Indian Health Service
Direct Service Tribes National Meeting

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Indian Health Service Update

by

Yvette Roubideaux, M.D., M.P.H.
Director, Indian Health Service

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 8th Annual National Meeting of Direct Service Tribes.

I looked over the agenda, and was pleased to see the presentations focus on the conference title "Commitment to Quality Health Care in our Native Communities." Thank you to everyone involved in the planning of this meeting.

Today I will be providing an update on what we are doing at IHS to help improve our ability to meet the health care needs of the American Indian and Alaska Native people we serve, with a focus on our Direct Services.

Before we get to an update on our progress on our agency priorities, I wanted to give you an update on the IHS budget. The budget is a huge factor in how we are able to change and improve the IHS.

You may remember that we got a big increase last year– a 13% increase. That helped us, of course, but it was not enough to meet the great needs in Indian Country, so we continue to struggle to meet our mission with available resources.

For this year, the President proposed a 9% increase. However, after the debate on the budget in Congress and the near government shutdown, and considering the shared responsibility we all have to help the economy and address the national debt, we ended up on a continuing resolution through the end of September with only a 0.4% increase of about $16.8 million.

However, many federal agencies sustained large cuts, in the hundreds of millions. Fortunately, thanks to all the support for us from this administration and the bipartisan support in Congress, we fared better than most, and we are grateful. However, you may know that we need to have an increase of $200-300 million each year to maintain current services and account for inflation and population growth.

Even so, I used what I have learned from tribal consultation to make the decision on how to allocate the small increase this year. Restoring the rescission (cuts) to clinical services, and adding some to Contract Health Services was the first priority. This benefited all Tribes, whether they were served by tribal or Direct Service facilities.

So what about next year, fiscal year (FY) 2012? Well, the President proposed a 14% increase for IHS in February. The House Appropriations committee recently marked up an increase of 10% for IHS. We don't know if that will survive the current budget debate in the House or the Senate, especially with the debt ceiling deal, discussions about fiscal responsibility, and upcoming negotiations on a deficit reduction plan and budget cuts. How all this will impact IHS is uncertain at this time. Congress is on break right now, but will be back in September to continue discussions on the budget. We will keep you posted.

The budget formulation process for FY 2013 is also in progress. We always have three budgets going at once. We have reviewed the recommendations from the tribal budget formulation workgroup and are proceeding with our HHS budget formulation process. Again, there is still a lot of support for IHS.

I also wanted to clarify something that I have heard Tribes say that "we know that you cannot advocate" – but actually that's not exactly true. I can and have been spending time advocating for the IHS budget as a part of the President's proposed budget within the administration and in meetings with Congress. I am just not allowed to tell you what to say to Congress. So don't worry – I am advocating all the time for the IHS budget. We have a lot of support at this moment in time, so we are trying to make as much progress as possible.

I would now like to provide an update on progress on our agency priorities. We have set four priorities to guide our work as we change and improve the IHS:

- 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.

We are making progress on these priorities, but it is clear we still have much more to do.

Our first priority is to renew and strengthen our partnership with Tribes. I have stated many times that I believe the only way we are going to improve the health of our communities is to work in partnership with them. That's why we all need to work to renew and strengthen our partnership with Tribes. We cannot work in isolation.

Our IHS Tribal Consultation Policy describes the need for national, Area, and local consultation. We have done a lot to improve consultation at the national level – I held Area listening sessions with all 12 IHS Areas this year and last year, either in person or by phone or videoconference. I have held over 300 tribal delegation meetings, and regularly meet with tribal advisory groups and workgroups, and attend tribal meetings. I am happy to see so many tribal leaders taking leadership roles on health issues.

I now have a good sense of national, regional, and local tribal priorities. Overall Tribes have stated that the IHS policy is good, and that improvements could be made on the process for consultation. One area they want to see more improvement in is Area and local consultations, and I have made it clear to Area and local leadership that we need to focus on improvements in this area. Let me know if you are seeing improvements.

President Obama has expressed a commitment to honor treaty rights and consult with Tribes, as he demonstrated when he met with tribal leaders in the Roosevelt Room at the White House in December 2010. In this meeting, the President said that while the next year or two would be very tough in terms of the budget, he would be mindful of the responsibility to Tribes. In addition to signing an Executive Order on Tribal Consultation, the President has held two White House Tribal Nations Conferences.

Department of Health and Human Services (HHS) Secretary Sebelius is also committed to tribal consultation, and at the first Secretary's Tribal Advisory Committee meeting (STAC), she signed the updated HHS tribal consultation policy. The STAC is the first Cabinet-level group of its kind.

My director's workgroup on tribal consultation met earlier this year – they reviewed input from all Tribes and have made many recommendations to improve the tribal consultation process. We have improved some parts of the tribal consultation process, including how we hold consultations, and have developed a new tribal consultation website.

One of their recommendations was to hold a "tribal consultation summit" that would be a "one stop shop" for Tribes to learn about all the consultation activities in IHS. We just held that summit a few weeks ago, and had very positive feedback. There is so much going on related to consultation, and Tribes enjoyed the opportunity to "catch up" all in one place. We will likely hold these summits on a regular basis.

One of our improvements is our new tribal consultation website – it is a listing of all our tribal leader letters. 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.

And of course I meet regularly with IHS advisory groups, including the Direct Service Tribes Advisory Committee (DSTAC). The DSTAC was established in 2005 to "provide leadership, advocacy, and guidance on policy and programs affecting Direct Service Tribes in a manner that promotes cultures, customs, and traditions." The committee represents Direct Service Tribes on IHS and Department-level committees and workgroups; actively participates in the IHS budget formulation process; and hosts this annual meeting in which Direct Service Tribes issues, concerns, and best practices are shared with tribal and federal health care administrators.

The DSTAC members have worked hard this year as they continue to participate in the Director's Area Listening Sessions and the HHS Regional Consultation Sessions. I am most grateful and appreciative of the assistance and advice the DSTAC and its members have provided to me and to the IHS.

The Office of Direct Service and Contracting Tribes is in the Office of the Director at IHS. I am grateful that Roselyn Tso has served as the Acting Director – she has done an outstanding job. We are in the process of interviewing and selecting the permanent director of this office, and I appreciate the participation of the DSTAC members in this process.

I wanted to make sure that you all knew that I awarded George Howell, the past Chair of the DSTAC, and IHS Director's Special Recognition Award for Tribal Partnership at my recent IHS Director's Awards Ceremony. I appreciate his commitment and partnership over the past few years.

I cannot overstate the importance I place on listening to and consulting with Tribes. Again, I have held over 300 tribal delegation meetings since becoming the IHS Director. I enjoy listening to the health priorities of tribal leaders in my meetings with them. We really have common goals – such as better patient care and the need for more funding and services.

I believe we will be so much more successful if we work in partnership with Tribes. We don't have to be in an adversarial relationship – we can find positive ways to work together to achieve our common goals. I am pleased to see we have breakout sessions at this conference on partnerships and shared governance at the local level.

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

- Improving the tribal consultation process;
- Improving our Contract Health Services (CHS) program;
- Priorities for health reform and implementation of the Indian Healthcare Improvement Act;
- Budget formulation – we are now considering FY 2013;
- Information Technology Shares;
- How to improve our Indian Healthcare Improvement Fund allocation;
- The Tribal Epidemiology Centers Data Sharing Agreement;
- The Special Diabetes Program for Indians 2-year extension; and
- Behavioral health issues – including suicide prevention, the distributions for the Methamphetamine and Suicide Prevention Initiative and Domestic Violence Prevention Initiative, and our Memorandum of Understanding (MOU) with the Department of the Interior on alcohol and substance abuse prevention and treatment.

All of these consultations will result 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 discussing this issue and generating helpful recommendations for improvement. Tribes have volunteered to help us better document the need for CHS funding and are also are willing 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 go to Congress to advocate for more funding. So this partnership helps all of us.

We are learning a lot from the $100 million increase in CHS funds we received in FY 2010 in terms of all the benefits the increased funding can have for our patients. For instance, some facilities have been able to authorize payment for referrals beyond Priority I as a result of these additional funds. That means more of our patients can get needed healthcare.

There is a breakout session on improving CHS business practices on Thursday if you are interested in learning more about this issue. We also have breakouts on third-party billing and ICD-10.

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 Indian Health Care Improvement Act. The second part is about internal IHS reform – how we are changing and improving the organization.

We are grateful for passage of the Affordable Care Act because 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 have begun 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 options for our patients.

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

The Affordable Care Act has the potential to benefit American Indian and Alaska Native individuals and Tribes and IHS, tribal, and urban Indian health facilities. Greater access to health insurance will help individuals in terms of more coverage and choices, and our health facilities in terms of reimbursements.

However, our efforts to change and improve are even more important because we must make sure we are competitive and that our patients continue to see us if they have better access to insurance coverage. That's why we need to focus on customer service, increasing quality, education, and coordination of services.

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 is now required for states applying for State Exchange establishment grants.

There are a number of "special provisions for Indians" in the law that apply additional benefits for Tribes and American Indian and Alaska Native individuals, such as monthly enrollment periods, no cost sharing, etc. One problem with the law is that there are three definitions of who is an Indian in the law that apply to different provisions, and fixing this will require legislation to ensure there is no confusion in enrollment or implementation of the Exchanges. We will have to think about how our business offices are going to teach our patients about their options regarding the Exchanges, including insurance and Medicaid enrollment and how we incorporate that into our referral and billing practices. So we have a lot to do just based on what the Tribes have been discussing.

We also have a lot to do to prepare for the delivery system reforms. We will talk about how we will be a part of the Partnership for Patients initiative to reduce harm in our hospitals. We need to learn more about the accountable care organization efforts and what our role might be with these groups of providers that are working to improve quality and lower costs. And we need to address how are we going to improve our ability to demonstrate quality improvements as payments are more aligned with quality. We need to start discussing what this means for IHS. For some facilities, over half of the budget comes from third-party billing, so this is a very important topic.

One big question I have been getting is what will happen if the Affordable Care Act is repealed? While congressional efforts to implement the Act are ongoing, there are challenges in the courts in several states. However, we are continuing to implement the law – both the Affordable Care Act and the reauthorization of the Indian Health Care Improvement Act. So we need to continue to prepare for its implementation.

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 on many parts of the Affordable Care Act through outreach calls, meetings, and listening sessions, and input is always welcome at

consultation@ihs.gov. There are facts sheets and other information at www.healthcare.gov, and we have provided information in letters to tribal leader.

We are also now reviewing new notices of proposed rulemaking on the implementation of the State Exchanges. HHS is announcing some tribal consultation sessions in the next month, and the Notices of Proposed Rule Making request comments in writing. You can look them up on www.regulations.gov and find them using the keyword *CMS-9989-P*.

Another great thing about the Affordable Care Act is the inclusion of the reauthorization of the Indian Health Care Improvement Act – which is great for Indian Country because this law is the main legislation that authorizes Congress to fund health care services for American Indians and Alaska Natives. And it ***permanently*** reauthorizes the Indian Health Care Improvement Act.

The Act 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. IHS is the lead on implementation and is working quickly to implement provisions of the law, in consultation with Tribes.

On July 5, I sent a letter to all Tribes with an update on our implementation of the Indian Health Care Improvement Act reauthorization. We used the summary table provided in the 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. I encourage you to review this and some of our dear tribal leader letters that explain some of the provisions.

Section 126 of the Act covers the crediting of third-party collections to the facility that provided the services. This is a self-implementing authority. Letters have been sent to tribal leaders and urban Indian programs explaining this authority. What this means for us is that there are no longer going to be bailouts or transfers of collections from one program to the other. Everyone gets their collections, and therefore everyone has to find a way to balance their budgets every year. Transfers among facilities can only occur if both facilities and the affected Tribe agree to it, and there is a payback plan in place.

Section 123 gives new authority for the provision of dialysis. However, we don't have appropriations yet.

Section 124 provides authority for long-term care; but again, we have no appropriations for it. However we are trying to make progress on this provision. Tribes have indicated they want primary control of long-term care, with IHS providing support in areas such as legal issues and interagency policy issues. We held a long-term care conference last November and got some great tribal recommendations. I will soon be sending out a letter to Tribes to request input on the recommendations from the conference.

Section 141 covers the facility construction priority list. You may know that we have a health facility construction priority list, and given our limited appropriations, we have not made much progress on it. This provision in the Indian Health Care Improvement Act required a congressional report on the total need – $2.4 billion on the current priority list, plus an additional $5 billion for the entire system need. It is hard to make progress on that with only $39 million per year of construction funding.

Sections 146, modular construction, is an example of how the Indian Health Care Improvement Act gives authorities for demonstration projects, but implementation would require additional appropriations.

Section 171 authorizes the Director of IHS to facilitate advocacy for Indian health policy and promote tribal consultation. It gives me more authority on American Indian and Alaska Native issues at the HHS level, and I have been taking advantage of that a lot by having a greater presence in HHS business. This is self-implementing.

Also, for Section 157, access to federal insurance, the Office of Personnel Management is giving an update later today on their implementation activities.

We recognize that education and communication on the Indian Health Care Improvement Act 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 – healthcare.gov – that helps the public understand how health reform benefits them;
- The National Indian Health Board, National Congress of American Indians, and National Council of Urban Indian Health are helping IHS with outreach and education; and
- We are using *Dear Tribal Leader Letters* to keep everyone updated.

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.

The next part of our second priority is about bringing internal reform to the IHS. In order to get the support we dearly need, the IHS must demonstrate a willingness to change and improve. It is clear that Tribes, staff, and our patients want change. By internal IHS reform, I mean we need to look at what we do well, and be honest about where we need to improve.

We requested and received tribal and staff priorities on how to change and improve the IHS. Tribal priorities for internal reform included:

- More funding for IHS, including a review of how we allocate funding;
- Improvements in our CHS program; and
- Improvements in the tribal consultation process.

We're working on these priorities, as I have already described.We are also making progress on the top staff priorities for internal IHS reform. 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. Many of our staff members want improvements in these areas, and our work starts with a strong message from the top that these are important areas for all of us. While I have set the tone from the top, we all have to help in setting the tone at the Area and local levels as well.

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 ways to provide quality care in more efficient and effective ways.

To improve the way we do business, we're working with our Area Directors in several areas. We're working 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.

To improve how we lead and manage staff, we have also been working on specific activities to make the hiring process more efficient and less time-consuming. We realized that we have to get our Human Resources division and our office supervisors to work together to make improvements. And we have made progress – we have reduced our average hiring time from 140 days to 81 days! We have also been working on improving pay disparities in some healthcare provider positions.

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 supporting our agency priorities and hold employees accountable for poor performance.

We have been working to address the issues raised in the Senate Committee on Indian Affairs Investigation of the IHS 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.

We have completed investigations of the IHS Albuquerque, Billings, Navajo, and Oklahoma 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.

One 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. We have since required this important background check before making any new hires, and actually went back and checked all 15,700 IHS current employees to make sure no one was on the list. Fortunately, we didn't find anyone else.

Our background checks prior to hire are extremely important. Hiring even one person on this list ruins 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 people to serve our patients.

Our third priority is to improve the quality of and access to care. Improving customer service is the most important activity for us as we move forward, and I am seeing some great new activities throughout the system. I recently awarded our first IHS Director's Award for Customer Service to 19 employees. 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. t is focused on improving how we deliver care that is focused on what our patients want and need. It also is about working better as a team.

We have expanded this 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. We are making improvements to the IPC, including building more internal capacity, simplifying and focusing the activities, creating a better evaluation, and making it work at all sites, not just those that have more resources or staff. It is basically about teamwork, improvement in care delivery, and a focus on

the patient. This initiative will help us with all the delivery system reforms in the Affordable Care Act.

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, by our own staff. By developing our own leadership capacity, we have a better understanding of how to successfully create a medical home in all of our facilities. We have a workshop on IPC on Thursday.

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.

The recent 2-year extension of the Special Diabetes Program for Indians (SDPI) will help us continue the successful activities of this program. They have achieved some important goals and showed that in partnership with our communities, we can reduce diabetes and cardiovascular disease risk factors in Indian country with innovative and culturally appropriate activities.

The SDPI Diabetes Prevention and Healthy Heart initiative grantees recently had their first meeting since the completion of the demonstration project. Since then, they have been working on dissemination of their best practices throughout the Indian health care system. We are so happy that their efforts can continue with the extension of the funding through 2013. They have shown that you can prevent diabetes and cardiovascular disease

We also just launched the Healthy Weight for Life initiative, which will unify all our efforts to promote a healthy weight among American Indians and Alaska Natives across the lifespan. 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. While progress has been made, overweight and obesity continue to drive up high rates of chronic disease. Taking action now is vital.

The webpage for the Healthy Weight initiative is at www.ihs.gov/healthyweight. I encourage you to have a look at the Action Guides. There is also a breakout session on childhood obesity tomorrow that focuses on behavior modification in schools.

And we have joined the First Lady's *Let's Move! in Indian Country* initiative. This included the launch of our IHS Baby-Friendly Hospital initiative in June in Shiprock, New Mexico. An interesting feature of the program was the use of digital storytelling to promote breastfeeding.

We will be promoting breastfeeding in our IHS hospitals because it has been shown that breastfeeding can reduce childhood obesity. We are working to make all IHS hospitals Baby-Friendly and to encourage all tribally managed hospitals to join us in this effort.

I am proud to say that with the help of Recovery Act funds, IHS has become 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 the IHS 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 EHR.

We have developed some materials to explain the EHR Incentive Programs for both Medicare and Medicaid and how adopting, implementing, upgrading, or demonstrating meaningful use of a certified EHR can qualify for incentive payments.

It's important to know that all eligible hospitals and eligible professionals must register as a first step to qualifying for the incentive payments. These incentive payments will be important to helping all facilities implement activities to achieve meaningful use of our EHR. If you don't already know about this, I encourage you to learn about it and register. You have to register as facilities or as providers. We cannot do it for you at headquarters.

If you go to my Director's blog, you can get access to the RPMS EHR certification press release, a fact sheet, some slides with basic steps, and links to websites for more information. It is now time for all eligible hospitals and eligible professionals to take steps to qualify for EHR incentive payments for meaningful use from Medicare and/or Medicaid. There is a workshop on Meaningful Use on Thursday.

Collaborations with other agencies are important in our efforts to improve the quality of and access to care. I have listed some key collaborations we are 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 American Indians and Alaska Native veterans who are eligible for the VA and the IHS.

I hope you have already heard that the Health Resources and Services Administration (HRSA) designated all IHS/tribal/urban Indian sites as eligible for the National Health Service Corps loan repayment and scholarship programs. With all the millions of dollars now available for the program through American Recovery and Reinvestment Act and Affordable Care Act funding, they will have many more physicians, dentists, and behavioral health providers available to work in our underserved facilities. Even though our facilities may not have fared well with the scoring system in the past, they are actually funding many more sites with lower scores, so we have a much better chance of getting these providers in our facilities. I sent a letter on this to all facility directors – please check my blog if you did not see it. The letter contains important instructions on how to take advantage of these new resources for more providers.

I have met with Assistant Secretary of Indian Affairs Larry Echohawk and his staff about several collaborative efforts, including suicide prevention. The Department of the Interior, the Substance Abuse and Mental Health Services Administration, and the IHS held listening sessions on suicide prevention with Tribes recently, and we held a joint suicide prevention summit just last week. The topic is of such interest that we had close to a thousand people attending the conference.

Suicide is a challenging and heartbreaking problem in Indian Country, especially among our young people. The IHS is committed to using a collaborative approach to addressing this crisis in our communities. No one agency can solve this alone, which is why partnership efforts such as this one are so important.

Our fourth priority is to make everything transparent, accountable, fair, and inclusive. These principles guide our work and decision-making.

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.

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 Indian Health Care Improvement Act 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 get updates on implementation of health care reform and other Indian health issues, you can visit my "Director's Corner," which is linked to the IHS home page. There you can get information on my presentations, Dear Tribal Leader letters, new and ongoing health initiatives, and other messages. You will also see an orange "Director's Blog" button that you can click on that will take you to my blog.

I use the Director's Blog to post brief updates on our activities and the latest IHS news at least weekly. 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 know that meeting with Tribes is important to the agency, and putting updates and pictures about the meetings on the blog helps. 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.

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.

The Affordable Care Act, and the reauthorization of the Indian Health Care Improvement Act, will also help Tribes and the IHS provide better care to American Indian and Alaska Native people. But we must be competitive so that our patients will still choose to use our healthcare services.

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, where we have a supportive President and administration, including 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. A lot of the support we have now is based on our willingness to demonstrate that we are changing and improving.

Thank you for your partnership as we change and improve the IHS. Now more than ever, we need to work together as a team. We are a system of healthcare and to survive all the challenges ahead, we must work even closer together. We have a responsibility to use our resources wisely and to continue to make progress to improve the quality of care that we deliver to all of our patients, including those served at our Direct Service sites. Because providing Direct Services will always be an important part of the future of IHS, our commitment remains strong to continue our efforts to change and improve the IHS.

Thank you, and I will now open the floor to any questions or comments you may have.