Columbia, Court of Federal Claims No: 18–0797V
11. Lisa Taylor, Elyria, Ohio, Court of Federal Claims No: 18–0798V
12. Scott Germaine on behalf of C.G., Richmond, Texas, Court of Federal Claims No: 18–0800V
13. Crystal Jensen, Tacoma, Washington, Court of Federal Claims No: 18–0802V
14. Christian M. Hayes, Helena, Montana, Court of Federal Claims No: 18–0804V
15. Matthew Hussong, Davenport, Iowa, Court of Federal Claims No: 18–0805V
16. Gordon Ernst, Washington, District of Columbia, Court of Federal Claims No: 18–0806V
17. Susan V. Torrey, Nampa, Idaho, Court of Federal Claims No: 18–0807V
18. George Segal, Austintown, Ohio, Court of Federal Claims No: 18–0809V
19. Balbina Ibe, Fountain Valley, California, Court of Federal Claims No: 18–0810V
20. James Clark, Marietta, Georgia, Court of Federal Claims No: 18–0813V
21. Jiaqian Wu, Houston, Texas, Court of Federal Claims No: 18–0814V
22. Michelle Marie Cobenias, Red Lake, Minnesota, Court of Federal Claims No: 18–0815V
23. Ali Fadhil, M.D., Chicago, Illinois, Court of Federal Claims No: 18–0816V
24. Calvin Johnson, Washington, District of Columbia, Court of Federal Claims No: 18–0817V
25. Willis H. Gibbs, Murfreesboro, Tennessee, Court of Federal Claims No: 18–0818V
26. Edward A. Clendon, Greensboro, North Carolina, Court of Federal Claims No: 18–0819V
27. Daniel Hedlund, Minneapolis, Minnesota, Court of Federal Claims No: 18–0820V
28. Ashley T. Hunsucker, Stanfield, North Carolina, Court of Federal Claims No: 18–0821V
29. Esther Mutema, Poughkeepsie, New York, Court of Federal Claims No: 18–0822V
30. Mary Ligouri, Phoenix, Arizona, Court of Federal Claims No: 18–0824V
31. Jerome Debeltz, Ely, Minnesota, Court of Federal Claims No: 18–0825V
32. Brandi Blessike and Barry Blessike on behalf of B.B., Alpharetta, Georgia, Court of Federal Claims No: 18–0827V
33. Erica Turner, Macon, Georgia, Court of Federal Claims No: 18–0828V
34. Kimberly A. Purtill, Charlotte, North Carolina, Court of Federal Claims No: 18–0832V
35. Susan Wigley, Aurora, Colorado, Court of Federal Claims No: 18–0834V
36. Donald Sipes, Camp Hill, Pennsylvania, Court of Federal Claims No: 18–0835V
37. Ana Marie Provencio, Phoenix, Arizona, Court of Federal Claims No: 18–0836V
38. Angela Overall, Vancouver, Washington, Court of Federal Claims No: 18–0838V
39. Mary Miceli, Staten Island, New York, Court of Federal Claims No: 18–0839V
40. Ronald Schneider, Union Grove, Wisconsin, Court of Federal Claims No: 18–0843V
41. Michelle Daniels, Marysville, Washington, Court of Federal Claims No: 18–0850V
42. Dennis Long, Springfield, Illinois, Court of Federal Claims No: 18–0857V
43. Bruce A. Ling, J.R., Quincy, Florida, Court of Federal Claims No: 18–0858V
44. Marianne Simeneta, Augusta, Georgia, Court of Federal Claims No: 18–0859V
45. Donna Skwiat, Jackson, New Jersey, Court of Federal Claims No: 18–0865V
46. Elizabeth McCann, Huntington Valley, Pennsylvania, Court of Federal Claims No: 18–0866V
47. Rhett Malpass, Troy, Michigan, Court of Federal Claims No: 18–0867V
48. Kellee Matlock, Washington, District of Columbia, Court of Federal Claims No: 18–0868V
49. Morgan Tirone, Englewood, New Jersey, Court of Federal Claims No: 18–0869V
50. Tonya DeCoursey, Washington, District of Columbia, Court of Federal Claims No: 18–0870V
51. Jim B. Bynum, Panama City Beach, Florida, Court of Federal Claims No: 18–0874V
52. Timothy J. Loken on behalf of G.L., Charlotte, North Carolina, Court of Federal Claims No: 18–0876V
53. Tiffany Wilson, Phoenix, Arizona, Court of Federal Claims No: 18–0877V
54. Christy L. Harrup, Greensboro, North Carolina, Court of Federal Claims No: 18–0880V
55. Mindy Lawson, Washington, District of Columbia, Court of Federal Claims No: 18–0882V
56. Kelsey Reed, London, Kentucky, Court of Federal Claims No: 18–0884V
57. Patricia L. Guzowski, Notre Dame, Indiana, Court of Federal Claims No: 18–0885V
58. Janardhana Donga, Sacramento, California, Court of Federal Claims No: 18–0886V
59. Lisa Sargent, Washington, District of Columbia, Court of Federal Claims No: 18–0888V
60. Daniel E. Bragg, Portland, Maine, Court of Federal Claims No: 18–0890V
61. Margaret Mitchell, Woodbury, Massachusetts, Court of Federal Claims No: 18–0892V
62. Candace M. Berlin, Winter Haven, Florida, Court of Federal Claims No: 18–0893V
63. Jeffrey Foster on behalf of B.N.F., Chattanooga, Tennessee, Court of Federal Claims No: 18–0904V
64. Catherine M. Raby, Nampa, Idaho, Court of Federal Claims No: 18–0906V
65. Audrey Henning, Ocean City, New Jersey, Court of Federal Claims No: 18–0907V
66. Carla Pavao, Hudson, Massachusetts, Court of Federal Claims No: 18–0908V
67. Rachelle Meyers, Summit, New Jersey, Court of Federal Claims No: 18–0909V
68. Charles W. Morrill, West Covina, California, Court of Federal Claims No: 18–0910V
69. Michael Volle, Burgettstown, Pennsylvania, Court of Federal Claims No: 18–0911V
70. Nicole Webb, Chicago, Illinois, Court of Federal Claims No: 18–0912V
71. Anderson Roy Dunn, III, North Bend, Washington, Court of Federal Claims No: 18–0913V
72. Adam Salky, Los Angeles, California, Court of Federal Claims No: 18–0914V
73. Brandon Keck and Jessica Cook on behalf of A.K., Fort Riley, Kansas, Court of Federal Claims No: 18–0915V
74. Jessica Sobczyk on behalf of I.S., San Antonio, Texas, Court of Federal Claims No: 18–0917V
75. Mary Freehling, Vienna, Virginia, Court of Federal Claims No: 18–0918V
76. Maria Jill Vandergriff and Jon-Michael Vandergriff on behalf of Roark Vandergriff, Deceased, Vienna, Virginia, Court of Federal Claims No: 18–0919V
77. Kevin Delapaz, Vienna, Virginia, Court of Federal Claims No: 18–0922V
78. Jacqueline Robinson, Vienna, Virginia, Court of Federal Claims No: 18–0924V
79. Jose Gamboa-Avila, Denver, Colorado, Court of Federal Claims No: 18–0925V
80. David Colucci, Henderson, Nevada, Court of Federal Claims No: 18–0926V
81. Ligia Gairdo, Cranberry Township, Pennsylvania, Court of Federal Claims No: 18–0929V
82. Donna Carmichael, Mankato, Minnesota, Court of Federal Claims No: 18–0930V
83. Susanna J Howard, Greensboro, North Carolina, Court of Federal Claims No: 18–0931V
84.Vanessa Nelson, Dresher, Pennsylvania, Court of Federal Claims No: 18–0932V
85. Terry Catching, White Plains, New York, Court of Federal Claims No: 18–0933V
86. Renee Smith, Beverly Hills, California, Court of Federal Claims No: 18–0936V
87. Michael Patton, Beverly Hills, California, Court of Federal Claims No: 18–0937V
88. James Owens, Beverly Hills, California, Court of Federal Claims No: 18–0938V
89. Theresa Ukpo, Beverly Hills, California, Court of Federal Claims No: 18–0939V
90. Kailey Kinslow, Beverly Hills, California, Court of Federal Claims No: 18–0940V
91. Barbara Goldman, Beverly Hills, California, Court of Federal Claims No: 18–0941V
92. Barbara A. Brown, White Plains, New York, Court of Federal Claims No: 18–0943V
93. Tracey Harris on behalf of C.H., Boston, Massachusetts, Court of Federal Claims No: 18–0944V
94. Sandra Williams, Dresher, Pennsylvania, Court of Federal Claims No: 18–0947V

[FR Doc. 2018–15739 Filed 7–23–18; 8:45 am]

BILLING CODE 4165–15–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Indian Health Service

Draft Indian Health Service Strategic Plan Fiscal Year 2018–2022

AGENCY: Indian Health Service, IHS.

ACTION: Request for comments; notice of Tribal Consultation and Urban Indian Confer.

SUMMARY: The Indian Health Service (IHS) is developing an Agency-wide Strategic Plan to guide the work and strengthen partnerships with Tribes and Urban Indian Organizations. The IHS is

seeking public comment on its Draft IHS Strategic Plan fiscal year (FY) 2018–2022 (Draft IHS Strategic Plan FY 2018–2022). Additionally, notice is given that the IHS will conduct a Tribal Consultation and Urban Indian Confer regarding the Draft IHS Strategic Plan FY 2018–2022. In addition to the virtual town hall sessions, the IHS will seek other opportunities to solicit input from Tribal and Urban Indian programs on the Draft IHS Strategic Plan FY 2018–2022 during the comment period. For IHS Strategic Plan events during the comment period, please check the IHS Event Calendar at: *https://www.ihs.gov/ihscalendar/.*

DATES: Comments due by August 23, 2018.

The IHS virtual town hall sessions:

1. Urban Indian Confer on August 3 2018, from 2:00 p.m.–3:30 p.m. (Eastern Time).

2. Tribal Consultation on August 6, 2018, from 2:00 p.m.–3:30 p.m. (Eastern Time).

ADDRESSES: Written comments on the Draft IHS Strategic Plan FY 2018–2022 may be provided by email, or by United States (U.S.) postal mail.

E-mail addresses are as follows:

For Tribes: consultation@ihs.gov.

For Urban Indian Organizations: urbanconfer@ihs.gov.

For IHS Employees and the General Public: IHSStrategicPlan@ihs.gov.

Please use ''DRAFT IHS STRATEGIC PLAN FY 2018–2022'' as the subject line.

U.S. Postal Mail: RADM Michael D. Weahkee, MBA, MHSA, Acting Director, ATTN: Draft IHS Strategic Plan FY 2018–2022, Indian Health Service, 5600 Fishers Lane, Mailstop: 08E86, Rockville, Maryland 20857.

FOR FURTHER INFORMATION CONTACT: CAPT Francis Frazier, Director, Office of Public Health Support, IHS, 5600 Fishers Lane, Mail Stop: 09E10D, Rockville, Maryland 20857. Telephone (301) 443–0222 (This is not a toll-free number).

SUPPLEMENTARY INFORMATION: The IHS participated in a strategic planning process informed by feedback received from Tribes, Urban Indian Organizations, and staff, as described in more detail below, to develop the Draft IHS Strategic Plan FY 2018–2022 for consideration. The IHS is committed to improving health care delivery services and enhancing critical public health services to strengthen the health status of American Indian and Alaska Native people throughout the health system.

The Draft IHS Strategic Plan FY 2018–2022 includes a revised IHS Mission statement, a new IHS Vision statement, and articulates how the IHS will achieve its mission through three strategic goals. The three strategic goals are: (1) To ensure that comprehensive, culturally acceptable personal and public health services are available and accessible to American Indian and Alaska Native people; (2) To promote excellence and quality through innovation of the Indian health system into an optimally performing organization; and (3) To strengthen IHS program management and operations. Each goal is supported by objectives and strategies. To review the current IHS Mission statement and priorities, please visit: *https://www.ihs.gov/aboutihs/overview/.*

The strategic planning Consultation and Confer process is an opportunity for the IHS to further refine and strengthen the Draft IHS Strategic Plan FY 2018–2022. The IHS appreciates the invaluable feedback received to date on the Draft IHS Strategic Plan FY 2018–2022 and seeks to ensure all Agency stakeholders have the opportunity to comment. As we build on the current Draft IHS Strategic Plan FY 2018–2022, we look forward to receiving your comments by August 23, 2018.

The Urban Indian Confer on August 3, 2018, and the Tribal Consultation on August 6, 2018, will be held telephonically and by webinar. A letter will be sent to Urban Indian Organization Leaders and Tribal Leaders to notify them about details associated with conference call and webinar schedules and call-in information.

To develop the Draft IHS Strategic Plan FY 2018–2022, the IHS used a process similar to the U.S. Department of Health and Human Services (HHS) Strategic Plan FY 2018–2022, including use of goals; objectives and strategies; environmental scans; Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis; and workgroup participation. The environmental scan reviewed several IHS Areas, Headquarters Offices, and other available documents, and the SWOT exercise was conducted with IHS staff. Informed by these documents and analysis, the IHS developed an initial framework for review and comment by Tribes, Urban Indian Organizations, and IHS staff. The IHS first initiated Tribal Consultation and Urban Indian Confer on the IHS Strategic Plan initial framework on September 15, 2017, and formed an IHS Federal-Tribal Strategic Planning Workgroup (workgroup) to review all comments and recommend a list of final goals and objectives for IHS leadership review and approval.

During the initial framework comment period (September 15, 2017–October 31, 2017), the IHS held listening sessions, presented at Tribal meetings, and held conference calls with Tribal and Urban Indian Organization leaders. The workgroup membership included IHS staff at the Area, Service Unit, and Headquarters levels (including a representative from the IHS Office of Urban Indian Health Programs); Tribal leaders or their designees. The workgroup reviewed the comments received from 150 Tribes, Tribal Organizations, Urban Indian Organizations and IHS staff on the initial framework and suggested strategies during six meetings over a 3-month period, resulting in final recommendations on the IHS Mission, Vision, Goals, Objectives, and Strategies. These recommendations are the basis of the Draft IHS Strategic Plan FY 2018–2022.

Since initiating Tribal Consultation and Urban Indian Confer on the IHS Strategic Plan initial framework, the IHS has issued four letters to Tribal Leaders and Urban Indian Organization Leaders to update Tribes and Urban Indian Organizations on progress. Additionally, the IHS issued several communications stating that comments on the Draft IHS Strategic Plan FY 2018–2022 will be accepted throughout the strategic planning process. The IHS strategic planning Web site includes more information about the IHS strategic plan timeline, as well as links to the Tribal Leader letters, Urban Indian Organization Leader letters, and workgroup activities.

The IHS values all feedback and input regarding the Draft IHS Strategic Plan FY 2018–2022 and invites Tribes, Tribal Leaders, and/or their designees to Consult and Urban Indian Organization Leaders to Confer on the Draft IHS Strategic Plan FY 2018–2022. Tribal Consultation will be conducted with elected or appointed leaders of Tribal Governments and their designated representatives. Those wishing to participate in the Tribal Consultation as a designee must have a copy of a letter signed by an elected or appointed Tribal official or their designee that authorizes them to serve as the representative of the Tribe. Urban Indian Confer will be conducted with recognized representatives from Urban Indian Organizations, as defined by 25 U.S.C. 1603(29). Representatives from other Tribal Organizations and Native non-profit organizations are welcome as observers. Those wishing to be recognized representatives from Urban Indian Organizations should provide documentation that their organization meets the definition at 25 U.S.C. 1603(29) and that the selected participant has the official capacity to

represent the organization. This documentation should be submitted by e-mail no later than 3 days in advance of the Tribal Consultation and Urban Indian Confer session to the address that follows: *IHSStrategicPlan@ihs.gov.*

The text of the Draft IHS Strategic Plan FY 2018–2022 is available at the IHS Web site at: *https://www.ihs.gov/strategicplan/and below.*

Indian Health Service (IHS)

Draft IHS Strategic Plan Fiscal Year 2018–2022

The Indian Health Service (IHS) provides a wide range of clinical, public health, community and facilities infrastructure services to approximately 2.2 million American Indians and Alaska Natives (AI/AN) from 573 federally recognized Tribes in 37 States. Comprehensive primary health care and disease prevention services are provided through a network of hospitals, clinics, and health stations on or near Indian reservations. These facilities are predominately located in rural and primary care settings and are managed by IHS, Tribes, and Tribal Organizations. In addition, IHS contracts with Urban Indian Organizations for health care services provided in urban centers. The Draft IHS Strategic Plan FY 2018–2022 includes the Mission statement, a new Vision statement and articulates how the IHS will achieve its mission through three strategic goals. Each goal is supported by objectives and strategies.

Mission: To raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level.

Vision: Healthy communities and quality health care systems through strong partnerships and culturally relevant practices.

Goal 1: To ensure that comprehensive, culturally acceptable personal and public health services are available and accessible to American Indian and Alaska Native people.

Goal Explanation: The Indian Health Service (IHS) provides comprehensive primary health care and public health services, which are critical to improving the health of AI/AN people. The Indian health system delivers care through health care services provided in IHS, Tribal, and Urban (I/T/U) health facilities (e.g., hospitals, clinics) and by supporting the purchase of essential health care services not available in IHS and Tribal health care facilities, known as the Purchased/Referred Care (PRC) program. Additional services include environmental health improvements as well as traditional healing to complement the medical, dental, pharmacy, laboratory, behavioral health and other primary care medical programs. Expanding access to these services in AI/AN communities is essential to improving the health status of the AI/AN population. This goal includes securing the needed workforce, strengthening collaboration with a range of public and private, Tribal, and Urban Indian providers and expanding access to quality health care services to promote the health needs of AI/AN communities.

Objective 1.1: Recruit, develop, and retain a dedicated, competent, and caring workforce.

Objective Explanation: Consistent, skilled, and well-trained leadership is essential to recruiting and retaining well-qualified health care professionals and administrative professionals. Attracting, developing, and retaining the needed staff will require streamlining hiring practices and other resources that optimize health care outcomes. Within the Indian health system, staff development through orientation, job experience, mentoring, and short and long-term training and education opportunities are essential for maintaining and expanding quality services and maintaining accreditation of facilities. Also, continuing education and training opportunities are necessary to increase employees' skill sets and knowledge to keep pace in rapidly evolving areas of medical science, prevention science, improvement science, and information technology, as well as to increase opportunities for employee career advancement and/or to maintain necessary professional credentialing and accreditation.

Strategies—The following strategies support this objective:

Health Care Recruitment and Retention:

1. Improve and innovate a process that increases recruitment and retention of talented, motivated, desirable, and competent workers, including through partnerships with Tribal communities and others.

2. Continue and expand the utilization of the IHS and Health Resources and Services Administration's National Health Service Corps scholarship and loan repayment programs, as authorized by the law, to increase health care providers at I/T/U facilities.

3. Support IHS sponsorship of fellowship slots in certain specialized leadership programs for recruitment of future physician leaders.

4. Evaluate new organizational structure options and reporting relationships to improve oversight of the Indian Health Professions program.

5. Expand the use of paraprofessionals and mid-level practitioners to increase the workforce and provide needed services.

6. Develop training programs in partnership with health professional schools and training hospitals and expand opportunities to educate and mentor Native youth interested in obtaining health science degrees.

7. Enhance and streamline IHS Human Resources infrastructure to hire well-qualified personnel.

Staff Capacity Building:

8. Strengthen the workforce to improve access to, and quality of, services.

9. Improve leadership skills, adopt a consistent leadership model, and develop mentoring programs.

10. Improve continuity processes and knowledge sharing of critical employee, administrative, and operational functions through written communications and documentation within IHS.

11. Improve workplace organizational climate with staff development addressing teamwork, communication, and equity.

12. Strengthen employee performance and responsiveness to the Agency, Tribes, and patients by improving employee orientation and opportunities for training and education, including, customer service skills.

Objective 1.2: Build, strengthen, and sustain collaborative relationships.

Objective Explanation: Collaboration fostered through an environment that values partnership is vital to expanding the types of services to improve population health outcomes that can be achieved within the health care delivery system. These relationships include those between Tribes, Urban Indian programs, communities, other government agencies, not-for-profits, universities/schools, foundations, private industry, as well as internal cooperation within the Agency and collaborative project management.

Strategies—The following strategies support this objective:

Enhancing Collaboration:

1. Collaborate with Tribes in the development of community-based health programs, including health promotion and disease prevention programs and interventions that will increase access to quality health programs.

2. Develop a community feedback system/program where community members can provide suggestions regarding services required and received.

3. Support cross collaboration and partnerships among I/T/U stakeholders.

Service Expansion:

4. Promote collaborations between IHS, other Federal agencies, Tribes, and Tribal Organizations to expand services, streamline functions and funding, and advance health care goals and initiatives.

5. Work with community partners to develop new programs responsive to local needs.

Objective 1.3: Increase access to quality health care services.

Objective Explanation: Expanded access to health care services, including individual and community health services, requires using many approaches and is critical to improving the health of AI/AN people and reducing the leading causes of death risk factors. Among the needs identified are increased prevention, specialty care, innovative use of health care providers, traditional medicine, long-term and aftercare services (which may require advancing holistic and culturally centered population health models), and expanded facilities and locations. To assess the success of these efforts, measures are needed to evaluate provider productivity, patient satisfaction, and align improvements in support operations (e.g., human resources, contracting, technology) to optimize access to quality health care services.

Strategies—The following strategies support this objective:

Health Care Service Access Expansion:

1. Develop and support a system to increase access to preventive care services and quality health care in Indian Country.

2. Develop and expand programs in locations where AI/AN people have no access to quality health care services.

3. Overcome or mitigate challenges and enhance partnerships across programs and

agencies by identifying, prioritizing, and reducing access limitations to health care for local AI/AN stakeholders.

4. Increase access to quality community, direct/specialty, long-term care and support services, and referred health care services and identify barriers to care for Tribal communities.

5. Leverage technologies such as telemedicine and asynchronous electronic consultation systems to include a more diverse array of specialties and to expand, standardize, and increase access to health care through telemedicine.

6. Improve team effectiveness in the care setting to optimize patient flow and efficiency of care delivery.

7. Reduce health disparities in the AI/AN population.

8. Provide evidence-based specialty and preventive care that reduces the incidence of the leading causes of death for the AI/AN population.

9. Incorporate Traditional cultural practices in existing health and wellness programs, as appropriate.

10. Improve the ability to account for complexity of care for each patient to gauge provider productivity more accurately.

11. Hold staff and management accountable to outcomes and customer service through satisfaction surveys.

Facilities and Locations:

12. In consultation with Tribes, modernize health care facilities to expand access to quality health care services.

13. In consultation with Tribes, review and incorporate a resource allocation structure to ensure equity among Tribes.

14. Develop and execute a coordinated plan (including health care, environmental engineering, environmental health, and health facilities engineering services) to effectively and efficiently execute response, recovery, and mitigation to disasters and public health emergencies.

Goal 2: To promote excellence and quality through innovation of the Indian health system into an optimally performing organization.

Goal Explanation: In pursuit of high reliability health care services [1] and care that is free from harm, the IHS has implemented several innovations in health care delivery to advance the population health needs of AI/AN communities. In many cases, innovations are developed to meet health care needs at the local level and subsequently adopted across the Indian health system, as appropriate. IHS will continue to promote excellence and quality through innovation by building upon existing quality initiatives and integrating appropriate clinical and public health best practices. Recent IHS efforts have been aimed at strengthening the underlying quality foundation of federally operated facilities, standardizing processes, and sharing health care best practices with other Federal, State, Tribal, and Urban Indian programs.

Objective 2.1: Create quality improvement capability at all levels of the organization.

Objective Explanation: Ensure quality improvement is operational in all direct care, public health, administrative, and management services throughout the system. Quality improvement will be achieved at all levels of the organization including Headquarters, Area Offices, and Service Units and will be made available to Tribes, Tribal Organizations, and Urban Indian Organizations, as requested. Creating quality improvement capability at all levels will require training, resources, commitment, and consistency to assure that every employee shares a role in continuous quality improvement in all IHS operations and services. This objective will build upon current efforts of the 2016–2017 IHS Quality Framework [2] to strengthen quality improvement related to data, training, and standards of care.

Strategies—The following strategies support this objective:

Quality Data:

1. Improve the quality of data collected regarding health care services and program outcomes.

2. Develop and integrate quality standards and metrics into governance, management, and operations.

3. Standardize quality metrics across the IHS and use results to share information on best practices, performance trends, and identification of emerging needs.

Continuous Quality Improvement:

4. Provide training, coaching, and mentoring to ensure continuous quality improvement and accountability of staff at all levels of the organization.

5. Evaluate training efforts and staff implementation of improvements, as appropriate.

Standards of Care:

6. Develop and provide standards of care to improve quality and efficiency of health services across IHS.

7. Adopt the Model of Improvement in all clinical, public health, and administrative activities in the Indian health system.

8. Adopt patient-centered models of care, including patient centered medical home recognition and care integration.

Objective 2.2: Provide care to better meet the health care needs of Indian communities.

Objective Explanation: Key to improving health outcomes and sustaining population health is culturally responsive health care that is patient-centered and community supported. IHS will implement culturally appropriate and effective clinical and public health tools, as appropriate, to improve and better meet the health care needs of AI/AN communities. This objective reinforces current efforts addressing culturally appropriate care and support dissemination of best practices.

Strategies—The following strategies support this objective:

Culturally Appropriate Care:

1. Strengthen culturally competent organizational efforts and reinforce implementation of culturally appropriate and effective care models and programs.

2. Promote and evaluate excellence and quality of care through innovative, culturally appropriate programs.

3. Promote the total health integration within a continuum of care that integrates acute, primary, behavioral, and preventive health care.

4. Explore environmental and social determinants of health and trauma-informed care in health care delivery. Expand best practices across the IHS.

5. Continue to develop and implement trauma-informed care models and programs.

Sharing Best Practices:

6. Work collaboratively within IHS, and among other Federal, State, Tribal programs, and Urban Indian programs to improve health care by sharing best practices.

Goal 3: To Strengthen IHS program management and operations.

Goal Explanation: This goal addresses issues of management, accountability, communication, and modernized information systems. IHS is committed to the principles of improved internal and external communication, and sound management. Assuring the availability and ongoing development of a comprehensive information technology (IT) system is essential to improving access to integrated clinical, administrative, and financial data to support individual patient care, and decision-making.

Objective 3.1: Improve communication within the organization with Tribes and other stakeholders, and with the general public.

Objective Explanation: This objective addresses the critical need to improve communication throughout the IHS, with employees and patients, with Tribes, with Urban Indian Organizations, with the many organizations working with IHS and with the general public. Most important is to assist Tribes, Urban programs, and IHS in better understanding Tribal and Urban Indian needs and IHS program needs, to encourage full participation in information exchange, and to engage Tribes and Urban programs in partnership and coalition building. This includes defining and characterizing community needs and health program needs, modifying health programs as needed, and monitoring the effectiveness of programs and program modifications.

Strategies—The following strategies support this objective:

Communication Improvements:

1. Improve communication and transparency among all employees, managers, and senior leadership.

2. Develop and define proactive communications plans for internal and external stakeholders.

3. Enhance health-related outreach and education activities to patients and families.

4. Design social media platforms that will ensure wide dissemination of information to interested and affected individuals and organizations.

Strengthened Partnership:

5. Assure quality reporting relationships between service units, Area offices, and

[1] High reliability health care means consistent excellence in quality and safety for every patient, every time. High reliability in health care improves: organizational effectiveness, efficiency, culture, customer satisfaction, compliance, and documentation. For more information about High Reliability Organizations, please see: *https://psnet.ahrq.gov/primers/primer/31/high-reliability.*

[2] The IHS Quality Framework 2016–2017 is available at: *https://www.ihs.gov/newsroom/includes/themes/newihstheme/display_objects/documents/IHS_2016-2017_QualityFramework.PDF.*

headquarters are clearly defined and implemented.

6. Effectively collaborate with other IHS offices (e.g., the Loan Repayment Program) and HHS Staff and Operating Divisions where missions, goals, and authorities overlap.

Objective 3.2: Secure and effectively manage the assets and resources.

Objective Explanation: This objective supports the delivery of health care through improved management of all types of assets and non-workforce resources. To elevate the health status of the AI/AN population and increase access to medical care, IHS must continue to help ensure patients understand their health care options and improve business process and efficiencies to the health care system. IHS will also increase the effectiveness of operations and reporting, while providing more assistance and infrastructure support to Areas and facilities.

Strategies—The following strategies support this objective:

Infrastructure, Capacity, and Sustainability:

1. Enhance transparency of the IHS management and accountability infrastructure to properly manage and secure assets.

2. Ensure that Federal, State, Tribal, territorial, and local Tribal health programs have the necessary infrastructure to effectively provide essential public health services.

3. Provide technical assistance to strengthen the capacity of service units and Area Offices to enhance effective management and oversight.

4. Apply economic principles and methods to assure ongoing security and sustainability of Federal, Tribal and Urban Indian facilities.

Improved Business Process:

5. Routinely review management operations to effectively improve key business management practices.

6. Optimize business functions to ensure IHS is engaged in discussions on value-based purchasing.

7. Develop policies, use tools, and apply models that ensure efficient use of assets and resources.

8. Strengthen management and operations through effective oversight.

9. Develop standardized management strategies for grants, contracts, and other funding opportunities to promote innovation and excellence in operations and outcomes.

Patient Education and Resources:

10. Strengthen patients' awareness of their health care options, including Medicaid and Medicare enrollment, which may increase access to health care and optimize third party reimbursements.

Objective 3.3: Modernize information technology and information systems to support data driven decisions.

Objective Explanation: This objective is to assure the availability and ongoing improvement of a comprehensive information technology (IT) system that meets the needs of providers, patients, and I/T/Us, including using technology to provide improved, timely access to care and to reduce the need for transit. This objective recognizes that qualified and capable IT staff and leadership are fundamental in achieving the strategies listed below and further reinforces the workforce objectives outlined elsewhere in the plan. An improved Indian health IT network increases access to integrated clinical, administrative, and financial data to support individual patient care, decision-making, and advocacy. The need for data will require the development of a system integrated with Tribal and Urban Indian programs that will address the current and projected clinical, administrative, and fiscal data needs. Timely fiscal data dissemination to all Federal partners when developing budgets is necessary to accurately address health care needs of Indian communities. Data quality (i.e., accuracy, reliability, and validity) and quality patient care will continue to play a highly visible role both within and outside the IHS. Data quality is only partially dependent upon technology. Improved data quality also reflects other sustained initiatives, such as accuracy of data entry, legibility of handwriting, appropriate and timely data exports, and accuracy of coding.

Strategies—The following strategies support this objective:

Health Information Technology (HIT):

1. Evaluate electronic health record needs of the IHS and the ability for the health information systems to meet those needs, create seamless data linkages, and meet data access needs for Tribes and Tribal program health information systems.

2. Develop a consistent, robust, stable, secure, state-of-the-art HIT system to support clinicians workflow, improve data collection, and provide regular and ongoing data analysis.

3. Modernize the HIT system for IHS Resource and Patient Management System (RPMS) or commercial off-the-shelf packages.

4. Align with universal patient record systems to link off-reservation care systems that serve AI/AN.

5. Enhance and expand technology such as the IHS telecom to provide access for consultative care, stabilization of care, decreased transportation, and timeliness of care at any IHS-funded health program.

Data Process:

6. Provide available data to inform decision making for internal and external stakeholders.

7. Act upon performance data and standardize data and reporting requirements.

8. Assure system of data sharing to solidify partnerships with Tribal Epidemiology Centers and other Tribal programs.

9. Establish capability for data federation [3] so that data analytics/business intelligence may be applied to disparate data stored in a single, general-purpose database that can hold many types of data and distribute that data to users anywhere on the network.

Note: This draft plan is developed for public consideration, it is intended to improve the management and administration of the IHS and strategic direction of the Agency over the next 5 years, and it is not intended to create any right, benefit, or legal responsibility, substantive or procedural, enforceable at law by a party against the United States, its agencies, or any person.

[3] Data federation provides an organization with the ability to aggregate data from disparate sources in a virtual database so it can be used for business intelligence or other analysis.

The IHS will publish an additional **Federal Register** Notice with the final IHS Strategic Plan FY 2018–2022 after all comments are received and considered.

Dated: July 16, 2018.

Michael D. Weahkee,

RADM, Assistant Surgeon General, U.S. Public Health Service, Acting Director, Indian Health Service.

[FR Doc. 2018–15740 Filed 7–23–18; 8:45 am]

BILLING CODE 4165–16–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Cancer Institute; Notice of Closed Meetings

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended, notice is hereby given of the following meetings.

The meetings will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Cancer Institute Special Emphasis Panel; NCI Program Project I (P01).

Date: September 17–18, 2018.

Time: 3:00 p.m. to 5:00 p.m.

Agenda: To review and evaluate grant applications.

Place: Bethesda North Marriott Hotel & Conference Center, 5701 Marinelli Road, North Bethesda, MD 20852.

Contact Person: Mukesh Kumar, Ph.D., Scientific Review Officer, Research Program Review Branch, Division of Extramural Activities, National Cancer Institute, NIH, 9609 Medical Center Drive, Room 7W618, Bethesda, MD 20892–9750, 240–276–6611, *mukesh.kumar3@nih.gov*.

Name of Committee: National Cancer Institute Special Emphasis Panel; NCI SPORE I (P50) Review.

Date: September 25, 2018.

Time: 8:00 a.m. to 2:00 p.m.

Agenda: To review and evaluate grant applications.

Place: Gaithersburg Marriott Washingtonian Center, 9751 Washington Boulevard, Gaithersburg, MD 20878.