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, Director of the Indian Health Service (IHS). It is a real pleasure to be here with you today at the annual meeting of the IHS National Combined Councils.

This meeting is focused on "Workforce Development" and is an opportunity for us, as the leadership team for the IHS, to discuss "creating, sustaining, and retaining a viable health professional workforce." This is especially important as we are facing a worsening shortage of primary health care providers over the next several years. Looking over the agenda, I see there are sessions on recruitment and retention, succession planning, organizational best practices, and leadership development. These are all important topics that we need to address as we move forward with the work of changing and improving the IHS.

I will be giving you a update today on our progress on these reform efforts and some of our accomplishments in fiscal year (FY) 2011.

Before I begin an update on our progress on our agency priorities, I wanted to update you on the IHS budget. The budget is a huge factor in how we are able to change and improve the IHS. We have made a lot of progress on increasing the IHS budget.

We have received increases in the IHS budget each of the last 4 years. Overall, the IHS budget has increased 29% since FY 2008. While the largest increases in the budget are usually targeted at only some of the budget line items, the overall impact has been significant. For example, the contract health service (CHS) budget has increased 46 percent from what it was in 2008; as a result, we are hearing that some facilities are able to pay for more than priority-one referrals and services. While the overall CHS need is significant (federal data indicates it was

The text is the basis of Dr. Roubideaux's oral remarks at the IHS national Combined Councils Meeting on January 24, 2012. It should be used with the understanding that some material may have been added or omitted during presentation.

$861 million last year), the increases are making a difference, and more patients are getting the referrals and services they need.

Funding for contract support costs, which are so important to our tribal partners, has increased 76 percent since 2008. Dental and mental health funding has increased 19 percent. And health care facility construction funding has increased by 132 percent.

These increases were achieved in partnership with Tribes, and with the support of this Administration and Congress. It shows that when all parts of the policy arena are in agreement, significant progress can be made.

The FY 2012 budget, which was just appropriated in December, includes several priorities from the President's budget as well as tribal priorities from the budget consultation process. This includes increases for CHS, the Indian Health Care Improvement Fund, health information technology (IT) security, direct operations, contract support costs, staffing for new facilities, and health care facility construction. Congress also included some decreases as savings in grant program funding and Sanitation Facilities Construction funding.

FY 2012 funding will be distributed to programs as soon as it is apportioned to IHS from the Office of Management and Budget (OMB), and that is expected to occur within the next week.

We are finishing up the FY 2013 budget formulation process and congressional justification, and we have been promoting tribal priorities from our budget formulation process. We will learn the outcome of these deliberations with the announcement of the President's budget, which is expected to be announced on February 13, 2012.

We are also in the early stages of the FY 2014 budget formulation process. We have completed the Area consultation sessions and are holding the national budget formulation session this week. I do consider both the national recommendations as well as the diversity of the Area recommendations in our budget formulation process. I do my best to make sure to take into account the priorities of Tribes from all Areas.

The FY 2012 appropriation includes over $62 million to complete the Barrow Hospital replacement project, which will be finished during FY 2013. Also included are funds to continue construction on San Carlos and Kayenta facilities, and to start the design of the Southern California Youth Regional Treatment Center.

We have been working aggressively with the Department of Health and Human Services (HHS), OMB, the White House, and Congress to advocate for the IHS budget. I know that our tribal partners are working hard to advocate for the budget as well. We have to do everything we can to take advantage of the immense support we have at this moment in time.

Last summer, right after the National Combined Councils meeting, I traveled with a congressional delegation to Oklahoma and South Dakota; the delegation included members of the House Appropriations Subcommittee on Interior, Environment, and Related Agencies. This was a chance to show the delegation how our federal resources are being used to provide healthcare. It was an opportunity to highlight some of our successes as well as the many challenges we face, and to give them a chance to see first-hand some of the incredible needs in Indian Country. This subcommittee is very supportive of the IHS and proposed a 10% increase for IHS in FY 2012. Even though we ended up with less than that, we are grateful that they took time to visit Indian Country.

As many of you know, we have set four priorities to guide our work as we change and improve the IHS. They are:

- To renew and strengthen our partnership with Tribes;

- To bring reform to IHS;
- To improve the quality of and access to care for patients who are served by IHS; and
- To have everything we do be as transparent, accountable, fair, and inclusive as possible.

Although there is still much to do, I am pleased to report that we are definitely making some significant progress on these priorities.

Our first priority is about partnering with Tribes. I have stated many times that the only way we are going to improve the health of our communities is to work in partnership with them. We have done a lot to improve consultation at the national level – I held Area listening sessions with all 12 IHS Areas in 2010 and 2011, either in person or by phone or videoconference. I have held over 350 tribal delegation meetings, and regularly meet with tribal advisory groups and workgroups, and attend tribal meetings and conferences.

Overall Tribes have stated that the IHS policy is good, but improvements could be made in the consultation process, especially at the local levels. Since last year, we have been working on Area and local improvements in consultation and partnership, and Tribes are telling me they see improvements. I have also asked all Area Directors and CEOs to send updates to Tribes on our progress at least quarterly.

Tribal consultation is a priority of President Obama, who has expressed a commitment to honor treaty rights and a priority to consult with Tribes. The President held his third White House Tribal Nations Conference in December, and met with tribal leaders to discuss priorities.

The Conference included a presentation by HHS Secretary Sebelius, breakout sessions on various topics of interest to Tribes, and remarks by President Obama. His speech included a review of progress to date on tribal issues and an expression of continued support for Tribes. Many other agencies and departments are implementing tribal consultation policies and activities as a result of the President's Memorandum on tribal consultation that targeted all federal agencies.

IHS has made improvements in our tribal consultation process. One of our improvements is our tribal consultation website – it is a listing of all our letters to tribal leaders. This was one of the recommendations from our consultation on the tribal consultation process. I encourage you to visit this site from time to time to see what we are working on with Tribes.

We will also be holding two Tribal Consultation Summits this year – one is scheduled for March 13-14, 2012, in the Washington, D.C., area, and another is scheduled for July in Denver, Colorado. Tribes recommended these Summits as a "one stop shop" for Tribes to learn about IHS consultation activities.

We have consulted with Tribes on many important issues in the past year, including:

- Improving the tribal consultation process;
- Improving our CHS program;
- Priorities for health reform and implementation of the Indian Health Care Improvement Act (IHCIA);
- Budget formulation;
- IT Shares – this is an important issue for our P.L.93-638 negotiations;
- How to improve our Indian Healthcare Improvement Fund allocation, which helps us fund the facilities with the greatest need;
- The Tribal Epidemiology Centers Data Sharing Agreement;

- Behavioral health issues – including Suicide Prevention, the distributions for the Methamphetamine and Suicide Prevention Initiative and the Domestic Violence Prevention Initiative, and our Memorandum of Understanding (MOU) with the Department of the Interior on alcohol and substance abuse prevention and treatment; and
- Priorities for implementation of the long-term care provision in the IHCIA.

All of these consultations are resulting in better decisions for the future of IHS and will help us improve patient care. I know we are making better decisions because we are partnering with the people we serve.

CHS is a good example. Lack of funding is a real problem and results in us not being able to pay for all needed referrals. Our CHS federal – tribal workgroup has been helpful in generating useful recommendations for improvement. Tribes have volunteered to help us better document the need for CHS funding and to share best practices and help us manage our programs better and more consistently.

Our work with Tribes on this issue is revealing that we have a lot to do in terms of education about CHS. As they learn how the program should be managed and the impact of lack of funding, Tribes are becoming more informed about CHS issues and are better prepared to advocate for the program. So this partnership helps the entire system.

We recently posted a summary of how the CHS program works in terms of approval of payment of referrals. I also posted a six-part series on my blog about understanding the CHS program. It is clearly complicated, and we are working on improving our business practices in this area. We also posted a diagram of the CHS referral process in response to our Combined Councils meeting last year and in response to recommendations at the Tribal Consultation Summit.

Everyone wants and needs to learn more about the CHS program. Fortunately, because of the increases in funding, more patients are getting referrals. However, everyone, including administrative and clinical staff, need to understand how the program works and participate in making improvements. Thank you for your help with this important program.

Our second priority is "to bring reform to the IHS." This priority has two parts – the first part includes passage of the health reform law, the Affordable Care Act, and the IHCIA. The second part is about internal IHS reform – how we are changing and improving the organization.

Last year we held sessions on the Affordable Care Act that helped us all better understand the new benefits of the law and how it will make quality, affordable healthcare accessible to all Americans, including our First Americans. It is designed to increase access to health insurance, help those who have insurance, and reduce healthcare costs.

The focus of this past year has been on access to health insurance, with many new insurance reforms. Also, discussions continue on implementation of the State Insurance Exchanges and the Medicaid expansion up to 133% of poverty level – both will start in 2014. This could result in more health coverage options for our patients.

Tribal consultation input has been very helpful in the implementation of the Affordable Care Act. For example, the State Exchanges will be developed to be ready by 2014 to make purchasing affordable insurance easier for individuals and small businesses. Tribal consultation plans are now required for states applying for State Exchange establishment grants. Tribes realize the benefits of having affordable insurance options and are now wondering about the federal Exchange that is available if their State does not establish an Exchange. There are

several Special Provisions for Indians related to the Exchanges, and the Centers for Medicare and Medicaid Services is working to incorporate tribal input.

We are now starting to hear about how the Affordable Care Act contains several provisions that will reform the health care delivery system, including how reimbursements and payment will be focused on quality rather than quantity. We discussed this at last year's meeting. This includes such initiatives as the Accountable Care Organizations, Partnership for Patients, etc.

This is a positive change, but it means we will need to make sure we are focusing on improving and measuring quality to maximize our third-party collections and maintain certification and accreditation.

The overall impact of the Affordable Care Act has the potential to benefit American Indian and Alaska Native individuals by giving them more choices about health coverage, and to benefit Tribes and Indian health facilities if more health coverage and reimbursements help us expand our services. However, we do need to learn more and work to ensure our patients continue to choose to see us if they suddenly have insurance or Medicaid, and we need to make improvements in our business offices now to adapt to the new law. That's why everyone needs to be learning more about the Affordable Care Act and taking action now.

While the Supreme Court is due to hear the repeal efforts for the Affordable Care Act, the Administration is confident that we will prevail and is continuing implementation of the law as planned.

Another great thing about the Affordable Care Act is that is includes the permanent reauthorization of the IHCIA, which updates and modernizes the IHS. The provisions are numerous, but many of them give IHS new authorities. This includes:

- New and expanded authorities for behavioral health prevention and treatment services;
- New and expanded authorities for urban Indian health programs;
- Authorities for the provision of long-term care services;
- Authorities for various demonstration projects, including innovative health care facility construction and health professional shortages;
- The authority for provision of dialysis services;
- Authorities to improve the CHS program; and
- Authorities to improve facilitation of care between IHS and the Department of Veterans Affairs (VA).

These are just examples of what is in the new law. Some provisions went into place at the time the law was passed, some provisions require more work, and some require funding to be implemented.

On July 5, 2011, I sent a letter to all Tribes with an update on our implementation of the IHCIA reauthorization. We used the summary table provided in our May 2010 letter to tribal leaders and added a "Progress" column so that it would be easier to track progress on implementation of the many provisions in the law.

We hope to provide an update soon. I encourage you to review how the new IHCIA provisions impact the work you do at the Area and local levels. IHS is the lead on IHCIA implementation and is working quickly to implement provisions of the law, in consultation with Tribes.

HHS is taking the lead on implementation of the Affordable Care Act, and IHS is working closely with HHS on the provisions that impact American Indians and Alaska Natives. We have

been conducting consultation activities through outreach calls, meetings, and listening sessions, and input is gathered from Tribes at consultation@ihs.gov. We have also provided information in letters to tribal leaders.

We recognize that education and communication on the IHCIA and the Affordable Care Act are priorities at this time. So we are taking steps to keep everyone informed:

- You can find updates on our implementation process on my Director's Blog at ihs.gov;
- HHS has a website – www.healthcare.gov – that helps the public understand how health reform benefits them. I encourage you to go to healthcare.gov – it has many easy ways to understand resources and to learn more about the Affordable Care Act.
- The National Congress of American Indians, National Council of Urban Indian Health, and the National Indian Health Board are helping IHS with outreach and education – and we certainly appreciate their assistance. We will be focusing this year more on the education of patients and community members on the benefits of the Affordable Care Act.
- The IHS Area Directors recently met with the HHS Regional Directors to collaborate on more staff education on the Affordable Care Act. HHS has developed a new slide presentation about the Affordable Care Act that we will be sharing soon with everyone.

I am encouraging everyone in the Indian health system to learn everything they can about this important new law and its impact on Indian health care.

We are also making progress on the top staff priorities for internal IHS reform. Remember, we requested input in 2009 on priorities for changing and improving the IHS. Overall, staff emphasized improving the way we do business and how we lead and manage our staff.

I've sent messages to IHS staff on improving our business and management practices – such as the importance of customer service, ethics, performance management, and professionalism.

We have to improve as a business. The first step is accepting we are in the business of healthcare. We have to be fiscally responsible, balance our budgets, and find more efficient and effective ways to provide quality care.

To improve the way we do business, we're working with our Area Directors to make our business practices more consistent and effective and to have better management controls throughout the system. One very important area where we have made significant improvements is in how we manage and monitor our budgets. By requiring facilities to balance their budgets each year, returning third-party collections to the facility of origin, regularly monitoring performance targets, and making improvements in the use of UFMS, IHS was able to demonstrate its best performance ever as a part of the HHS Audit.

We have been also been working to address the issues raised in the Senate Committee on Indian Affairs Investigation of the Aberdeen Area and are implementing corrective actions in a number of areas. In addition to making improvements in the Aberdeen Area, we are conducting reviews of all IHS Areas to ensure these problems are not occurring elsewhere. So far, we have completed reviews of the Albuquerque, Billings, Navajo, Oklahoma City, Phoenix, and Aberdeen Areas.

Overall, we are finding that we have appropriate policies in place, but we need to ensure we are consistently implementing those policies across the system.

To improve how we lead and manage staff, which is particularly relevant to this meeting, we have been working to make the hiring process more efficient and less time-consuming. And we

have made progress – we have reduced our average hiring time from 140 days to 81 days! We are focused on implementing standard Position Descriptions and job analyses, with the goal of more timely and effective advertisement that results in the right candidates.

We have also been working on improving pay disparities in some healthcare provider positions. These steps should help greatly with our recruitment and retention efforts. We are hoping this meeting can also help us with our efforts to recruit, hire, and retain needed health care providers.

And we have been making improvements to our performance management system to improve accountability. By cascading more specific, measurable performance indicators to all employees, we can reward employees for good performance and hold employees accountable for performance issues.

An important part of improving employee performance is rewarding good performance. In addition to the Director's Awards given out this year, we have also held Area award ceremonies. I will be announcing the call for nominations for the 2011 Director's Awards soon and will be posting a program book from the 2010 Director's Awards with pictures of the award winners.

Another workforce improvement we have made is to ensure that we check all new hires to make sure they are not excluded from federal hire due to past offenses. This was a problem found in the Senate investigation of the Aberdeen Area. Our background checks prior to hire are extremely important. Hiring even one person on this list takes away from all our great hires because our patients lose confidence in us. We are emphasizing that everyone who hires a new employee is accountable for their suitability. We must hire the best healthcare providers to serve our patients.

Another workforce development step we have taken at HQ is to start a series of trainings for our staff to help them gain the skills they need to help us change and improve.

We are also promoting more supervisory training. We will be sponsoring several training opportunities in 2012, including the completion of the Supervisor 101 sessions for the Albuquerque and Navajo Areas. In addition, the Supervisor 101 training was video-taped during one of the Headquarters sessions, and once the final editing is complete, the DVDs will be distributed to managers and supervisors Agency-wide.

Also planned for 2012 is the roll-out of the next level of supervisor training, Supervisor 202. Supervisor 202 will have an expanded focus on employment law, as well as employee and labor relations. We plan to conduct one Supervisor 202 session in each Area. The completion of this training by managers and supervisors will help improve workforce skills and Agency performance.

Our third priority is to improve the quality of and access to care. Improving customer service is an important activity for us as we move forward, and I am seeing some great new activities throughout the system. I awarded our first IHS Director's Award for Customer Service to 19 employees and groups in 2010. However, we still have much to do in this area.

The Improving Patient Care (IPC) initiative is an important part of how IHS will make progress on this priority. This is our patient-centered medical home initiative that is focused on improving how we deliver care that is centered on what our patients want and need. It also is about working better as a team. We have expanded the IPC initiative to 90 sites in the Indian health system and plan to gain support for expanding these types of activities to all of our sites. This initiative will help us with all the delivery system reforms in the Affordable Care Act.

And the new Partnership for Patients that was recently launched will help improve the quality of care by focusing on reducing harm and improving patient safety in our hospitals.

We will be focusing on reducing hospital-acquired conditions and hospital readmissions. This will also impact our ability to demonstrate improvements in the quality of care delivered to our patients.

Like I said, IPC is about teamwork. We are working to develop capacity and leadership within IHS to ensure that we can eventually implement this important initiative in all of our sites, with our own staff. By developing our own leadership capacity, we will have a better understanding of how to successfully create a medical home in all of our facilities. I hope you can join the IPC workshop on Thursday. We are working to expand this throughout the entire Indian health system, so it is important that you know about this program.

We have also learned that this program can be even more successful with peer-to-peer learning. This year, our program staff have been demonstrating how to implement this program in our very diverse settings. Our IPC program staff members are now the experts in how to make this a successful program in the Indian healthcare system.

The Special Diabetes Program for Indians (SDPI) also continues its successful activities. They have shown that in partnership with our communities, we can reduce diabetes and cardiovascular disease risk factors in Indian country with innovative and culturally appropriate activities. For example, the Diabetes Prevention Program, designed as a demonstration project to translate research findings into real world settings, achieved the same level of weight loss as the original Diabetes Prevention Program Research study funded by the National Institutes of Health. The SDPI is up for reauthorization in 2013.

We've also launched the Healthy Weight for Life initiative to unify all our efforts to promote a healthy weight among American Indians and Alaska Natives. We now have a website with information on evidence-based, proven approaches to help fight the obesity epidemic that is threatening the health and well-being of Indian people. The webpage for the Healthy Weight initiative is at www.ihs.gov/healthyweight . I encourage you to have a look at the Action Guides.

We are also participating in the national Million Hearts Campaign, with its goal of preventing a million heart attacks and strokes over the next 5 years. We are already doing much to help with this initiative. In November, I attended the SDPI Diabetes Prevention and Healthy Heart Initiatives Meeting in Albuquerque, New Mexico, where I viewed posters from each of the 68 grant programs. The posters documented their successful prevention activities through photos, activity summaries, and client testimonials.

And we have joined the First Lady's *Let's Move! in Indian Country* initiative, which includes our IHS Baby-Friendly Hospital initiative. We will be promoting breastfeeding in our IHS hospitals because it has been shown that breastfeeding can reduce childhood obesity.

We recently launched the Baby-Friendly Hospital initiative at the Phoenix Indian Medical Center. They had some great exhibits, activities, and displays to promote breastfeeding. We are working to make all IHS hospitals Baby-Friendly and to encourage all tribally managed hospitals to join us in this effort.

Our Methamphetamine and Suicide Prevention Initiative is also reporting some impressive accomplishments for 2011. During the first year of this congressionally-funded initiative:

- 4,370 individuals were identified with a methamphetamine disorder;
- 1,240 people entered a methamphetamine treatment program;
- Over 4,000 people participated in suicide prevention activities;
- 42,895 youth participated in prevention or intervention programs; and

- 647 people were trained in suicide crisis response.

And in 2011 our Domestic Violence Prevention Initiative:

- Created over 220 project-affiliated full-time staff positions;
- Developed 21 interdisciplinary Sexual Assault Response Teams;
- Served over 2,100 victims of domestic violence and/or sexual assault;
- Screened over 9,100 patients for domestic violence;
- Made over 3,300 referrals for mostly domestic violence services;
- Reached nearly 9,500 community members through community and educational events; and
- Provided 37 trainings events for approximately 442 participants on domestic violence, mandated reporting for abuse, child maltreatment, dating violence, and bullying.

I am also pleased to be able to say that the IHS obligated 100 percent of its Recovery Act funding on time. This means that many American Indian and Alaska Native people are benefiting from new equipment, renovations, sanitation facility construction, and IT improvements.

And I am also proud to say that with the help of those funds, IHS was the first large federal healthcare system to have a certified electronic health record (EHR). And we are working hard to implement the meaningful use of electronic health records in the Indian health system. This is an important first step in the process for IHS, tribal, and urban Indian health sites that use our Resource and Patient Management System (RPMS) to qualify for and receive the new EHR Incentive Payments from Medicare and Medicaid. This could help bring valuable new resources to the Indian health care system. It is also important for Tribes that don't use RPMS, because they can still qualify for incentive payments if they use a certified electronic health record.

I am also proud to report that IHS recently achieved the top agency rating for IT portfolio management in HHS.

And if you haven't already heard, we need to implement the new ICD-10, or we won't be able to bill for reimbursements. It is extremely important that everyone at the Area and local levels are working to learn more about what they need to do now.

Our list of accomplishments also includes Government Performance and Results Act (GPRA) measures. In FY 2011, for the first time ever, we met all of our clinical GPRA measurement goals. Congratulations to all the IHS and tribal sites that worked hard to make improvements in the quality of healthcare that we deliver.

Everyone should know where they are for FY 2012 measures – we are halfway through the GPRA year and now is the time to ensure we have a good result this year also.

Some of you here today may have also attended our July National Combined Councils meeting in Bethesda, Maryland, where we discussed our agency reform efforts and strategies to improve the quality of care. We talked about more communication and working together on our reforms at the last meeting. We did hold two calls with the council leadership since then, and have made progress on some of the priorities from last year. I look forward to talking with the councils again this year to hear their priorities and discuss progress on moving forward.

Collaborations with other agencies are important in our efforts to improve the quality of and access to care. We have a number of key collaborations that we are currently working on. I hope you all can help us with our work on the implementation of the VA-IHS MOU – the next steps in

working on this will be at the Area and local levels to help improve coordination of care for Native veterans who are eligible for the VA and the IHS.

I hope you have already heard that HRSA designated all IHS, tribal, and urban Indian health sites as eligible for the National Health Service Corps (NHSC) loan repayment and scholarship programs. With all the millions of dollars now available for the program through Recovery Act and Affordable Care Act funding, they will have many more physicians, dentists, and behavioral health providers available to work in our underserved facilities. This will certainly help with our workforce development goals.

I sent a letter on this to all facility directors that contains important instructions on how to take advantage of these new resources for more providers. So far, 490 IHS, tribal, and urban Indian health program sites are approved for this program, and we have increased the number of providers in Indian health sites to 221. So this program is working to provide needed health professionals at our sites.

Our fourth priority is to make everything transparent, accountable, fair, and inclusive. These principles guide our work and decision-making. Accountability for individual and program performance is important, especially in this political environment. In order to get the support we need, we have to demonstrate that our activities result in improved outcomes – for local programs and for the system as a whole.

We are also implementing the IHCIA provision that directs IHS to establish a policy to "confer" with urban Indian health organizations. This will help us communicate better with the organizations that we fund to provide health services in urban communities.

To increase transparency, I have been communicating more, including messages from the Director and my Director's Blog. That is where you can receive the most updated information on IHS activities and initiatives. I use the Director's Blog to post brief updates on our activities and the latest IHS news at least weekly. You can link to our tribal consultation website and view letters to tribal leaders.

This is one of many efforts to be more transparent about what we're doing as an agency. I think it's important for the public to understand the good work we are doing as an agency, and putting updates and pictures on the blog helps tell the story. This is the first place we post the most updated information on the IHS and Indian health care. I encourage you to visit my blog on a regular basis.

We recently checked the number of hits to the IHS Director's blog, and in 2011, we had over 35,000 hits.

We have had some challenging workforce issues to deal with in the IHS, including a history of challenges in recruitment, hiring, and retention. And we face even greater challenges with anticipated primary care workforce shortages in the future.

We have so many strengths to work with – improvements in our hiring process, pay systems, loan repayment, and NHSC programs, and overall changes and improvements in IHS. The initial input on IHS reform gives us many areas to focus on for improvement, and this conference's agenda includes many resources to help us. It is time for us to make this a top priority of our reform activities.

In summary - we are working to change and improve the IHS through our reform efforts. These efforts should help us do better at the business of healthcare and provide better quality services. Improving our workforce through specific workforce development activities is an important part of IHS reform. I know that the information we are sharing at this meeting will be helpful for our progress.

The Affordable Care Act, and the reauthorization of the IHCIA, will also help Tribes and the IHS provide better care to American Indian and Alaska Native people.

I would like to thank all of you for what you do every day to help IHS meet its mission. I know that working in IHS is challenging. However, I very much appreciate your efforts to continue the good work we do despite these challenges. While changing and improving the IHS may seem like a daunting and challenging task, I still believe we're in a unique time in history, with a supportive President and administration, lots of support at HHS, and bipartisan support in Congress for reform. We must take advantage of this opportunity to change and improve the IHS. We are making progress, and I know we can continue changing and improving the IHS.

Thank you and I hope you enjoy the meeting!