National Indian Health Board
Consumer Conference

September 27, 2011

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 National Indian Health Board's (NIHB) 28th Annual Consumer Conference. The theme of this conference, "Health, Hope, and Heroes," is a great theme because all of you – our health care providers and our tribal leaders – are my heroes for what you do every day to improve health for American Indian and Alaska Native people.

Today I will be providing an update on what IHS is doing to change and improve. We are working hard to improve our ability to meet the health care needs of American Indian and Alaska Native people, in partnership with Tribes and tribal organizations such as the NIHB. I am grateful for our partnership with NIHB.

Before I begin an update on our progress on our agency priorities, I want to update you 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 of 13%. That helped us, of course, but it was not enough to meet the great needs in Indian Country, so we continue to struggle to fulfill 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 an increase of $200-300 million each year to maintain current services and account for inflation and population growth.

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 a 10% increase for IHS.

The text is the basis of Dr. Roubideaux's presentation to the NIHB on Sept. 27, 2011. It should be used with the understanding that some material may have been added or omitted during presentation.

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. We will keep you posted.

Today you may have heard that the Senate passed two options for a continuing resolution until October 4 or November 18. We will learn about the outcome later this week.

The budget formulation process for FY 2013 is also in progress. 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 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. We are trying to take full advantage of all the support we have right now to make as much progress as possible.

Of course, all of our work to increase the IHS budget is in the context of the relative underfunding of IHS compared to other federal sources of healthcare.

But I do still have hope for IHS and the budget. I recently attended a congressional delegation trip to Oklahoma and South Dakota with 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, our successes, and the many challenges we face along with the incredible need. This subcommittee proposed a 10% increase for IHS in FY 2012, so we are very grateful that they took time to visit Indian country.

Now l would like to provide an update on our progress on our agency priorities. The four priorities we have set to guide our work as we change and improve the IHS 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.

We are making progress on these priorities, but it is clear we still have much more to do. 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. 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 and conferences such as this one.

Overall Tribes have stated that the IHS policy is good, but improvements could be made in the consultation process. 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. Please let me know if you are seeing improvements.

Tribal consultation is a priority of President Obama, who has expressed a commitment to honor treaty rights and a priority to consult with Tribes. He met with tribal leaders in the Roosevelt Room at the White House in December 2010. In that 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. At the first meeting of the Secretary's Tribal Advisory Committee (STAC), she signed an updated HHS tribal consultation policy. The STAC is the first Cabinet-level group of its kind. Also, based on a recommendation from the STAC, the Secretary sent a letter to all state governors encouraging them to consult with Tribes on programs for which they receive federal funding.

The Secretary and I recently visited several sites in Alaska, including Cook Inlet Tribal Council, Alaska Native Medical Center in Anchorage, Anaktuvuk Pass, Barrow, Tanana Village, and the Tanana Chiefs Conference in Fairbanks. We met with the Alaska Native Tribal Health Consortium while we were in Anchorage. We talked with the Community Health Aide at the Anaktuvuk Pass Health Clinic and were able to understand their challenges providing healthcare in a very rural isolated setting. We visited the Village of Tanana and had time to talk with elders about health issues. We also visited the Barrow Hospital construction site.

The director's workgroup on tribal consultation met earlier this year – they reviewed input from all Tribes and have made many recommendations on improving 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 in July 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 had great attendance at the summit, and 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 the site from time to time.

As I said, I attend many tribal meetings and conferences such as this one today and the NIHB Tribal Health Reform Implementation Summit that was held on April 19, 2011. Health reform is an important and urgent topic right now, so I was pleased to see the NIHB giving this level of attention to the issue. There was great attendance at the health reform summit.

I also attended the NIHB Board Meeting in January. I meet regularly with the NIHB Board of Directors and appreciate their partnership as we work together to improve Indian health.

I also meet regularly with the Tribal Self-Governance Advisory Committee to discuss self-governance issues, such as the budget, expanding self-governance in HHS, and contract support costs. And I attended the Direct Service Tribes Annual Conference that was held in August in Nashville. Sandra Ortega is the chair of the Direct Service Tribes Advisory Committee, and we meet regularly with the committee for advice and input on how we can best serve the Tribes in the facilities that we manage directly.

I have also met recently with the Arctic Slope Native Association tribal delegation and a Nome tribal delegation, and attended a tribal delegation meeting with the Alaska Compact cosigners. Tribal delegation meetings are an important way that IHS can meet and discuss issues in a government to government relationship. 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 the Domestic Violence Prevention Initiative, and our MOU with the Department of the Interior on alcohol and substance abuse prevention and treatment.

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 are also 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. I recently posted a series of blogs that explain the CHS program.

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.

We are reviewing the recent GAO report on documenting unmet need in the CHS program and will have the CHS workgroup review their recommendations in the context of their work already on the topic. The Workgroup is looking at the current CHS distribution formula for increases in our appropriations. The formula includes user population, cost, and access factors. The goal of the workgroup was to review the impact of the FY 2010 increases, and then make recommendations on whether to change the formula or keep it the same.

We recently posted on our website a summary of how the CHS program works in terms of approval of payment of referrals. It is clearly complicated, and we are working on improving our business practices in this area.

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 health coverage 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 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, quality assurance, 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 different definitions of who is an Indian in the law that apply to different provisions. Fixing this will require legislation to ensure there is no confusion in enrollment or implementation of the Exchanges. The administration has reviewed the non-uniformity of definitions of Indian in Affordable Care Act and has determined that there is no administrative solution. The Secretary affirmed at the recent STAC meeting that she does not have the administrative authority to change the definitions in the law. We are willing to work with Tribes and Congress to explore legislative solutions. We are interested in convening a discussion with Tribes to gather input on legislative solutions to the issue. Perhaps at the National Congress of American Indians (NCAI) conference we can arrange to meet on this topic.

We will have to think about how our business offices are going to teach our patients about their options regarding the Exchanges, 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. This is the topic of discussion in the Tribal Caucus tonight. 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 in these groups of providers that are working to improve quality and lower costs. We must look at how we are going to improve our ability to demonstrate quality improvements as payments are more aligned with quality or value, rather than volume. So we need to start discussing what all 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 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 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 on www.healthcare.gov, and we have provided information in tribal leader letters.

We are also now reviewing new Notices of Proposed Rulemaking on the implementation of the State Exchanges. HHS held some tribal consultation sessions recently on these notices. Also it is important to submit comments in writing. You can look these up on www.regulations.gov.

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 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. I encourage you to review this and our other Dear Tribal Leader letters that explain some of the provisions.

For example, section 126 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 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 Tribes agree 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 requesting input on the recommendations from the conference. Also, we just recently signed a Memorandum of

Understanding (MOU) between the Centers for Medicare and Medicaid Services (CMS), the Administration of Aging (AoA) and IHS to collaborate on technical assistance to Tribes on long-term care services.

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, which came to $2.4 billion for the current priority list, plus an additional $5 billion for the entire system need. It is hard to make progress on that with only $40-50 million per year of construction funding.

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.

Section 154 amends section 405 to allow sharing of medical facilities and services between IHS and the VA and also allows IHS to be reimbursed by the VA or the Department of Defense for services provided to eligible veterans. We know that this is a top tribal priority, and I can report that we are making progress – our two agencies are in direct discussions about how VA will reimburse IHS and Tribes for care they provide to Native American Veterans who are also eligible for VA health care. IHS and VA staffs will report to the Secretaries of HHS and VA by the end of the year on reaching a mutually acceptable reimbursement agreement. We plan to gather input and consult with Tribes in the near future.

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;
- We are using Dear Tribal Leader Letters to keep everyone updated; and
- The NIHB, along with the NCAI and National Council of Urban Indian Health, are helping IHS with outreach and education – and we certainly appreciate your assistance. We will be focusing this year more on education of patients and community members on the benefits of the Affordable Care Act.

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. And we have to ensure this message is stressed 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 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.

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 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 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 healthcare providers to serve our patients.

We also have started a series of trainings for our staff at headquarters for career development and to help them gain the skills they need to help us change and improve.

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. It 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.

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.

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.

The recent 2-year extension of the Special Diabetes Program for Indians 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 Special Diabetes Program for Indians 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'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 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.

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. We will be promoting breastfeeding in our IHS hospitals because it has been shown that breastfeeding can reduce childhood obesity.

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 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.

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.

And I am very pleased to report that for the first time that anyone can remember, we met all of our Government Performance and Results Act goals for FY 2011. Congratulations to all the IHS and tribal sites that worked hard to make improvements in the quality of healthcare that we deliver.

At our recent National Combined Councils meeting in Bethesda, MD, we discussed our agency reform efforts and strategies to improve the quality of care. I also awarded Southcentral Foundation's Traditional Healing Clinic with an IHS Director's Special Recognition Award for their innovative clinic that sits right in the Primary Care Center of the Alaska Native Medical Center. Western providers and traditional healers co-exist in the same medical facility.

Collaborations with other agencies are important in our efforts to improve the quality of and access to care, such as our partnerships with the Health Resources and Services Administration (HRSA), the VA, CMS, the Department of the Interior (DOI), the U.S. Public Health Service Commissioned Corps, and the Substance Abuse and Mental Health Services Administration (SAMHSA).

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 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 the 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. 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 the NHSC program, and we have increased the number of providers in Indian health sites to 216. So this program is working to provide much-needed health care professionals at our sites.

I have met with Assistant Secretary of Indian Affairs Larry Echohawk and his staff about several collaborative efforts, including suicide prevention. The DOI, SAMHSA, and IHS held listening sessions on suicide prevention with Tribes recently, and we held a joint suicide prevention summit just last month. 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 Indian Health Service 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.

Suicide mortality is increasing in all Areas, but especially in Alaska. We heard about this problem everywhere we went in our trip with Secretary Sebelius. And we heard about it at the Action Summit for Suicide Prevention in August 2011 in Scottsdale, AZ, where we discussed how federal agencies are collaborating on suicide prevention efforts. We learned about many best practices and effective and culturally appropriate strategies to address this problem. The attendance at the Action Summit was over 1000 people, consistent with the great level of interest in solutions to this heartbreaking problem in our communities.

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 through 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. I am grateful for the partnership of the NIHB as we work on these efforts.

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.

We recently checked the number of hits to the IHS Director's blog and in the last three months, we had over 10,000 hits from about 8,800 unique users.

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.

I want to thank the NIHB for your partnership as we change and improve the IHS.