IHS National Combined Councils Annual Conference

National Council of Clinical Directors, National Council of Chief Executive Officers, National Council of Chief Medical Officers, National Oral Health Council, National Council of Chief Consultants, National Council of Nurse Consultants

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"Addressing Patient Care through Partnerships and Prevention"

by

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Good Morning and welcome to the National Combined Councils Annual Conference. It's a pleasure and an honor for me to meet with you today. I have come to view this meeting as perhaps the single most important meeting I have with our leadership from the field — and it is very clear to me about where our mission really happens, and that is in the field. Our mission is to raise the health status of Native Americans to the highest possible level, and I know that this room is filled with individuals and groups of individuals who have dedicated themselves to making significant contributions, in one way or another, to helping us accomplish that mission.

Some of you are playing significant roles in the areas of clinical skill and compassion in caring for patients, some of you demonstrate your passion for improving the health status of Indian people in implementing innovative ideas to provide better care or more care with less money, and others are helping all of us with their ability to streamline work and make things happen more efficiently and effectively. I want to recognize all of you for your dedication and commitment to raising

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the health status of our people. I am thankful for the work that each one of you does and would like to extend my sincere appreciation for a job well done.

I also want to take this opportunity to recognize and thank the chairs of the combined councils.

- Dr. David Yost is the current chair, as well as the chair elect of the National Council of Clinical Directors.
- Ms. Carol Dahozy is the current chair of the National Council of Nurses. Mr. Dennis Randles is the chair elect for the NCON. I want to express my appreciation for the NCON and all of our nurses as they have accomplished significant work in the area of recruitment and retention- in the face of a national shortage of nurses. We know how vital they are to every component of our organization - so I appreciate the work being done to assure that we are adequately staffed.
- Ms. Cathy Keene is the current chair of the National Council of Chief Executive Officers. Mr. Ed McLemore is the chair elect for the NCEO.
- Dr. Bill Morningstar is the chair of the National Oral Health Council. The Oral Health Council will meet tomorrow and elect their new chair - so we will know who Dr. Morningstar's replacement is - tomorrow.
- The Council of Chief Medical Officers has had a difficult year- in that two of our Area CMOs passed away this year. We lost Dr. Steve Mader from the California Area and Dr. Erv Lewis from the Albuquerque Area. Both of these CMOs were important to us and their deaths were untimely. Steve Mader was the Chair of the Council of Chief Medical Officers. Dr. Doug Peter, Dr. Vince Berkley, Dr. John Kittredge took over a number of responsibilities Dr. Mader had as Chair of their Council, and the CCMO will be electing a new chair for their group in the course of their meetings this week.

I want to thank each of your for leadership and your dedication to our mission. I know that you are not taking leadership roles in your respective Councils because you need more to – I think that your leadership underscores the fact that you are committed to raising the health status of Indian people. Any measure of success we can celebrate today really is the result of **people working together** to fulfill our mission. Thank you for your work on these Councils.

I believe that now more than ever before, we need to be people working together to achieve our mission — in fact – the Tribal programs, the IHS Service Units, the Area Offices, Headquarters, and even the Department are a whole community of people, working together in our own ways to improve the health status of Indian people. We all have a role. I would like to talk to you today about a number of things going on within this community of people working to improve Indian health care. I am hopeful that you will join me in working on some of the initiatives that I am going to talk about because - **you have a role**.

I appreciate the theme you chose for your meeting- **Keeping Patients First**. Historically, the IHS has been successful in improving the health status of the American Indian and Alaska Native population by primarily focusing on preventive and primary care services and developing a community-based public health system. Examples can be seen in the dramatic decreases in mortality rates for certain health problems between 1972-1974 and 1997-1999:

Decreases in Mortality Rates:

- Maternal mortality reduced 79%(from 31.6 to 6.7 per 100,000);
- Tuberculosis mortality reduced 86% (from10.7 to 1.5 per 100,000);
- Gastrointestinal disease mortality reduced 72% (from 6.7 to 1.9 per 100,000);
- Infant mortality reduced 65% (from 25 to 8.8 per 100,000);
- Unintentional injuries mortality reduced 54% (from 206.7 to 95.1 per 100,000).
- The average death rate from all causes for the American Indian and Alaska Native population dropped a significant 21% between 1972-1974 and 1996-1998
- **Population Growth** - From 1990 to 2000, the American Indian and Alaska Native population grew at a rate of 26%, while the total U.S. population grew by only 13%. The Census Bureau projects a 40% increase in the American Indian and Alaska Native population from 2000 to 2025.
- In addition, the 1999 unemployment rate for the American Indian and Alaska Native population was 2.5 times higher than the rate for the rest of the population;
- **Poverty Rates** - the percent of the American Indian and Alaska Native population living in poverty was more than three times that of the non-Hispanic white population in 1999 (25.7% compared to 8.1%).
- **Educational Levels** - Educational levels, which influence economic prospects, also reflect significant differences. The 2000 census reported that among people aged 25 and older who identified their race as American Indian and Alaska Native only, 11% had a bachelor's degree or higher compared with 26.7% of all people aged 25 and older; only 71% of American Indian and Alaska Natives had at least a high school diploma compared to 84.1 % of all people in the 25 and older age range.

So, as we **keep patients first** - we need to be ever mindful that we are working with a population with a number of significant socioeconomic barriers that we know impact health. With those kinds of numbers in mind, it is clearly no surprise to any of us that our patients, the American Indian and Alaska Native population, suffer disproportionately from a number of health problems. For example:

- The 1999-2001 death rate from alcohol abuse was more than 6 times higher among American Indians and Alaska Natives than the rate for all races in 2000;

- In 2001, American Indians and Alaska Natives were 2.6 times more likely to have diagnosed diabetes than non-Hispanic whites and the death rate from diabetes was 2.9 times higher among American Indians and Alaska Natives than non-Hispanic whites;
- The death rate from diabetes in the American Indian and Alaska Native community has increased by 79.9% between 1972-1974 and 1999-2001.
- The 1999-2001 mortality rates for the American Indian and Alaska Native population (adjusted to compensate for misreporting of American Indian and Alaska Native race on state death certificates) are 21% higher than the 2000 mortality rate for U.S. All Races.

The growth in American Indian and Alaska Native population and chronic disease rates, as well as socioeconomic constraints, are increasing the challenge of effectively improving the health status of this population.

Therefore, as an Agency, we are establishing three major focus areas, or director's initiatives. They are:

1. Health Promotion and Disease Prevention (HP/DP)
2. Behavioral Health
3. Chronic Disease Management

Early on in my tenure as Director of the Indian Health Service (IHS), I announced my Health Promotion and Disease Prevention Initiative. As a Nation we are struggling with chronic diseases such as diabetes, heart disease, obesity, cancer, asthma, and depression. This initiative is a reflection of my conviction that we must address the primary prevention of these chronic diseases if we are to critically influence the future health of our patients and our communities. To that end, I have taken a number of actions aimed at health promotion and disease prevention, which include the following:

- Indian Health Summit; Health Promotion and Disease Prevention Policy Advisory Committee; Area HP/DP coordinators; Healthy Native Communities Fellowship; "Just Move It Campaign"; Boys and Girls Clubs; MOU with Canada, NIKE…
- Stop The Pop Campaign - 8 emerging leaders from the Department of Health and Human Services (HHS) assigned to work on this campaign.
- An obesity workgroup will be launched in April. Jean Charles-Azure is taking the lead with this very complex and important work.
- And finally, for 2 years in row now - I have come to this meeting and have met on the Sunday afternoon prior to the meeting - with a team of nutritionists and other key staff who are committed to improving access to nutrition care for Indian people. They are passionate about prevention and perplexed about how to make this happen in our organization. I announced last year that we had an alarmingly low ratio of Registered Dieticians to population served - we believe we have made little if any increase in the level of nutrition care

available to our population. I look forward to continued work with this collaborative workgroup, and to addressing their recommendations for improving access to nutrition care.

Addressing behavioral health issues is also essential. We need to focus on screening and primary prevention in mental health, especially for depression, which manifests itself in suicide, domestic violence, and addictions. These unhealthy behaviors are killing Indian people and we can do something to help. We know that depression also makes chronic disease management more difficult and less effective. We need to more effectively utilize treatment modalities that are available; we also need better documentation of mental health problems and greater funding. We now have more effective tools for documentation through the behavioral health software package and I believe that Tribal communities are focusing more on these mental health needs. We also need to work with other organizations such as the Substance Abuse and Mental Health Services Administration (SAMHSA), as well as many of the Tribal organizations and foundations that can help us with these problems.

As I mentioned earlier, as a nation and in Indian country, we are struggling with chronic diseases such as diabetes, heart disease, obesity, cancer, asthma, and depression. We must address not only the primary prevention of these chronic diseases if we are to critically influence the future health of our communities, but we must look at better chronic disease management in our clinical care of our patients. I have asked Dr. Kelly Acton and Dr. Craig Vanderwagen to bring together a team to develop a strategic plan to address chronic disease. They had their first meeting in December and I look forward to hearing about their recommendations for our health systems.

I've highlighted several of the actions that I have taken to jump start a change in the culture of our organization to one that not only continues to provide exceptional health care, but also one that really does make preventive health, behavioral health and chronic disease management a priority. I need to ask you - **What have you done - at your Service Unit, in your programs? What are you doing about improving access to nutrition care, about addressing mental health and behavioral health problems our people are facing and implementing chronic disease management models? You have a role.**

We can no longer simply complain about the scarcity of resources for preventive health, behavioral health and chronic disease management – we have to do something about it.

We have great pride in our role in public health service, and we hold dear the promise of the effectiveness and benefits of preventive health. Yet often we seem to find it difficult to identify the resources necessary for tomorrow's preventive health because of the perceived scarcity of resources to manage today's disease and illness.

I challenge each of you to help me be smarter about where to direct our present resources for the most benefit, how to change and redesign our services to be maximally cost-effective, and how to do this so as not to merely protect the status quo of today's programs, but to do so to truly invest our precious resources to build a different and

healthier future. I need your help - we need to work together to **keep our patients first**, to eliminate the health disparities of our patients - I want to hear from you on this.

I've worked diligently on partnership**s** with SAMHSA, with Nike, with the Administration for Children and Families and their Head Start program, with the Administration for Native Americans, with the Health Resources and Services Administration, with the Administration for Healthcare Resources and Quality, and with the Centers for Disease Control and Prevention and the National Institutes of Health in the areas of diabetes research, treatment, and prevention. This Administration has made it clear to everyone in HHS that the responsibility for improving the health status of Indian people and for eliminating health disparities does not rest with IHS alone.

Former Secretary Tommy Thompson and his staff have made a notable effort to visit and get to know Indian Country, and it is increasingly clear that their visits have resulted in increased attention and funding by the Department through a variety of grants and projects in Indian Communities. We anticipate that this will continue with the former Deputy Secretary assuming his new position as Director of the White House Domestic Policy Council and with incoming Secretary Leavitt.

I've also worked on the reestablishment of the Intradepartmental Council for Native American Affairs (ICNAA) and this has helped to build collaboration between all HHS programs so that American Indian and Alaska Native health issues are addressed by all programs of the Department. Of the 320 programs within HHS, 125 of them were established for or directed toward Tribes and Tribal organizations. This reestablishment has resulted in significant increases in grant funding to Tribes and Tribal programs. The ICNAA has charged the Assistant Secretary for Planning and Evaluation to conduct a study to determine the barriers that our communities face when applying for HHS grants. Key HHS staff within each of the 125 programs will be surveyed as well as key contacts in the Indian community. The survey of HHS staff will be conducted within the next month and the outside focus group effort of the Tribes is to occur in late spring or early summer of this year. We know this to be the first critical step in developing the appropriate changes within HHS to ensure better access by our communities.

We've also actively pursued partnerships and alliances with other federal agencies outside of HHS, including partnering with the Department of Veterans Affairs to improve the access and quality of health care for our nation's American Indian and Alaska Native veterans. We have also reestablished the National Child Protection workgroup, which is an interagency collaboration between the IHS, BIA, and the Department of Justice to educate individuals working in American Indian and Alaska Native communities about child protection laws, indicators, and reporting procedures.

In 2004, the agency GPRA results reflect the difficulty of maintaining services in light of increasing demand, as the number of annual GPRA targets that were met dropped below 70%. At the same time, it is important to note that the number of patients actually receiving care has risen and we did make significant progress on some important indicators.

For example, in 2004, the screening rate for diabetic nephropathy rose from 38% last year to 42%. Furthermore, our 2002 Diabetes Care and Outcomes Audit, which

includes participation from over 239 programs and represents care to over 100,000 patients with diabetes, provides evidence for improved intermediate outcomes of care - mean hemoglobin AlCs dropped from 11% in 1994 to 7.97%, and blood pressure, lipid levels, are cardiovascular risk factors are all improved. The audit also documented dramatic improvements in the availability of community-based programs to prevent and treat diabetes. A 62% increase in healthy eating programs for children and families, a 42% increase in programs for management of overweight in children and a 51% increase in physical activity programs for children and youth was reported. Clearly these improvements are due, in large part, to the special diabetes program funding we have received from Congress.

We are excited about these improved outcomes and also about the fact that the outcomes demonstrate our competence to Congress, and perhaps they will work with us to deal with other significant health and chronic disease issues in our population. It you are interested in reading more about these outcomes and also about best practices in diabetes prevention, Dr. Kelly Acton and others put together a Report to Congress and it is available on the Diabetes Prevention Program web site.

In addition to our significant progress in diabetes treatment and prevention, we also made progress in increasing the pneumococcal vaccination rate for adults over 65 years of age from 65% in 2003 to 69% in 2004. The Whiteriver Service Unit actually achieved a vaccination rate of 96%. The improvement in pneumococcal vaccination rates is important because studies have shown that American Indian and Alaska Native people are at high risk for this disease; the 1999-2001 American Indian and Alaska Native death rate from pneumonia and influenza was 42% greater than the 2000 U.S. All Races death rate. Vaccination of the elderly against this disease is one of the few medical interventions that has been shown to improve health status and save on medical costs.

The annual GPRA evaluation and the Diabetes Audit are just a couple of measures that are used to assess our performance. One other important measure is the Performance Assessment Rating Tool (PART) used by OMB (Office of Management and Budget). The single IHS program assessed by the PART for this budget cycle was the Health Care Facilities Construction Program, which received an overall score of 92%. One of the strengths of this program is its clear linkage to annual GPRA indicators and ultimately to the long-term goal of reducing the Years of Potential Life Lost (YPLL). In essence, this program documents how the construction of health care facilities contributes to expanding access to critical services as identified by clinical performance measures documented in the IHS GPRA plan at specific sites once they are completed and staffed. This increase in access to critical services over time results in the reduction of premature deaths as measured by YPLL.

Clearly, the I/T/U programs have demonstrated the ability to improve American Indian and Alaska Native health over time. I am convinced that our commitment to measuring the quality of our clinical care has been embraced throughout the field - and I salute you for your dedication to this significant aspect of **Keeping Patients First.** I would appreciate your continued support for measuring the quality of our clinical care in 2005. This year we will begin quarterly reporting on the GPRA measures. I believe this

can help us improve - I want to see us start to use the data we are reporting to make decisions in using our resources and managing our programs. I have a number of clinical quality of care measures in my performance contract and in other program requirements this year and those of you with the IHS in this room are going to see a cascade of my performance objectives down through the Agency to your performance appraisals. I believe this can and will help us to continue to make strides in improving the health status of American Indian and Alaska Native people - as we measure clinical quality of care, it gives us opportunities to improve quality of care. So - look for a cascade of these clinical care measures and other required reporting. I hope you'll join me as we work toward improved health outcomes, because you have a role**.**

I am particularly proud of the Agency's continued achievements in the area of health information technology. As you know, the President has set it as a national priority for all Americans to have electronic health records within 10 years. He expects Federal agencies to take the lead on this, and established the Office of the National Coordinator for Health Information Technology, under Dr. David Brailer. A number of IHS staff are actively working with Dr. Brailer's office and on related inter-agency initiatives such as the Federal Health Architecture and Consolidated Health Informatics. Although we are a small agency, we have a long history of developing and deploying highly capable clinical information systems designed for our missions of quality care delivery and public health. This experience, and the rich data resulting from use of these applications, makes us an important and credible partner in the national health information technology activities.

I am pleased to acknowledge the certification of the IHS Electronic Health Record (EHR). I believe Keith Longie and Terry Cullen will have more to say about this, but I want to recognize the ongoing efforts of Dr. Howard Hays, and Federal staff, contractors, and the testers and users in the field who have contributed to the development of the EHR, the Clinical Reporting System, and all the other technological enhancements that are helping us to achieve a culture of excellence in the Indian Health Service. Be sure to check out the EHR demonstrations being held throughout the conference.

Let me move from prevention to some administrative and reorganization updates. First, I want to make you aware of some of the things I have done to reorganize Headquarters and the way we do business. This year there were significant changes to the Headquarters organizational structure. These changes are intended to improve our support of those in the field, our responses to the Department and Congress, and achieve the management and performance goals of the President and the Secretary. I am in the process of filling key Headquarters positions, beginning with the selections of Robert McSwain as the IHS Deputy Director and Phyllis Eddy as the Deputy Director of Management Operations for the IHS.

In addition to changing the organizational structure at headquarters, I am also in the process revising our entire senior leadership meeting infrastructure - I'm giving the charters, membership, and makeup of our executive leadership type meetings a makeover. To that end, I have established the Director's Executive Council or DEC. The DEC replaces the ELG. So, the chairs from your councils no longer represent you on the ELG - they represent you on the DEC. I have established the DEC as one of my policy

advisory groups. The membership of the DEC includes 3 Area Directors (currently Mr. Jim Toya, Mr. Pete Conway, and Dr. Kathleen Annette): representatives from the combined councils (currently Dr. David Yost, Ms. Cathy Keene, Ms. Carol Dahozy, and Dr. Vince Berkley) and representatives from Headquarters (currently Mr. Bruce Chelikowsky from OEHE, Mr. Doug Black from OTA, and Dr. Rick Olson from OCPS). The DEC is chaired by Mr. Toya and I have given this group an ambitious and challenging workload for the coming year. The charges that I have given this group include the following:

1) Health Promotion and Disease Prevention - I want policy recommendations that will help support improved health outcomes - what needs to be changed in order to move us away from the status quo. Do we need changes in loan repayment and the scholarship program, and the RRM methodology to support a change toward a culture of prevention? Dr. Kathleen Annette is responsible for leading this initiative within the DEC.
2) Administrative Consolidations - we are in the process of on consolidating our HR program. To that end, HR for both of our personnel systems - civil service and commissioned corps - will be handled regionally. We plan to consolidate other administrative services - Acquisitions, Real Property, and others. I want policy recommendations on how we can consolidate cost effectively, with timely delivery of quality services and consistency in the delivery of services nationwide. Mr. Toya is leading the DEC effort on this charge.
3) Residual and Inherent Federal Functions – I need policy recommendations regarding the level of resources the Agency needs to carry out its Federal functions effectively and perhaps consistently throughout the Agency. Dr. Annette will be the lead for this work.
4) Strategic Human Capital - what policies needed to be adopted to support leadership development and succession planning, what can be done to revamp/strengthen our HR program so that we can be effective in recruiting and retaining good staff. Mr. Toya is the lead on this work.

The four charges replace the annual work plan - and therefore, replace the objectives that each of the Councils put forward each year. But I want you to know that as I put together this charge for the DEC - I heard you. I know that for the past few years human resource issues have been at the forefront of your concerns, and so I have made Strategic Human Capital Management one of the four charges for the DEC. I think we have an excellent group, and they have begun to put together a strategy for addressing the four charges, and I am looking forward to seeing their recommendations.

While I am in the neighborhood of Human Capital - I would like to spend just a couple more minutes on the issue of Succession Planning. I think all of us are aware that we are seeing our colleagues retiring or planning to retire in unprecedented numbers. I believe that over half of our staff is retirement eligible in the next 5 years - and that is not just an IHS phenomena - this is occurring government-wide.

How many of you who are planning to retire within the next year or two are training someone to replace you? You represent our senior management - and I am guessing that not many of you have trained someone to step into your shoes. This year, we are going to be required to do a succession plan where we assess competencies of our management team at the Headquarters, Area office, and service unit management levels to identify a pipeline to be created for targeted management positions. We all need to identity one or two people who could replace us and begin mentoring and training them. We are going to need to give them an opportunity to be in exchange programs and to participate in formal training programs. I need you to set aside resources for this purpose. We will be getting back to you with a formal request for a succession plan and budget for your organization. Succession Planning is another "you have a role" issue.

Before I move on to the budget, I would like to give you one final administrative type update. Last year I approved the institution of a National Core Formulary for the Indian Health Service. The purpose of the National Formulary is to promote high quality care for our patients by ensuring that all Federal facilities carry and provide standard of care drugs to treat those chronic conditions that we see most often and cause the most illness in our population. Another purpose is to help facilities with cost containment in certain high cost drug classes. The National Core Formulary will be developed and maintained by the National Pharmacy and Therapeutics Committee. This is a group of 8 physicians and 6 pharmacists representing IHS, Tribal, and Urban facilities in all 12 Areas. They have already begun to meet — I understand that there is a handout circulating at this meeting that describes the National Formulary process, and that further publications and a website are in the works. It is my expectation that all IHS direct care facilities will be in compliance with the National Core Formulary by October 1, 2005. I also hope that Tribal and Urban facilities will see the value of the National Formulary and decide to participate as well.

Maintaining the level of resources necessary to best meet the health needs of Indian people is an ongoing challenge, so I would like to say a few words on the status of the IHS FY 2005 and 2006 budget appropriations.

The fiscal year 2005 budget authority for the IHS is $2.99 billion. This is a $63 million, or approximately 2.2%, increase over the fiscal year 2004 enacted budget level. Adding in funds from health insurance collections estimated at $633 million, designated diabetes appropriations of $150 million, and $6 million for staff quarters rental collections, increases the budget for the IHS to $3.8 billion in program level spending.

The FY 20005 budget also allows us to fund 2 additional epidemiological centers. We funded one in Oklahoma last year and this year we will be funding an epidemiological center for California and one for the Navajo Area.

This month the President released his 2006 budget request for the Indian Health Service. The budget request for the Indian Health Service continues to reflect the commitment of the President and the Secretary to meeting the health needs of Indian people within the scope of national priorities. The President's budget request for the Indian Health Service must be considered in the context of the national budget request and the proposed increases for the Department. And we need to keep in mind that many

of the increases in the budgets proposed for HHS programs will also benefit Indian people.

The proposed IHS budget authority for FY 2006 is $3 billion. This is a $63 million, or approximately 2%, increase over the FY 2005 enacted budget level. Adding in funds from health insurance collections estimated at $642 million, designated diabetes appropriations of $150 million, and $6 million for staff quarters rental collections, increases the proposed budget for the IHS to $3.8 billion in program level spending.

The challenge for the IHS is to continue to provide access to quality health care for an increasing population. An estimated 1.8 million American Indians and Alaska Natives will be eligible for IHS services in 2006, an increase of 1.6% over 2005 and 9.4% since 2001. The FY 2006 budget includes new funds to help provide for the additional 29,000 people who are expected to seek services in FY 2006, cover increased pay costs for the Federal and Tribal employees who provide these services, and meet rising costs. Funds will go primarily to Clinical Services (operation of hospitals and clinics, and purchase of medical care), but also to other IHS programs that are providing additional services and support functions. Some highlights of the FY 2006 proposed budget include:

- An additional $32 million toward covering increased Federal and Tribal employee pay costs,
- A total of $3 million to fund the construction of 24 units of new and 5 units of replacement staff quarters for the Harlem and Hays outpatient facilities in Montana,
- An additional $35 million to add staffing for six outpatient facilities,
- An additional $5 million for contract support costs, for a total of $269 million,
- An additional $27 million for contract health service costs, and
- $150 million for diabetes prevention and treatment grants. Through the Special Diabetes Program for Indians, the IHS has awarded $650 million in grants over the past 5 years to over 300 Tribes and Indian organizations to support diabetes prevention and disease management at the local level.

I would also like to take this opportunity to mention an important milestone in the history of the Indian Health Service. In July of 1955, the Indian Health Service was officially transferred from the Bureau of Indian Affairs to the Public Health Service, making FY 2005 the 50th anniversary year for the Indian Health Service.

In FY 2005 we are embarking on a special year of celebrations, and you will see special acknowledgements of our 50th year in a variety of places and special events. The specially designed 50th Anniversary logo is appearing on IHS official documents now, and a 50th Anniversary reference library of historical documents and photographs is being compiled, which will be available on the IHS website and on a special 50th Anniversary CD. A visual picture of our history will also be made available to each of you in the form of specially designed posters that depict the history and major accomplishments of the

IHS. Also, we will be highlighting the successes and accomplishments of the past 50 years at major IHS meetings throughout the year, including my monthly Director's Staff meeting at IHS Headquarters.

We are also publishing a new edition of the "Gold Book," which was first published in 1957 as a comprehensive report to Congress on the status of the health of American Indians and Alaska Natives around the time of the transfer. The new version will show the progress made in the last 50 years, and our plans for facing the challenges of the next 50 years.

I hope all of you here will join us as we recognize this important date in the history of the Indian Health Service.

I would like to say a *thank you* to all of you who took the time from your busy schedules to attend and participate in this meeting, and those of you that helped to organize and make this meeting possible. I want you to remember the challenges I put out - they are amongst the top priorities for the Agency, for Indian health care - and each of you has a role. So, in closing I'd like to highlight the challenges I've offered in the last hour. They are:

1) Embrace clinical quality of care and other performance measures -participate fully in the cascade of performance plans and other required reporting. Use this data in your decision making.
2) Do your part to change our organizational culture - we need to continue to provide high quality primary care while becoming a wiser and more effective preventive care organization for our patients and communities. What are you going to do to devote more resources for prevention at your site? What can we all do together to focus our resources on health promotion/disease prevention, chronic care, and behavioral health?
3) Figure out who the one or two people in your organization are that can replace you - help them get the skills they need to do an even better job at your job than you are doing.

We are a community - all of us working to improve the health status of American Indians and Alaska Natives. I have given you some updates and I have let you know about some of the top priorities for the Agency in the next 9-12 months. You have a role and I look forward to continuing our mutual efforts on behalf of the health and wellness of American Indian and Alaska Native people.

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