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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 pleasure to be here with you today at the Association of American Indian Physicians (AAIP) annual conference. It is great to see old friends, and always refreshing to see the students who are attending.

Thank you to Dr. Walker and the AAIP Board for inviting me to speak. I also want to acknowledge Margaret Knight, the AAIP Executive Director, and her staff for all their hard work in coordinating this meeting. I know that this meeting means a lot to the physicians and the students, so thank you so much.

I reviewed the agenda, and am pleased to see so many sessions on innovative approaches to improving healthcare in Native communities. We are working hard in the Indian Health Service towards the same goal of improving the healthcare services and the health status of American Indians and Alaska Natives. Today I will talk a little about what we are doing to address the healthcare disparities in our patient population.

The last time I was at an AAIP event was at the Patty IronCloud National Native American Youth Initiative meeting in Washington, D.C., in June. It was so great to see all the young students interested in health professions!

Dr. Phil Smith spoke at the Youth Initiative. He is an American Indian physician who works in the Office of Public Health Support at IHS Headquarters. One of the great parts of my job is seeing American Indian and Alaska Native physicians and health professionals such as Dr. Smith working hard in the Indian health system. I think there are more of us in leadership positions these days, and more are being recognized for their contributions.

Another Native member of my senior leadership, Dr. Kathy Annette, received a Presidential Merit Award last year at the State Department. Some of you may know that Dr. Annette, after 25 years in the IHS, is leaving to go be the CEO of a foundation in Minnesota to help rural communities. We are grateful for her years of work.

I am sure many of you here today know Dr. Charlene Avery, a Native physician who is the Director of the IHS Office of Clinical and Prevention Services. She is doing a great job helping us make improvements to the IHS. You may also know Dr. Lyle Ignace, who joined us as the Director of the Improving Patient Care Initiative at Headquarters. This is our patient-centered medical home initiative. He is helping us make some improvements to this great program that we have expanded to 68 more sites this year.

Other Indian physicians in leadership positions in IHS include a number of our chief medical officers – including Dr. Dawn Wylie, Dr. John Farris, Dr. Ty Reidhead, Dr. L.D. Thomas, and Dr. Rod Cuny. We even have Indian colleagues among our chief clinical consultants group, such as Dr. Ann Bullock. And we have many Clinical Directors at IHS who are also Indian physicians and who are helping us with local clinical leadership and management.

I am so glad to have American Indian physicians in leadership positions to help us improve care for the patients we serve. I know that there are some future leaders in this room as well today. Someone in this room may be the Director of the IHS someday. So it's important for all of us to learn what we can from the presentations at this meeting to help us in our current and future work.

We have some award-winning American Indian and Alaska Native physicians this year. Dr. Rex Quaempts was selected to represent the Special Diabetes Program for Indians Healthy Heart Program Demonstration Project Grantees at the recent IHS Director's Awards Ceremony. His program, along with the rest, demonstrated the successful translation of research findings related to cardiovascular disease risk reduction in 30 diverse IHS, tribal, and urban Indian health settings.

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 and traditional healers and practices co-exist in the same medical facility. They also have a traditional herb garden right outside.

And of course, I always enjoy seeing Dr. Rhoades, one of our former IHS Directors, at Indian health meetings – his post-director life has been rich and full of outstanding work and advocacy for Indian people. He gives me hope that there is life after this job!

Well, I am glad to have all this help from American Indian and Alaska Native physicians, because the IHS continues to faces significant challenges as we work to fulfill our mission.

Health disparities continue to persist for American Indians and Alaska Natives compared to other populations. For instance, diabetes mortality rates are still nearly three times higher for American Indians and Alaska Natives than for the general U.S. population, and suicide rates are nearly twice as great. Alcohol induced mortality is 6 times greater. Even though IHS has made great progress in reducing health disparities, we still have much work to do.

And we have this enormous amount of work to do with very limited resources to provide care. A lack of adequate resources is a huge barrier to fully meeting the mission of the IHS and reducing health disparities. Per capita expenditures for IHS are much lower than those for other federal healthcare sources, such as Medicare, Veterans Health Administration, Medicaid, etc.

All the problems and challenges we have in the IHS – health disparities, lack of healthcare providers, lack of updated facilities, delays in providing care, for example – seem to fundamentally result from our lack of resources.

But while we are trying hard to get more funding for the IHS, we also have to do everything we can to continue to make progress in improving the care we provide and ultimately reducing health disparities for the patients we serve.

As many of you may know, we have set four priorities to guide our work as we change and improve the IHS. The first priority is to renew and strengthen our partnership with Tribes; our second priority is to bring reform to IHS; the third priority is to improve the quality of and access to care for

patients who are served by IHS; and the fourth priority is to have everything we do be as transparent, accountable, fair, and inclusive as possible.

These priorities are a framework for our system, our leadership, our healthcare providers, and our administrative staff to help make contributions to helping change and improve the IHS. We are making progress on our agency priorities, but we have much more work to do.

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 last year the IHS got a big budget increase – a 13% increase – that helped us, but of course, the need is so much greater and we continue to struggle to meet our mission with available resources. For this year, the President proposed a 9% increase. However, with the debate on the budget in Congress, the shared responsibility we all have to help the economy and address the national debt, and the near government shutdown, we finally ended up on a continuing resolution through the end of September, but with only a 0.4% increase of about $16 million. However, many federal agencies sustained large cuts, in the hundreds of millions.

Fortunately, all the support for us from this administration and the bipartisan support for IHS in Congress led to us faring better than others, 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.

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 just last month. We don't know if that will survive the current debate about the budget in the House or the Senate. Especially with the debt ceiling deal that tied the raise of the debt ceiling to fiscal responsibility and budget cuts. The Senate is expected to work on their FY 2012 markups in September after the break.

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, while there is still a lot of support for IHS; we don't know what the impact will be on the IHS of future discussions about budget cuts. However, as the IHS Director, I continue to advocate for our budget within the administration and with members of Congress. We have a lot of support at this time, so we are trying to make as much progress on the budget as possible.

So let's return to progress on our agency priorities, starting with our first priority to "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 tribal consultation policy is good, and that improvements could be made on the process for consultation.

One area they want to see more improvement on is in the Area and local consultation. So we now need to focus on improvements in Area and local consultation, and I have made this clear to our Area and local leadership. We can do so much more if we work in partnership.

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 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 Kathleen Sebelius is also committed to tribal consultation. She signed the updated HHS tribal consultation policy at the first Secretary's Tribal Advisory Committee (STAC) meeting. 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 we 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, 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 website from time to time.

I cannot overstate the importance we are placing on listening to and consulting with Tribes. 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. 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, now considering FY 2013;
- Information Technology Shares in our Public Law 638 negotiations with Tribes;
- 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 the distributions for the Methamphetamine and Suicide Prevention Initiative and the Domestic Violence Prevention Initiative, and the Memorandum of Understanding (MOU) with the Department of the Interior (DOI) 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. While lack of funding is a real problem and the reason that we cannot pay for all the needed referrals, Tribes have volunteered to help us better document the need for CHS funding and also are willing to share best practices and help us manage our programs better and more consistently. We are learning a lot from the large increase in CHS ($100 million) we received in FY2010 and all the benefits the increased funding can have for our patients. Some facilities have been able to authorize payment for referrals beyond Priority I as a result. That means our patients get needed healthcare. It is our responsibility to make sure they get that care in the timely manner.

Our work with Tribes on this issue is revealing we have a lot to do in terms of education about CHS. Tribes are even better informed and prepared to go to Congress to advocate for more funding as they learn how the program should be managed and the impact of lack of funding. So this partnership helps all of us.

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. We are also now starting to talk about health care delivery system reforms to focus more on quality and reducing costs. There are a number of payment reforms and system redesign efforts, such as the accountable care organizations, that we really need to have more discussions about on how it will impact the Indian health system.

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 and Medicaid will help individuals in terms of more coverage and choices, and our health facilities in terms of reimbursements. We have so much to potentially benefit from because of the Affordable Care Act. This is especially important for many of our facilities because over half of their budgets are actually from third-party collections.

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. So it is very important for us to understand what is in the law and how it will impact us.

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 with Tribes on many parts of the Affordable Care Act through outreach calls, meetings, and listening sessions. There are facts sheets and other information on http://www.healthcare.gov/, and we have provided information in tribal leader letters.

One of the things we need to do, and I think that AAIP and all of you can help us with greatly, is to have more discussions about the Affordable Care Act among providers, administrators, and programs within the IHS system. We need to be strategically thinking of how we will adapt, change, and take advantage of all the new benefits in this law.

One question I get all the time is what will happen if the Affordable Care Act is repealed. There have been some attempts to do this in Congress, and there are also some court cases making their way to the Supreme Court. Until those are decided, we are moving ahead with implementation of the law.

The Indian Health Care Improvement Act was included in the Affordable Care 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. That's our challenge – this is an authorizing law; it did not come with additional funding. So we have more work to do.

IHS is the lead on implementation and is working quickly to implement provisions of the law, in consultation with Tribes. It is also important for everyone who works in the Indian health system to understand the new authorities in this law.

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 our other tribal leader letters that explain some of the provisions.

We recognize that education and communication are priorities at this time. So we are taking steps to keep everyone informed. Everything you learn about today will be available in one of these formats:

- You can find updates on our implementation process on my Director's Blog at http://www.ihs.gov/;
- HHS has a website – http://www.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.

Again, 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.

We have to improve as a business. The first step is accepting we are in the business of healthcare. One of the most harmful things we have done in recruitment over the years is telling people that IHS is somehow "easier" than the private sector, and that healthcare providers can "escape" the business worries of the private sector. That is just plainly not true, especially now with the changing U.S. healthcare system and our lack of resources. We have to be fiscally responsible, balance our budgets, and find ways to provide quality care in more efficient and effective ways. Now more than ever, we need to focus on the business of healthcare.

To improve the way we do business, we're working with our Area Directors to improve how we manage in several areas. One very important area where we have made significant improvements is in how we plan, manage, and monitor our budgets. We're working to make our business practices more consistent and effective and to have better management controls throughout the system. We are meeting more frequently with our leadership on these topics.

To improve how we lead and manage staff, we have also been working on specific activities to improve the hiring process by making it more efficient and less time-consuming. We have realized the only way it is going to improve is for both Human Resources (HR) staff and supervisors to help make improvements. Blaming each other is no longer acceptable. Basically, by understanding the hiring process better and having both HR and supervisors work together, we will see improvements. We have also been working on improving some disparities in pay compared to the private sector in some healthcare provider positions. Title 38 has allowed us to be more competitive for salaries in many specialties.

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 progress on our agency priorities and hold employees accountable for poor performance.

We have also 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. We are also conducting reviews of all IHS Areas to make sure that the findings of the investigation are not happening elsewhere. Overall, we are finding that we generally have policies in place, but we need to work on ensuring we are consistently implementing those policies across the system. We have completed investigations of the Albuquerque, Billings, and Navajo Areas so far. The Oklahoma Area review is this week.

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. 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.

Some have complained that this is busy work – however, hiring one person on this list ruins all our great hires because our patients lose confidence in us. This is an important simple step. It just takes a few minutes to go to the Office of Inspector General website and check the list of excluded

individuals. We should not be hiring people we would not want to take care of our own beloved family members. Just because we have a vacancy and are short staffed doesn't mean we should hire just anybody. Our background checks PRIOR to hire are extremely important. 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. However, we still have much to do in this area. I was really excited to honor recipients of our new IHS Director's Award for Customer Service at the recent IHS Director's awards ceremony. We also have to understand that even if we provide the highest quality of care, poor customer service can ruin everything, because the care was poor quality from the patient's perspective.

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. 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. It will also help us play a bigger role in all the new delivery system reforms related to the Affordable Care Act in the coming years.

The IPC held its first learning session in Tucson in February, held its second learning session in Denver, and just recently held a virtual learning session. We are working to develop capacity and leadership within IHS to ensure that we can implement this important initiative in all of our sites eventually. By developing this initiative with our own leadership, we have a better chance of understanding how to successfully create a medical home in all of our facilities.

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 have been working on dissemination of their best practices and are actually meeting this week in Denver. 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.

The new Partnership for Patients that was recently launched by Secretary Sebelius will help reduce harm by focusing on reducing hospital acquired conditions and hospital readmissions. We will be working on this initiative as a system. We need to participate in this initiative since future payment models will be based on our ability to demonstrate quality of care rather than the number of patients we have seen.

We have also increased restorative and preventive care to our youngest patients as a result of the Early Childhood Caries initiative. These efforts are aided by implementation of the Electronic Dental Record throughout IHS. Currently, 73 sites are operational.

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. I encourage you to have a look at the Action Guides for healthcare providers and for communities. While progress has been made, overweight and obesity continue to drive up high rates of chronic disease. Taking action now is vital.

And we just launched our IHS Baby-Friendly Hospital Initiative in Shiprock, New Mexico, to promote breastfeeding to help reduce obesity. An interesting feature of the program was the use of

digital storytelling 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.

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.

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 help all facilities implement activities to achieve meaningful use of our electronic health record. 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.

And I am pleased to tell you that the Cherokee Nation Health Services – a tribal program – is the first program in the Indian health care system to receive a Meaningful Use incentive payment.

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 we are working on with other federal entities, including the Health Resources and Services Administration (HRSA), the VA, the Centers for Medicare and Medicaid Services, the DOI, the U.S. Public Health Service Commissioned Corps, and the Substance Abuse and Mental Health Services Administration (SAMHSA).

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 just held a joint Action Summit for Suicide Prevention in Scottsdale, Arizona. The topic is of such interest that we had over 1000 people at the conference.

We are working 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 Indian and Alaska Native veterans who are eligible for the VA and the IHS.

We have a great partnership with HRSA and thanks to Dr. Mary Wakefield, the HRSA Administrator, for helping get all Indian health sites eligible for the National Health Service Corps program, which will help with recruitment of healthcare providers.

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 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 available 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 to all facility directors – please check my blog if you did not see the letter – it

contains important instructions to take advantage of this new resource for more providers. I hope all the students can learn about this program as well.

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. 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 help fund to provide health services in urban communities. Since our programs are run by IHS, Tribes, and urban Indian programs, we have to make sure we are being inclusive of all their needs in our decision-making.

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 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. 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 place we post the most updated information on the IHS and Indian health care. I encourage you to check it 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, provide better quality services, and ultimate, reduce health disparities in the communities we serve.

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.

Overall, we are beginning to make progress on our priorities and are moving forward on the challenging work to change and improve the IHS. 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 all that you are doing to help us 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. Thank you to AAIP for focusing this meeting on health disparities. If we all work together, we can make a difference for the people and the communities we serve.

Thank you!