework was developed by assessing current IHS quality policies, practices, and programs, incorporating standards from national experts, consulting with Tribal leaders, conferring with Urban Indian Organizations and including best practices from across the IHS system of care and other HHS divisions. The Framework will strengthen system wide support for quality improvements and increase accountability at all levels of the system through data and reporting structures.

**CMS and IHS Expand Collaboration to Improve Health Care in Hospitals:** The Centers for Medicare & Medicaid Services (CMS) now includes IHS hospitals in its national Hospital Improvement and Innovation Networks contract, which aims to reduce adverse events in public and private sector hospitals by 20 percent and hospital readmissions by 12 percent. This commitment to American Indian and Alaska Native (AI/AN) health care is part of ongoing CMS and IHS work to address issues in hospitals before they can adversely impact patients.

**CMS Selects Quality Improvement Organization to Support Quality Improvement at IHS Hospitals:** CMS awarded a new contract to help support best practices and other operational improvements for Direct IHS-operated hospitals that participate in the Medicare program. HealthInsight, a current Quality Innovation Network – Quality Improvement Organization, is partnering with IHS hospitals to continuously improve the quality of care for Medicare patients. These efforts benefit all patients receiving care at these facilities. With this collaborative strategy, CMS and the IHS are working together to achieve and sustain improvements in quality of care.

**Contract Awarded for Hospital Surveys, Education and Training in Eight States:** A 1-year contract was awarded for \$700,000 to The Joint Commission for accreditation services for Direct

IHS-operated medical facilities and training and education services to strengthen quality and patient safety. Training and education will benefit IHS facilities in Arizona, Minnesota, Montana, Nebraska, New Mexico, North Dakota, Oklahoma, and South Dakota. Like other hospitals in the private and public sectors, IHS hospitals are now “surveyed” by independent experts so the IHS can identify and correct issues before they affect patients. IHS hospitals will benefit from this new contract that will test their readiness for compliance surveys conducted by CMS.

**Hospital Engagement Network Launched:** In 2016, CMS extended to IHS participation in the Hospital Engagement Network (HEN) 2.0, to provide evidence-based efforts in quality improvement and technical assistance. The HEN was made available to all IHS Direct Service facilities, focusing on quality improvement methods intended to reduce avoidable readmissions and hospital acquired conditions (e.g. central line blood infections, pressure ulcers, and falls).

**Medical Equipment Policy:** In June, the IHS expanded efforts to ensure medical equipment used at IHS facilities is up to date, properly maintained, and reliable, through the establishment of a new policy (Special General Memorandum 2016-02) on the minimum standards for medical equipment management, purchase, maintenance and replacement.

## **STRENGTHENING WORKFORCE, STAFFING, AND LEADERSHIP DEVELOPMENT**

**Proposed Headquarters Realignment:** The IHS proposed a realignment at IHS Headquarters to strengthen operations and oversight responsibilities by establishing clearer lines of accountability. The realignment will improve efficiency and effectiveness of program operations and prioritizes Service Unit workforce supply, quality improvement, and hospital operations. Through early January 2017, the IHS will gather feedback on the proposal from Tribal and Urban leaders, employees, and other stakeholders.

**HHS Expands Eligibility of HRSA's National Health Service Corps (NHSC) Program to Include IHS Hospitals:** This expansion of eligibility includes all Direct IHS-operated hospitals, as well as IHS-owned, tribally operated hospitals. The NHSC gives health care providers scholarship or loan repayment assistance in exchange for working for at least two years in a service area experiencing staffing shortages. While the NHSC focuses on primary care, providers in small hospitals often switch back and forth between providing hospital care and outpatient clinic services. This expansion means that NHSC providers who work in both an IHS outpatient clinic and an IHS hospital providing inpatient services will be able to count more of their inpatient time toward the loan repayment and scholarship service requirements.

**Deploying Members of the U.S. Public Health Service:** Since January, the Executive Council and the U.S. Surgeon General have worked together to deploy 165 United States Public Health Service (PHS) Commissioned Corps Officers to quickly assist in work underway to correct deficiencies at GPA hospitals. These deployments continue, including 24 Officers currently onsite helping to strengthen hospital care in the GPA. These Officers include experts in quality assurance, nurse leaders focused on outpatient and urgent care, pharmacists, and medical officers, who work alongside health care providers at Direct IHS-operated hospitals in each IHS Area. This crosscutting collaboration with the Department helps fulfill staffing needs in the short-term, while the IHS continues to work toward long-term strategies to adequately staff hospitals across the system. To date, four Officers have been hired permanently at Service Units in Pine Ridge, South Dakota, Winnebago, Nebraska; and Rosebud, South Dakota, through this initiative. Critical vacancies in the GPA and other high priority sites are now advertised via discipline-specific and Corps-wide listservs, with a focus on expedited commissioning for applicants and loan repayment incentives for all. The IHS and PHS Commissioned Corps are also finalizing parameters for an open application period in which all applicants would be only be considered by the IHS for specific critical positions.

**New "Global Recruitment" Plan:** The IHS is streamlining the recruitment process with a new Global Recruitment initiative, making it easier for health providers to find and apply for positions with the IHS, thus allowing hiring officials to fill critical vacancies faster. Global Recruitment allows for efficiencies in hiring for both human resources and hiring managers, reduces redundancy for commonly recruited positions, and attracts a greater pool of qualified candidates. For example, an applicant would only need to apply to a single job announcement and indicate areas they are interested in working by simply noting locations.

**American College of Emergency Physicians (ACEP) Partners with IHS on Emergency Services:** Through Executive Council facilitation, the IHS and ACEP recently partnered to more

effectively leverage ACEP expertise and training resources focused on telehealth and emergency care. This collaboration helps advance larger, ongoing efforts to provide AI/AN communities with the best quality care possible in a patient-centered, safe, and trusted manner. The IHS also is committed to sharing ACEP best practices, models, and policies with Tribes and Urban Indian programs and strengthening emergency care services through future partnerships with Tribes, local communities, and regional health care systems around Emergency Department care.

**IHS Interim Policy for Drug Testing for Reasonable Suspicion:** The IHS is reaffirming its commitment to maintaining a drug-free workplace for all its employees and the patients we serve. The IHS has developed an interim policy (Special General Memorandum 2016-04) to ensure a drug free workplace and to provide guidance to supervisors and managers on drug testing based on a reasonable suspicion of drug use. The intent of this interim policy is to offer assistance to those who need it, while being clear that any illegal drug use is incompatible with Federal service, especially health care services.

**Additional Recruitment Tools and Expanded Pay Scales:** Working closely with the Executive Council, the IHS has enhanced a host of administrative actions in support of staff recruitment and administration, including securing approval to use additional relocation benefits for qualified job candidates, as well as expanded pay scales for emergency room doctors so that salaries at the IHS are more competitive. The IHS received approval to increase Title 38 physician pay table maximums for Emergency Medicine, a critically important specialty. This enables the IHS to approve annual pay of up to \$300,000 (a 20 percent increase) for staff physicians and \$325,000 (a 23 percent increase) for more senior physicians who are supervisors or clinical department heads.

The IHS also gained authorization for intermittent physicians to receive Title 38 Physician and Dentist Pay. The IHS has established new Title 38 special salary pay tables for Certified Registered Nurse Anesthetists and Certified Nurse Midwives that allow for more competitive salaries for these critical nursing specialties. The IHS will pursue additional new or increased Title 38 special salary rates over the next fiscal year (FY). The IHS has partnered with HHS and the Office of Personnel Management (OPM) on efforts to gain use of additional Title 38 authorities to enhance to be more competitive with the VA and private sector employers.

**Funding Made Available for National Native Health Research Training Initiative:** Community-based research on AI/AN health status is critical in addressing health disparities and ensuring the delivery of evidence based, quality care to patients. In support of this research, the IHS announced a funding opportunity for a new project called the National Native Health Research Training Initiative. This cooperative agreement will help build capacity and share best practices in AI/AN health research and will promote tribally driven research through education and training opportunities. The award amount is approximately \$225,000 per year for a project period of up to 5 years.

**USUHS and IHS Partner on Increasing the Number of Physicians for IHS Service in Tribal Communities:** Through the Executive Council, an agreement between the IHS and the Uniformed Services University of the Health Sciences (USUHS) has been reached to support four medical school students annually. This will increase the number from two to four

physicians completing training and entering the IHS workforce following completion of their training. Each student will fulfill a service commitment to IHS for 10 years, which means the IHS will gain 40 years of physician service from each annual graduating class. This is a long-term, cost-effective approach that decreases reliance on contract physicians to fill IHS physician workforce vacancies. This will also grow a physician workforce dedicated to serving AI/AN patients.

**IHS and HRSA Collaboration to Improve K-12 Health Career Pathways for Indian Youth:**

With a specific focus on Indian Youth at the Pine Ridge Reservation, HRSA's Office of Regional Operations in Region 8 has worked with the IHS this year to coordinate efforts among key regional stakeholders, including the following: South Dakota State University College of Nursing; the IHS Pine Ridge Service Unit; the Oglala Sioux Tribe; Oglala Lakota College; the State Office of Rural Health, the regional Area Health Education Center; University of South Dakota Medical School; and the local public schools system. Through monthly calls and quarterly in-person meetings in Rapid City, South Dakota, this group helps advance health workforce development programs, such as guest speakers for students, job shadowing opportunities, and health career camps for youth, and seeks to extend health education programs from the participating colleges to the Pine Ridge Reservation. The IHS will assess this effort as a model for developing similar initiatives in other regions of the country to develop longer term pathways to increase the number of Tribal members entering health professions.

**Scholarships and Student Loan Repayment Program Revisions:** The IHS Scholarship and Loan Repayment programs serve as two of the primary recruitment and retention programs to increase the number of health care providers serving Indian Health Programs. In terms of program improvement, the IHS is expanding the number of scholarships and loan repayment opportunities available for critical health specialties such as doctors, nurses, behavioral health providers, and pharmacists.

## **INNOVATION AND TELEMEDICINE**

**IHS and Children's Hospital of Philadelphia Partner on Pediatric Telehealth:** The IHS and the Children's Hospital of Philadelphia entered into a Memorandum of Understanding (MOU) to explore the creation of a pediatric specialty consultation service using telehealth for AI/AN children served by the IHS. Pediatric specialty consultation services will benefit Tribal communities in Arizona, Nevada, New Mexico, and Utah. Through this MOU, services specifically for pediatric care and consultation will be designed for patients who live in very rural areas and may not be able to travel long distances to see a specialist.

**\$6.8 Million Telemedicine Services Contract Awarded to Avera Health, South Dakota:** A contract for \$6.8 million will provide telemedicine services to the GPA Service Units that serve approximately 130,000 American Indians and Alaska Natives. Telemedicine services use electronic communications to connect health care providers and patients for remote clinical appointments, as well as some nonclinical services. Telemedicine has demonstrated its effectiveness in making care more accessible as opposed to having patients travel long distances to obtain services. This contract expands access to care through telemedicine services at IHS health facilities in Iowa, Nebraska, South Dakota, and North Dakota.

## **BEHAVIORAL HEALTH SERVICES**

**HHS Launched National Tribal Behavioral Health Agenda:** This first-of-its-kind collaborative Tribal/Federal blueprint highlights the extent to which behavioral health challenges affect AI/AN communities, in addition to strategies and priorities to reduce these problems and improve behavioral health among AI/AN. This agenda is the result of extensive consultation among Tribal leaders, the Substance Abuse and Mental Health Services Administration (SAMHSA), IHS, and the National Indian Health Board.

**IHS Implemented Groundbreaking Opioids Policy:** In July, the IHS announced a new requirement for health care providers working in IHS Federal Government-operated facilities, including doctors, pharmacists, nurse practitioners and other providers who prescribe opioids. These providers are required to check State Prescription Drug Monitoring Program (PDMP) databases prior to prescribing and dispensing opioids for pain treatment longer than 7 days and periodically throughout chronic pain treatment. This is one of the first such actions by any Federal agency involved in direct medical care. Checking a State PDMP before prescribing helps to improve appropriate pain management care, identify patients who may be misusing, abusing, or diverting drugs, and prevent patients access to controlled substances. This policy will also help identify patients who may be misusing controlled prescription medications for intervention and treatment.

**IHS Signed Interagency Agreement with Bureau of Indian Affairs and Bureau of Indian Education on Native Youth Behavioral Health Services:** Under this agreement, each Agency is allowed to establish local partnerships through Memoranda of Agreements (MOAs) between IHS federally operated mental health programs, Bureau of Indian Education (BIE) operated elementary and secondary schools and Bureau of Indian Affairs Office of Justice Services (OJS)-operated juvenile detention centers to provide mental health assessment and counseling services, including telebehavioral health services. In the first year of this agreement, more than 25 schools could access these services. Under this 10-year agreement, behavioral health services will be offered at BIE schools and OJS facilities. Tribes, tribally controlled schools, or detention facilities may enter into a MOA with the three agencies for these services; however, Tribal participation is completely voluntary.

**IHS Partners with Two Leading Universities for Behavioral Health Residency Program:** The IHS entered into two Memorandums of Understanding (MOUs), with the Washington University in St. Louis and with the University of Michigan to advance the recruitment, retention and development of behavioral health clinicians in Indian Country. Through the MOUs, the IHS will collaborate with each of the universities in bringing AI/AN social work students and qualified graduates to IHS health facilities for internships and clinical residencies, as well as supporting education, research and evaluation.

**42 New Methamphetamine and Suicide Prevention Initiative Generation-Indigenous Awards Announced:** With the overall goal of preventing suicide and substance use, awards were made to 42 Tribes, Tribal organizations, Urban Indian organizations, and IHS Federal Government programs for a total of more than \$7 million for 1 year. Awardees will focus on increasing positive youth development, fostering resiliency, and promoting family engagement

among AI/AN youth up to, and including age 24 in AI/AN communities. These awards will provide more access to health services by growing the number of behavioral health providers who specialize in working with children, adolescents and families.

**IHS Navajo Area Launches Navajo- and English-Language Suicide Prevention Multimedia**

**Campaign:** The IHS launched a new suicide prevention campaign in partnership with the Navajo Nation, local community members, and organizations to prevent suicide-related behaviors and connect young people to behavioral health care within the Navajo Nation. The bilingual Navajo and English language campaign, Iiná Ayóó'íí'ní, which translates as “Love Your Life,” uses modern media to share traditional Navajo teachings and features Navajo young people.

## **EXPANDING HEALTH COVERAGE AND HEALTH CARE SERVICES**

**Medicaid and Medicare Enrollment Pilot Launched at Six IHS Facilities:** A new enrollment pilot program targets IHS patients eligible for Medicaid and Medicare who are not accessing health care and support services available through these programs because they are not enrolled. This new effort aims to increase Medicaid and Medicare enrollment of IHS patients at six health facilities in four states. The participating facilities are as follows: Phoenix Indian Medical Center in Arizona; Pine Ridge Hospital in South Dakota; Rosebud Hospital in South Dakota; Sioux San Hospital in South Dakota; Blackfeet Community Hospital in Montana; and Quentin N. Burdick Memorial Health Care Facility in North Dakota.

**Tribal Consultation Initiated for Draft Policy to Expand Community Health Aide Program:** The IHS announced a draft policy that if implemented, would begin a process of expanding the use of community health aides at IHS facilities across the country. Facilities operated by the Federal government and Tribally-operated facilities could see expanded opportunities under the new policy for these aides, a group that could include dental health aide therapists and community health representatives. Community health aides are proven partners in health and it is the Agency's goal to see them utilized to the fullest extent permissible in Direct IHS-operated and in Tribally-run hospitals and clinics. In 2016, 171 behavioral health, dental health and community health aides and practitioners in Alaska were certified. Of these, 28 were certified for the first time, while 143 were certified at a higher level or renewed their certification. IHS continues to consult with Tribal leaders about the possibility of increasing the use of community health aides as part of IHS' ongoing commitment to provide access to quality health care.

**IHS Tribal Consultation on Draft Purchasing Health Coverage Policy:** The IHS consulted with Tribal leaders and conferred with Urban Indian organization representatives on a draft policy that provides guidance to IHS Area Offices regarding the current IHS policy when Tribes, Tribal organizations and Urban Indian health programs wish to purchase health coverage for IHS beneficiaries with Indian Self-Determination and Education Assistance Act (ISDEAA) funding or other IHS-appropriated funds. Under the Indian Health Care Improvement Act, Tribes, Tribal organizations, and Urban Indian organizations may purchase health coverage, or "sponsor" premiums, for IHS beneficiaries using Federal funding to the extent available under the law. This draft policy also supports IHS facilities by increasing third-party billing revenue, which in turn increases resources available for IHS to spend on patient care.

**Partnership to Reduce Cancer's Impact on Native Communities:** Through an historic collaboration, IHS and Roswell Park Cancer Institute in Buffalo, New York, are partnering to reduce the effects of cancer in Native communities across the country. This innovative partnership focuses on health care and the provision of cancer prevention services in American Indian and Alaska Native communities as well as the facilitation of research and expansion of career and educational opportunities for these populations.

**New Funding Awarded to Promote HIV/AIDS Prevention and Engagement in Care:** The IHS and Centers for Disease Control and Prevention (CDC) announced two new cooperative agreements together totaling \$500,000 per year for HIV and AIDS prevention and care activities

by Tribes, Tribal organizations and Urban Indian organizations. Awardees receive up to \$100,000 a year for up to five years for community services including pre-exposure prophylaxis (PrEP), risk reduction for persons who inject drugs and support for people living with HIV and AIDS to stay in treatment. This effort is part of an ongoing IHS collaboration with CDC which funded the agreement and is providing subject-matter expertise.

**\$7.6 Million Awarded for the 4-in-1 Grant Opportunity for Urban Indian Programs:** IHS awarded 29 grants totaling up to \$7.6 million over three years to make healthcare services more accessible to AI/AN residing in urban areas and to support operations at Urban health facilities. Thousands of Urban Indian patients will benefit from increased funding and services in four health program areas. These programs are integral components of the IHS improvement in patient care initiative and the strategic objectives focused on improving safety, quality, affordability and accessibility of health care.

**\$138 Million Awarded for Diabetes Prevention and Treatment for American Indians and Alaska Natives:** The IHS, through its Special Diabetes Program for Indians awarded funding awards totaling approximately \$138 million to prevent and treat diabetes in AI/AN. Grant funds went to Tribes, Tribal organizations, Urban Indian organizations and IHS facilities. The Special Diabetes Program for Indians Community-Directed grants programs made awards to 301 programs for FY 2016. Diabetes is one of the most serious health problems for AI/AN, who suffer from among the highest rates of diabetes in the country.

## **BUDGET, ORGANIZATION, AND PROCESS IMPROVEMENTS**

**Promoting Tribal Self-Determination and Self-Governance:** Since 1975, the IHS has entered agreements with Tribes and Tribal organizations to plan, conduct, and administer programs authorized by Titles I and V of the Indian Self-Determination and Education Assistance Act (ISDEAA). In 2016, the IHS transferred over \$2.7 billion of the Agency's appropriation to Tribes and Tribal Organizations through Title I contracts and Title V compacts:

- Under Title I, there are 234 Tribes and Tribal organizations operating 275 contracts and 351 annual funding agreements, which comprise approximately \$980 million.
- Under Title V, the IHS Tribal Self-Governance Program reached a major milestone this year with Self-Governance activities in all 12 IHS Areas. The IHS now has 94 Self-Governance compacts and 118 funding agreements; through which \$1.8 billion of the IHS budget is transferred to Tribes and Tribal organizations. Sixty-two percent of federally recognized Tribes participate in Title V.

**IHS Updates Policy on Contract Support Costs:** In October, the IHS released an updated IHS policy on contract support costs (CSC). This has been a high priority goal for both the IHS and Tribes. The policy is published in the *IHS Indian Health Manual* at Part 6, Chapter 3. This major accomplishment derived from the dedicated work of the CSC Workgroup, comprised of Tribal leaders and IHS staff, and was the first update to the policy in 10 years. The new policy clarifies and improves processes and will guide Tribes and the IHS in the preparation, negotiation, determination, payment and reconciliation of CSC funding transferred to Tribes, in accordance with the ISDEAA. This policy underscores IHS's commitment to providing clear, effective, transparent communication about the resources that Tribes can expect when choosing to assume responsibility for providing health services to their Tribal members.

**Tribal Management Grants Awarded to Support Tribal Self-Determination:** IHS awarded 16 Tribes and Tribal organizations more than \$1.5 million in 2016 Tribal Management Grant Program awards. These annual IHS Tribal management grants assist Tribes in preparing to assume all or part of existing IHS programs and further develop and improve their health management capability. Tribes have the right to assume responsibility for providing health care to their members and to operate and manage health care programs or services previously provided by IHS, subject to certain requirements, as authorized by the ISDEAA.

**Tribal Leader Database:** IHS launched a Tribal Leader physical address database achieving 97 percent accuracy for physical mail distribution in September 2016, coordinated by the IHS Office of Direct Service and Contracting Tribes.

**Tribal Consultation:** IHS carried out Agency-wide Tribal Consultation activities and to implement President's Executive Order 13175 and associated Presidential Memoranda directing federal agencies to consult with Tribal governments.

**IHS Tribal Self-Governance Advisory Committee:** The TSGAC meets quarterly with the IHS Principal Deputy Director in Washington, D.C. Throughout the year, the TSGAC addressed

several issues including: Veterans Administration's (VA) Tribal Consultation on VA plans to consolidate programs to improve access to care; ACA/IHCIA implementation and education; Self-Governance transition plan review and approval; the IHS budget; TSGAC Agency Lead Negotiator (ALN) survey results and update; housing opportunities to support Tribal health initiatives; and the CSC Policy and Workgroup. Joint discussion between the TSGAC and the IHS Principal Deputy Director also occurred regarding outstanding IHS Consultation issues, such as: the Draft Quality Framework; the Catastrophic Health Emergency fund (CHEF); the Community Health Aid Program (CHAP) Proposal; the IHS Circular on Tribal Premium Sponsorship (TPS); and the IHS Realignment. These topics and others were discussed during the 2016 Annual Tribal Self-Governance Consultation Conference that convened in Orlando, Florida on April 24-29, 2016 with over 700 conference attendees.

**IHS Direct Service Tribes Advisory Committee:** The DSTAC meets quarterly with the IHS Principal Deputy Director and held its most recent quarterly meeting on November 16 and 17 in Albuquerque, New Mexico. The 2016 national Direct Service Tribes (DST) meeting was held in partnership with the Great Plains Tribal Chairmen's Health Board Health Summit on August 31 through September 1 in Rapid City, South Dakota. The DST National meeting topics were received positively and meeting had its highest level of attendance and participation. During the recent quarterly meeting, the DSTAC engaged in a strategic planning process where priorities were developed and will be used to strengthen services to Direct Service Tribes. Additional topics covered included the IHS national budget process and improving overall communication and reporting to Direct Service Tribes. The IHS will continue to work with the DSTAC implement elements of the strategic plan.

**IHS National Tribal Advisory Committee on Behavioral Health:** The National Tribal Advisory Committee (NTAC) on Behavioral Health advises the IHS on programming and service delivery and sets national priorities in behavioral health.

**IHS Budget Formulation Workgroup:** Through the IHS Budget Formulation Workgroup, the IHS and Tribes collaborate to develop recommendations for the IHS budget each year. Tribal representatives from the IHS Budget Formulation Workgroup presented the full FY 2018 Tribal budget recommendations to the HHS Budget Council on June 20 in Washington, DC. The FY 2018 Budget Workgroup priorities include: fully funding Current Services; program increases for Hospitals and Health Clinics; Purchased/Referred Care (PRC); Mental Health; Alcohol and Substance Abuse; and Dental Health. The IHS Budget Formulation Workgroup participated in the FY 2018 Evaluation and FY 2019 Planning Meeting on July 26-27 in Denver, Colorado. The workgroup evaluated the FY 2018 budget formulation process and suggested improvements for the next budget cycle. The workgroup also discussed and planned the FY 2019 budget formulation process. In the FY 2019 process, budget recommendations will include both national and Area-specific budgets. The FY 2019 National Budget Formulation Meeting will be held in the Washington, DC area on February 16-17, 2017.

**IHS Facilities Appropriations Advisory Board:** The Facilities Appropriation Advisory Board (FAAB) is established as a standing committee of Tribal leaders or their designees and IHS representatives. The primary purpose of the FAAB is to make recommendations to the IHS Director on matters involving all IHS Office of Environmental Health and Engineering (OEHE)

programs. The recent accomplishments by the FAAB include the following: finalized IHS Circular No. 2015-04: Facilities Appropriation Advisory Board – Charter May 22, 2015; established a Facilities Needs Assessment Workgroup to provide material for updating reports; participated in the preparation of the 2016 Facilities Needs Assessment Report completed and submitted to Congress in June 2016; and reviewed the updated the annual OEHE Appropriations Information Package used during the budget formulation process and other venues.

**IHS Contract Support Costs Workgroup:** The CSCWG met in September to review the final Contract Support Costs (CSC) policy. The CSC policy was approved and implemented in October 2016. The last time the policy was updated was in 2007, and the updated and improved policy was developed in partnership with the CSCWG. The policy also includes a CSC calculation tool to better calculate CSC. The IHS continues to work in partnership with the CSCWG and is committed to meeting in early 2017. In addition to the implementation of the CSC policy, the IHS is also working to schedule CSC training on the new policy.

**IHS Information Systems Advisory Committee:** The Information Systems Advisory Committee (ISAC) held their second semi-annual meeting of 2016 on August 10-11 in Catoosa, Oklahoma. The following are ISAC meeting outcomes: (1) recommended the IHS elevate efforts to address the Drug Enforcement Administration electronic prescribing of controlled substances (EPCS) regulations on two-factor authentication (i.e., identity proofing) for IHS/Tribal/Urban (I/T/U) providers and to ensure the IHS Electronic Health Record e-prescribing software application is certified; (2) requested an analysis of how IHS can provide vital, non-Protected Health Information and non-confidential information to Tribes, to be submitted to ISAC in the next 90 days; (3) approved the ISAC Information Technology (IT) Priorities for FY 2018-2019, focusing on critical technical and healthcare IT needs of the Indian health system, revising the previous list, and adding a new priority, “Usability;” (4) conducted the bi-annual review of the Indian Health Manual, Part 8, Chapter 2, “Information Systems Advisory Committee Charter,” and approved revisions; (5) approved the draft IHS Office of Information Technology (OIT) IT Service Catalog and fully support the next steps proposed by the OIT to seek further input on the Catalog through public review; (6) through the IHS CIO, will electronically request ISAC membership nominations from IHS Area Directors to fill expired/expiring ISAC term appointments from their respective Areas, in coordination with Area Tribal and Urban programs so they too have an opportunity to nominate individuals to ISAC.

**IHS Tribal Leaders Diabetes Committee:** The Tribal Leaders Diabetes Committee (TLDC) held a virtual meeting on December 6, 2016 to provide information to the members about current Special Diabetes Program for Indians legislative updates and the role of the TLDC as a Tribal Advisory Group.

**IHS Federal Staff Meeting:** To improve the performance of Agency work surrounding ISDEAA and IHCIA, IHS convened a three-day federal staff meeting and training to focus on Agency consistency in practice surrounding ISDEAA and IHCIA activities. The last meeting of this type was held in 2006. This meeting addressed changes in law, policy and practice. IHS introduced quality improvement models for IHS staff from every organizational level to adopt and immediately implement.

**New Regulation Implemented for Tribes to Negotiate Medicare-Like Rates:** The IHS has begun implementing a new regulation that gives IHS, Tribal and Urban Indian health programs the ability to cap payment rates at a "Medicare-like rate" to physician and other non-hospital providers and suppliers who provide services through the Purchased/Referred Care (PRC) program. The PRC program funds primary and specialty health care services that are unavailable at IHS or Tribal health care facilities and are therefore purchased from private health care providers. This can include hospital and outpatient care, as well as physician, laboratory, dental, radiology, pharmacy and transportation services.

**New IHS Procurement Policy:** This process provides transparency and efficiency for the goods and services provided across IHS. This new robust procurement planning process will identify opportunities for consolidation, eliminate duplication, gain efficiencies, and leverage best practices.

**2016 Partnership Conference:** IHS hosted a 2016 Partnership Conference in Phoenix, Arizona, in June, sponsored by the IHS Office of Resource Access and Partnerships (ORAP) and the IHS Office of Information Technology (OIT). The Conference focus, "Providing Quality, Patient-Centered Care Through Health Information Technology (HIT) Innovation and Improved Business Practices," brought together nearly 1,000 Federal, tribal and urban health care administrators, managers, and front-line staff who work in information technology, business offices, PRC programs, and health information management departments.