Indian Health Service

Indian Health Partnerships Conference

August 13, 2013

Indian Health Service Update

by

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Good morning. I am Dr. Yvette Roubideaux, Acting Director of the Indian Health Service (IHS). It's great to be here with you today at the Indian Health Partnerships Conference. I would like to thank Carl Harper, Director of the Office of Resource Access and Partnerships, the program leads, and everyone who helped make this conference possible. We're all excited that so many of you have joined us for this important conference.

The focus of the conference is on implementation of the Affordable Care Act (ACA) and getting staff prepared to start helping our patients enroll in the Health Insurance Marketplaces beginning October 1 of this year. We want to ensure the Indian health system is prepared to answer questions and assist our patients as they learn about and may choose to take advantage of the new benefits of the law.

Today I will provide an update on the ACA in the context of what we are doing to change and improve the IHS.

Let me first say how much I appreciate all your hard work and dedication, whether you are a CEO, medical provider, benefits coordinator, health records staff, or other administrative or support staff. It takes all of you, working together, to ensure the effective implementation of the ACA provisions, which are an important part of our ongoing efforts to improve the health status of American Indian and Alaska Native people.

October 1, 2013 is a really important date. That's when the ACA Health Insurance Marketplaces open for enrollment for people who want to purchase more affordable health insurance or who want to enroll in the Medicaid Expansion if it is present in your State.

So starting October 1, it is the responsibility of every IHS employee to be able to do one of two things: answer questions from patients about the ACA, or refer them to someone who knows the answer. "I don't know" is not an acceptable answer.

And actually, it is likely that YOU will be the person at your local facility who is expected to know the answer. So it is really important that you share the information you learn at this meeting with everyone in your facility and help our system prepare for October 1.

The text is the basis of Dr. Roubideaux's oral remarks at the Indian Health Partnerships Conference on August 13, 2013. It should be used with the understanding that some material may have been added or omitted during presentation.

I would like to start by talking about the IHS budget. The ACA will definitely have an impact on the IHS budget. And we all know that the budget is a huge factor in our ability to provide the services our patients need. Per capita expenditures for IHS are much lower than those for other federal health care sources, such as Medicare, Medicaid, and the Department of Veterans Affairs (VA). It's clear that a lack of adequate resources is a huge barrier to fully meeting the mission of the IHS. Many of the challenges and issues we struggle with at the IHS relate to this lack of resources. So advocating for more funding has been a top priority.

But in addition to our appropriated funding, IHS also depends on revenues from third-party resources (private insurance, Medicare, Medicaid, etc.) for a significant part of our budget; in some facilities, almost half of their budget is from third-party reimbursements.

So if the ACA means potentially more resources for IHS, you can see how important those resources would be. Especially since our budget that results from congressional appropriations is of more concern these days. It seemed like we were on a roll prior to this year. We've received increases in the IHS budget each of the last 4 years. Overall, the IHS budget authority has increased 29% since fiscal year (FY) 2008. Within this increase, there have been some significant targeted increases; for example, the 46% increase in Contract Health Service (CHS) funding has made a difference. Almost half of all federal CHS programs are now funding more than Priority 1(life or limb) referrals.

For example, this increase in funds, along with concentrated efforts to improve their CHS program, has resulted in an increase in orthopedic care for patients at the IHS Shawnee Service Unit. In 2011, the deferred referrals for orthopedic care were more than the approved referrals. However, with the increased CHS funding in FY 2012, the number of CHS referrals increased, and the approved orthopedic referrals were much higher.

So more resources do make a difference.

IHS has a Tribal Budget Formulation process, and that's when Tribes can learn about the budget and propose funding levels and priorities. They have helped advocate for increases in the IHS budget. And the annual Department of Health and Human Services (HHS) Tribal Budget and Policy Consultation is where the Tribal Budget Formulation Workgroup presented their recommendations for the IHS budget and had a session with Secretary Sebelius to discuss their budget and policy priorities.

However, the FY 2013 budget this year is a different story, and the budget climate has certainly changed. The final IHS FY 2013 budget authority is $4.1 billion, which is lower than the FY 2012 budget of $4.3 billion. The FY 2013 budget includes an increase of $53 million for additional staffing for new health care facilities that have been constructed, which is great. But it also includes across-the-board rescission cuts of $8 million and sequester cuts of $220 million.

IHS is engaged in extensive implementation efforts to absorb the cuts associated with sequestration on the federal side. However, the impact is significant: reduced services, denied referrals, and a significant change in the way we're doing business to protect the IHS mission. We know the budget is having a negative impact on tribal programs as well.

We've already implemented a number of cost-saving changes to the way we carry out our work, including many reductions in administrative functions such as travel reductions, new restrictions on conferences, delayed or reduced purchasing and contracting, hiring delays and lapsing of positions, and efforts to enhance third-party collections. Thank you for your help with all these measures.

You may have also heard about the efficiency in spending initiatives that require federal reductions in travel and strict conference approvals and oversight. We had to get approval for this conference.

We're doing everything we can to protect our agency mission to the greatest extent possible. For instance, we've held many virtual meetings to help reduce travel and training costs. We're holding meetings with hundreds of participants using webinar technology so that we can continue the important work of the agency. We're actually offering some of the sessions in this conference via Adobe Connect since some people who wanted to attend this conference did not have the necessary travel funds. Thank you for your patience as we use this new format.

We're doing everything we can to eliminate the need for sequestration and to get the IHS budget back on track. That's why we're supporting the FY 2014 President's Budget Request, which was released in April. It has enough deficit reduction to replace sequestration entirely, but still protects important priorities such as IHS and other tribal programs.

The FY 2014 President's Budget proposed a 2.9% increase in budget authority for the IHS from the FY 2012 enacted level, with a total budget request of $4.4 billion, which would help get us back to where we need to be – continuing the upward trend of the IHS budget. This adds $124 million to the IHS appropriation compared to FY 2012, and includes increases for the CHS program, staffing for new facilities, pay costs, and contract support costs for tribal programs. The next step is for Congress to pass a budget for FY 2014, but given the budget climate, we're likely to be on a Continuing Resolution starting October 1.

So third-party resources could be a big help with all this uncertainty about our budget.

I am so grateful that HHS makes the IHS budget a priority. The President also has said that IHS is a priority. Even with all of this support for the IHS, it is still a difficult budget climate. As a result, we have to do everything we can to maximize our revenues, whether they are from appropriated dollars or are from third-party reimbursements. The ACA has the potential to help us on the revenue side of the budget.

Especially with all the uncertainty about the budget, we need to keep focused on our efforts to change and improve the organization, guided by our four agency priorities. And all our work on these priorities will help us with implementation of the ACA. So now I would like to provide an update on our agency priorities, with a focus on how they help us with the ACA implementation.

Our first priority is to renew and strengthen our partnership with Tribes. The only way we're going to improve the health of our communities is to work in partnership with them.

Working to improve tribal consultation is an important part of this priority. We've seen evidence throughout our system that we accomplish more when we work in partnership with our communities. We've done a lot to improve consultation at the national, Area, and local levels. The input we have received from Tribes over the past three years has helped with policy and regulation development for the ACA.

Now, many of our discussions in tribal consultations are focusing on the implementation of the provisions in the reauthorization of the Indian Health Care Improvement Act (IHCIA) and the ACA, including preparations for the Health Insurance Marketplaces starting October 1.

I recently attended the inaugural meeting of the White House Council on Native American Affairs, which was established by Presidential Executive Order to convene federal agencies to better collaborate on tribal issues. The meeting was held in the Indian Treaty Room in the Eisenhower Executive Office Building at the White House and included several Cabinet Secretaries, including HHS Secretary Sebelius and Department of the Interior Secretary Jewel, who serves as the Chair.

This Council now will give attention to tribal priorities at the highest level of government. And in a listening session with Tribes before the meeting, health is one of those priorities, including help with implementation of the ACA.

Secretary Sebelius is committed to helping improve the IHS. She has signed an updated HHS Tribal Consultation Policy with her Secretary's Tribal Advisory Committee (STAC), which is the

first Cabinet-level tribal advisory group. We often discuss the ACA implementation at STAC meetings.

Tribal consultation is a major activity for IHS because we need to understand the priorities and issues of the communities we serve. The ACA always comes up as a topic at our listening sessions with Tribes.

National tribal listening sessions are an important forum for fostering mutual understanding and hearing about priorities. Area listening sessions are also an important venue for me to hear about Area and local issues, such as the last California Area Listening Session. I also meet with tribal organizations like the National Indian Health Board on a regular basis.

I also meet regularly with the Tribal Self-Governance Advisory Committee (TSGAC), which focuses on Tribes that manage their own health programs under the Indian Self-Determination and Educational Assistance Act. Many Tribes have chosen this option, and overall they are doing a great job. And a Direct Service Tribes Advisory Committee (DSTAC) quarterly meeting was recently held in Rockville, Maryland. They advise the agency on issues related to the facilities that IHS continues to manage directly. I'm glad that the DSTAC and TSGAC leadership are starting to meet together on common issues.

We also hold individual meetings with Tribes, such as a recent Tribal Delegation Meeting with the Redding Rancheria.

Tribal consultation has been extremely important as we've been preparing for the ACA. Tribes want to make sure that our patients and our system can benefit from the new law as it is implemented.

We've conducted a number of tribal consultations in the past few years, and we've concluded or made decisions on many of these. I would like to highlight two of them today that are relevant to our discussions.

The first is the consultation since 2010 on improving the CHS program, which is how we pay for referrals for services in the private sector. We've consulted with Tribes on how to improve the referral process. One of those improvements has been making online CHS training available on the IHS website. We've also made significant progress on gathering better data on CHS denials and deferrals. For FY 2012, the shortfall for CHS was $973 million – almost a billion dollars of need beyond our funding. That's why CHS is a priority in budget formulation, since this impacts all Tribes. We also recently heard a recommendation from the workgroup to keep the CHS funding distribution formula the same.

The CHS workgroup have made some very key recommendations for improving our CHS business practices. More referrals are being made, we're tracking deferred and denied referrals more accurately, and we're working with outside providers to improve the referral and billing process. We appreciate the work of all those who are helping with this important effort. I know that many of you have helped make these improvements, so thank you so much for helping us change and improve our CHS program.

The second consultation is the consultation on the VA-IHS Memorandum of Understanding (MOU) that was signed in 2010, and the recently signed VA-IHS National Reimbursement Agreement. Through this agreement, VA can reimburse IHS for direct care services to eligible American Indian and Alaska Native veterans. The agreement implements Section 405 of the IHCIA, and serves as the agreement for all IHS federal facilities.

Tribal consultation was critical to the completion of the final agreement and it includes the tribally recommended Office of Management and Budget all-inclusive rate for outpatient services provided to American Indian and Alaska Native veterans eligible for IHS and the VA.

We're actually making progress on improving coordination of care for veterans eligible for IHS and VA under the MOU, and can now bill the VA for direct care services provided to Native

veterans. The initial 10 federal sites are now billing the VA, and they are receiving payments from the VA! That's more dollars for services for everyone served by the facility. We are implementing the billing process at all our federal sites, so thank you for helping us implement this important reimbursement agreement. I know that the tribal sites are also entering into agreements with the VA and receiving reimbursements.

Our second IHS priority is "to bring reform to the IHS." This priority has two parts – the first part involves the ACA and the IHCIA. The second part is about internal IHS reform.

First, I would like to spend some time on the ACA. I know that you will learn a lot more during this conference, but I wanted to cover some of the basics. Remember, you will need to be able to answer questions from our patients, and you need to have the correct answers.

The purpose of the ACA is to increase access to quality healthcare coverage for all Americans, including our First Americans. I hope you already know that the benefits of the ACA for American Indians and Alaska Natives are significant. They can benefit from all the reforms, whether they have insurance now, want to purchase affordable insurance through the "Health Insurance Marketplaces," or can take advantage of the Medicaid expansion starting in 2014. Indian elders will benefit from how Medicare is being strengthened with more affordable prescriptions and free preventive services.

We know that some states are not choosing to expand Medicaid, but we hope they change their minds soon. The expansion means that more low income adults will be able to get health coverage.

And of course, we're thrilled that the Indian Healthcare Improvement Act, our authorizing legislation, was made permanent by the ACA. So IHS is here to stay.

Sometimes Tribes and patients ask me why they should care about the ACA, since they already get their healthcare through IHS. The answer is that while IHS is here to stay and will remain a health care system that our patients can access, the ACA is about options for additional health coverage. It's another way the government meets its responsibility for health care for American Indians and Alaska Natives. It is an additional option for our patients.

Right now, about 23% of our patients have private insurance; that means when they come to us for a visit, we can bill their insurance. That means more resources at the local level for services for all patients. The same is true for other coverage. About 38% of IHS patients are currently on Medicaid. With the ACA and Medicaid expansion, many more of our patients may be eligible for Medicaid.

Medicare and the VA account for a smaller portion – less than 10 percent – of the health coverage that our patients have, but they also bring in more resources. However, a good proportion – approximately 30% – of our patients have no health coverage other than IHS. This is the group that may benefit the most from the ACA. In fact, we estimate that we could see an additional $95 million in third-party collections in FY 2014. So making sure our patients understand their choices related to the new benefits of the ACA is critical.

As I mentioned at the beginning of this presentation, an important date is coming up soon – October 1, 2013 – that's when enrollment begins for the ACA Health Insurance Marketplaces and the Medicaid Expansion. It's especially important that everyone understand what new benefits are available now and in about 50 days from now.

The key things that you need to know are that the Health Insurance Marketplaces, whether run by the state or the federal government in your state, will be a way for individuals to purchase more affordable insurance if they are interested for any reason, such as not having employer-sponsored insurance or just wanting more choices for their healthcare.

Or they can enroll in the Medicaid expansion in the Marketplaces. More of our patients are likely to be eligible for Medicaid now, since it will only be based on income less than 133% of

poverty level. The Medicaid Expansion also gives our patients more choices about their healthcare, and potentially more reimbursements for our facilities.

While enrollment starts on October 1, the coverage will start January 1, 2014. So this means starting October 1, our patients can find out their new choices related to health coverage. So we have to be ready to help them enroll in the Marketplaces.

Individuals can apply or enroll in the Marketplaces through a number of different ways – by phone or mail, online, or in person. They can submit an application to the Marketplace, which will determine their eligibility to purchase insurance and whether they qualify for premium tax credits or cost-sharing reductions so that they don't have to pay copays or deductibles when they use their insurance. They can also determine if they are eligible for Medicaid. It is important to encourage everyone to enroll to see what benefits are available to them.

There are special provisions for American Indians and Alaska Natives who are members of Tribes. They won't have copays or deductibles if they go to IHS, or anywhere if their income is below a certain level. Given the tax credits available, American Indian and Alaska Native patients may be able to pay very little in premiums for insurance after they determine their eligibility. And they have the option to enroll on a monthly basis, not just once a year. So we have to encourage them to at least take a look at their individual eligibility.

There will also be a way during the Marketplace enrollment process that our patients can determine if they meet the exemption or can apply for a waiver from the mandate to have health coverage. And that relates to the "definition of Indian" in the ACA.

You may have heard about the "definition of Indian" issues in the ACA related to specific benefits of the ACA. IHS eligibility is not affected and will remain the same. The definition of Indian in the ACA impacts three areas of benefits – access to monthly enrollment for those purchasing insurance; access to cost-sharing waivers (which means not having copays for those who have insurance); and the minimum responsibility payment, or penalty, for not having health coverage.

The challenge is that the ACA law was written with definitions of Indian that are narrower than IHS eligibility, and that include only members of Tribes. IHS eligibility is broader and includes members and descendants of Tribes.

During tribal consultation on this issue, Tribes in general have said that they want the definition of Indian in the law to be equal to IHS eligibility. However, since the definitions are in the law, it will take Congress to fix it. HHS has been giving technical assistance to Congress on this issue.

The good news is that HHS recently announced that all American Indians and Alaska Natives who are eligible to receive services from IHS will receive an exemption from the minimum responsibility payment under the ACA. This means that all American Indians and Alaska Natives who are eligible for IHS will not have to pay the penalty for not having insurance coverage.

Prior to this exemption, based on the specific definition of Indian in the ACA, only tribal members would have been exempt from the requirement to maintain minimum essential coverage under the law. This announcement means that all American Indians and Alaska Natives eligible for IHS services are exempt from the minimum responsibility payment. And our tribal partners were essential in reaching this point, because this decision reflects the comments and feedback received from Indian Country.

While this is great news, we do still need to work with Congress on corrections to the definition of Indian as written in the law related to access to monthly enrollment and cost-sharing waivers. Again, it doesn't change IHS eligibility; it just makes sense that the same people who are eligible for IHS should also benefit from the ACA provisions specific to Indians.

It will be important for all of our patients to go to the Marketplace to determine if they are exempt or can get a waiver from the penalty for not having health coverage, which will be possible for everyone who is eligible for IHS.

So in addition to the normal eligibility rules, there are special benefits for American Indians and Alaska Natives who are members of Tribes and/or are eligible for IHS.

Our patients are likely to need help with this since, as you can see, it is complicated. There will be people to help – there are various ways that groups or individuals can assist people during enrollment in general. We're working with our local staff, including those in the business office, to help assist our patients. This is especially important since many of our patients who have used IHS their entire lives may not be familiar with insurance. They also may not realize that they are eligible for special benefits.

So in case you were wondering, the people who will help our patients – are all of you! Remember, you need to be able to answer their questions or refer them to someone who knows the answer. So I am glad you're here!

In addition to the training we have at the conference this week, there will be web-based training available soon, including training available for certified application counselors who can assist individuals with enrollment. We expect that at least one person at each IHS facility will complete that training before October 1. You will hear more about it later today.

I know that many of you have been involved in planning efforts at the local level. Since the potential to impact our bottom line is significant, IHS has developed a business planning template to help ensure our facilities have the opportunity to benefit from their patients' increased access to affordable health coverage, as this could mean more resources through third-party collections, and more services for everyone we serve. However, we have to plan, because patients may get more coverage and then decide to go elsewhere for their care. And if they do, that's resources that are going elsewhere. Given our budget situation, you can see how serious a problem this would be for our facilities.

The template covers understanding the local health insurance market and the potential patients who might enroll; assessing the workload for the facility, including the business office and the CHS program; and looking at marketing for staff and patients to ensure they know what to do and that they want to continue to receive their care at the facility.

A copy of the planning template was sent to all IHS Service Units – it's required for federal sites, and recommended for tribal and urban Indian health programs.

We're also working with the Qualified Health Plans, or QHPs, that will offer insurance for purchase in the Health Insurance Marketplaces in 2014; they are establishing networks and should be working with our local sites.

The QHP Addendum for IHS, tribal, and urban Indian health programs is now available to help explain the special authorities for working with these programs.

We're also working on Contracting Guidance for Service Units when they enter into agreements with QHPs, and we will share this guidance when it's completed. There are workshops on all of these topics at this conference.

A major focus over the next few weeks to months is training for our staff and Tribes on the ACA, which is what this conference is all about. We're also working with HHS and the Center for Consumer Information and Insurance Oversight on training for our staff. In addition, the national tribal organizations are helping us with outreach and awareness training. The National Indian Outreach and Education initiative, which includes partners from all IHS Areas, have conducted over 330 ACA training sessions so far, and plan to do many more this year. They're also developing helpful materials on the ACA, including a website. I encourage you to take a look at some of the

helpful tools and information on this site. We appreciate all their help in getting information out to Indian Country on this very important health legislation.

And we have a number of other resources for training, such are enrollment assistance training, webinar training, PowerPoints, fact sheets, etc.

Our goal is that all staff will be able to respond to questions that patients have about the ACA, or will know where to refer the patients for further information.

You can go to https://www.healthcare.gov/ to learn more about your options related to the ACA. This will help you access the federal Marketplaces, and if your State has a separate website, it will link to that site. This is where anyone can go starting October 1 to see if they are eligible for the Medicaid expansion, or to compare rates for purchasing health insurance in their state. We will be referring our patients to this website, and you may be assisting them, so please familiarize yourself with this website.

Those of you on the technical side can go to the website http://marketplace.cms.gov to get information on training and resources to help you learn more about the ACA. I know that some of you will be going back and conducting trainings yourself, so you can get materials here.

There's a tribal website – http://tribalhealthcare.org – that was developed by the National Indian Outreach and Education partners. I encourage you to take a look at some of the helpful tools and information on this site.

And we have a slide show, tailored to the American Indian and Alaska Native population, to help with outreach and education efforts in Indian communities. In the concurrent session, ACA 101, you will see an updated version of this presentation that you can use locally. We need all of your help to make sure all American Indians and Alaska Natives know what benefits are going to be available starting in 2014.

So how do we reassure our patients that they should go to IHS for their care if they have so many new choices? One way is to ensure that they know that we're changing and improving the organization to better serve them, and that we're using our resources efficiently and effectively.

We are working on internal reform efforts to change and improve the IHS, and to better prepare us to take advantage of the benefits of the ACA and the IHCIA. Our internal reform efforts are focused on improving the way we do business and how we lead and manage our staff, with an emphasis on customer service, ethics, professionalism, and performance management.

To improve the way we do business, we're working with HHS and our Area Directors to improve how we manage our budgets and to improve our financial management. And we're working to make our business practices more consistent and effective throughout the Indian healthcare system.

To improve how we lead and manage staff, we're working on specific activities to make the hiring process more efficient and proactive, and less time-consuming. We're using the new HHS supervisory training for our managers, and improving our performance management process to praise top performing employees and to better hold accountable those employees who aren't performing well.

We're also working on improvements in pay systems and other strategies to improve recruitment and retention, which are big issues at all of our sites, and may get worse due to the looming shortage of primary care providers in the U.S. in general. We're working on specific activities to make our hiring process more efficient and proactive, and less time-consuming.

We're working on various ways to address the shortage of physicians and health professionals in the Indian health system, such as our scholarship and loan repayment programs. And we're using the National Health Service Corps to recruit more providers; all our sites are now eligible for National Health Service Corps placement. We currently have approximately 311 full-

time providers employed at our Indian health program sites, which is a substantial increase from the 260 providers we had at this time in 2012.

All these reforms are ongoing and are helping us change and improve the agency's business practices, which is fundamental to our reform efforts and to preparing for the ACA.

Our IHS senior leadership team at headquarters and our Area Directors are the leaders in our efforts to reform the organization and implement the ACA. We meet regularly to ensure that we continue to make progress.

Our third priority is to improve the quality of and access to care. We have emphasized the importance of customer service, and I am now starting to see and hear about activities to improve customer service throughout the system. Customer service is even more important now that the ACA is going to give our patients more choices. I tell our staff that even if you think you are providing the highest quality of care, patients won't see that if someone treats them poorly in the clinic. If we want our patients to continue to use our facilities when they have more choices for health coverage, we have to have outstanding customer service and show them that we provide accessible, quality health care. Otherwise, we risk losing patients and much needed revenues.

We are working on a number of initiatives to help improve the quality of care and promote healthy Indian communities. One of the most important of these is our Improving Patient Care (IPC) program.

The IPC is our patient-centered medical home initiative that is designed to improve the coordination of care for patients. This is about making changes that will result in measurable improvements in patient-centered care. The patient-centered medical home is a big focus of the changing health care system in the U.S. So if our sites get recognition as a "medical home," they might be able to get better reimbursements in the future. We plan to expand this initiative throughout the entire IHS system – currently we have 127 sites.

Many of these sites are doing really outstanding work, including reducing waiting times, improving no-show rates, and arranging the system so that patients can see the same providers each time they come to the clinic, which results in better coordination of care. Those are the types of improvements that will keep our patients coming back, even if they have more choices.

For example, the IHS Fort Yuma Health Center has implemented ambulatory clinic care teams that have worked to reduce no-show rates from about 20% to 9%; thereby increasing the number of provider-to-patient opportunities. They have also formed patient-centered task teams to improve patient outcomes, including successfully lowering A1C levels in patients identified with very high levels.

The IHS Claremore Indian Hospital is also actively involved in the IPC collaborative. Their Family Medicine Clinic was the first department of focus, and they have improved access to care by reducing appointment availability delays from an average of 140 days to 1.5 days, and decreasing no-show rates from an average of 30% to10% of scheduled appointments. They're also improving continuity of care by establishing Patient Care Teams so patients see the same providers over time.

And the IHS Warm Springs Health and Wellness Center Patient-Centered Primary Care Home has achieved several improvements in health care provision. With the use of the Electronic Health Record and IPC Collaboration, the service unit is able to deliver a more comprehensive and patient-focused care. As a result, the service unit received recognition as a Tier-3 Patient-Centered Primary Care Home with the highest possible rating from the state of Oregon in 2012.

Using the EHR reminder component allows the service unit to track each patient's health screening and maintenance needs. For example, with the implementation of colon cancer screening clinic reminders, the screening rates have increased from 38.3% in 2007 to 81.7% in 2012. Since launching the HIV screening reminder, the service unit has achieved the highest HIV screening rate in the IHS.

And the IHS Wewoka Indian Health Center reports that their implementation of IPC concepts has helped them streamline processes, decrease inefficiencies, maximize productivity, and increase patient satisfaction. This includes decreasing wait times from over 3½ hours to an average of 67 minutes, and reducing appointment availability delays from an average of 135 days to just one day.

The IHS Improving Patient Care initiative is making a difference, and we're working to have it implemented in all of our direct care sites as well as encouraging our tribal programs to implement it. This will help us in the context of the ACA.

A few other initiatives are also helping us improve the quality of care. The better our services, the more patients will chose to stay with us when the Health Insurance Marketplaces make more options available to them.

One of the most important of these programs is the Special Diabetes Program for Indians (SDPI). This program has shown that, in partnership with our communities, we can prevent and treat diabetes in Indian country with innovative and culturally appropriate activities. So we're very pleased that this program was recently reauthorized through 2014.

Last September I attended the SDPI Diabetes Prevention and Healthy Heart Initiatives Meeting right here in Denver, Colorado. I viewed posters from the grant programs that documented their successful prevention activities through photos, activity summaries, and client testimonials. It was very inspiring to see the innovation, enthusiasm, and expertise of our grant program activities.

Our 2011 SDPI Report to Congress clearly shows that the SDPI programs have done an incredible job of implementing activities to prevent and treat diabetes in the communities we serve. And we just published our evaluation of the SDPI Diabetes Prevention Program, which showed that we can reduce new cases of diabetes through prevention activities!

I hope you've seen the dramatic drop in the rate of new cases of end stage renal disease (ESRD) in American Indian and Alaska Native people with diabetes when compared with other racial and ethnic groups in the U.S. Between 1995 and 2006, the incident rate of ESRD in American Indian and Alaska Native people with diabetes fell by 28% – a greater decline than for any other racial or ethnic group. All of this occurred while SDPI has been implemented. While we cannot say cause and effect, I believe these efforts are making a difference. But the SDPI needs to be reauthorized by Congress after FY 2014.

And I want to say thanks to the members of the Tribal Leaders Diabetes Committee, who have been helping with the consultation and oversight of the SDPI.

We're also focusing on behavioral health issues, which are a top tribal priority. We're making progress on our National Behavioral Health Strategic Plan and our National Suicide Prevention Plan. And the evaluation data from the Methamphetamine and Suicide Prevention and the Domestic Violence Prevention Initiatives are very promising. I recently sent out a letter to tribal leaders about our completed consultation on the FY 2013 funding distribution for both of these initiatives.

We're also working on plans to help address the growing problem of prescription drug abuse through a workgroup in our National Combined Councils.

There are a few other quality initiatives we're working on to improve the quality of and access to care for our patients. Our Healthy Weight for Life initiative unifies all our efforts to promote a healthy weight among American Indians and Alaska Natives. And our IHS Baby-Friendly Hospital Initiative, which is our contribution to the First Lady's *Let's Move! In Indian Country* initiative, is promoting breastfeeding to reduce childhood obesity. Congratulations to Rosebud, Pine Ridge, Belcourt, Phoenix Indian Medical Center, and Claremore Service Units for achieving the Baby Friendly designation!

Another initiative we're participating in is the national Million Hearts Campaign, with its goal of preventing a million heart attacks and strokes over the next 5 years, by focusing on improvements in "ABCS"– aspirin, blood pressure, cholesterol, and smoking cessation.

And the new Partnership for Patients that was launched by HHS will help improve the quality of care by focusing on reducing harm and improving patient safety in our hospitals. And we're working under an agreement with the Centers for Medicare and Medicaid Services to establish a new hospital consortium to work on improving quality and meeting accreditation requirements in our hospitals. We plan to establish a system-wide business approach to accreditation.

We're also implementing Meaningful Use with our Electronic Health Record, and are now receiving incentive payments throughout the system. IHS was the first federal government health system to develop a certified EHR that met Meaningful Use Stage 1 requirements, such as electronically capturing health information and computerized provider order entry. We're now focusing on furthering developing our certified EHR to meet Meaningful Use Stage 2 requirements.

Health Information Management (HIM) has an important role in implementing the ACA. I notice on the agenda there are a number of sessions on this topic, such as ICD-10 codes and electronic billing capacities. HIM is becoming increasingly important, not just because of our continuing transition from paper to electronic medical records, but also because of the health information exchange and interoperability requirements of Meaningful Use.

And there are some important changes coming to HIM in the next few months. Patient records from other facilities will start coming to us electronically, through a secure e-mail system. And providers will be able to create an electronic patient summary document to send with patient discharges, referrals, and other transitions of care. Patients will have access to a Personal Health Record portal, where they can view their medical information, send secure messages to their doctors, and download or send their records to another provider. For veteran patients, we will be able to search for their records online and download a summary of their care at the VA.

And, of course, beginning in October 2014, all of our claims have to be coded using ICD-10. I hope all your facilities are planning training strategies for billers, coders, and others who need to use these new codes.

For more information, there are sessions on these topics at this meeting.

I also wanted to mention our recent trip to the Navajo Nation with HHS Secretary Sebelius. We visited several tribal health programs, including their behavioral health program that incorporates Native culture and traditions into its services.

We also visited the Gallup Indian Medical Center, where Traditional Healers work together with the medical providers to promote the health and wellness of our patients. The role of traditional medicine in our system is something that we continue to define, and there are best practices to share in this area. Providing culturally competent services is also a way to make our care patient centered.

And congratulations to the Emergency Department at Gallup Indian Medical Center for being the first federal IHS facility to achieve the Level III Trauma Designation. This type of designation, similar to accreditation, helps our patients see that we do provide high quality care.

Our fourth priority is to make all our work transparent, accountable, fair, and inclusive. We've worked hard to improve transparency and communication about the work of the agency. This includes working with the media, sending more email messages and letters to tribal leaders, and holding regular internal meetings.

We're also emphasizing accountability and fairness in the way we do business – by evaluating our programs and focusing on areas of greatest benefit, and by always considering fairness when dealing with staff and making programmatic decisions.

Inclusiveness is a part of these priorities because the IHS has to ensure that our decisions consider the impact on all our patients, whether they are served in an IHS, tribal, or urban health facility. One area of interest here is that we're working on our final new urban confer policy. Instead of consultation, the IHCIA authorizes IHS to "confer" with urban Indian organizations.

This priority is particularly important as the ACA is implemented. As more of our patients have health coverage, of course we would want them to continue receiving services at IHS. Our ability to show that we are improving and providing quality of care is going to help encourage our patients to continue using our facilities, which could mean more third-party resources that will help improve access to services for everyone we serve.

Communicating our improvements will help. In terms of accountability, we are seeing that our efforts over the past few years are resulting in improvements in care at the overall national level. We need for all our sites to be able to demonstrate improvements to our patients at the local level.

When you look at national Government Performance and Results Act trends over the past several years, you can see significant improvements in many of the measures, such as an increase in the percent of mammography screenings, tobacco cessation interventions received, depression screenings, and colorectal cancer screenings.

So the increased funding we've received in the past few years, along with more accountability and a focus on improving the quality of care, are making a difference. But we know we still have more to do. And the potential for increased resources with the ACA means that these improvements will be able to continue. So that's why we need everyone to understand what they need to do over the next few weeks.

One thing we have been doing is working to communicate more about our agency reform efforts. We just launched a new IHS website, and I hope you can take some time to look at the new format. We actually realized that our website needed to be more customer friendly for our patients, and not just focused on what our staff need. So one of the first things you see now on the website homepage is how to find health care. I am certain that individuals who realize they are exempt from the mandate for health coverage if they are eligible for IHS will be looking for the nearest facility, and they can use our website to easily locate a facility.

You can also see a link to my Director's blog. I use the Director's Blog on the IHS website 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 regularly post updates to my blog, including ACA updates, so I encourage you to keep checking them for the latest information on Indian health issues. You can also subscribe for updates, and search the blog.

I will close now by just saying once again how I appreciate all your support as we work together to reform and improve the IHS, and to implement the ACA with all its potential benefits for the people we serve. I am glad you are here, and I hope you take advantage of the all the great sessions and make sure to take the information back to your facility. Remember, everyone needs to be ready to answer questions, or refer to someone who knows the answer. In many facilities, you are expected to be the one who knows the answers. October 1 will be here very soon – less than 50 days. This conference is a great start to getting all of our facilities ready.

Despite all the challenges we face, I am confident that by working together, especially with our tribal partners and communities, we can ensure that all American Indian and Alaska Native people get the health care they need and deserve – and that they understand the new choices available to them starting on October 1 when the Marketplaces are open for enrollment. I know that I can count on you to help make sure all of our patients can benefit.

Thank you, and I hope you enjoy the conference.