Remarks for RADM Michael D. Weahkee
National Indian Health Board (NIHB) Board of Directors
2018 1st Quarter Meeting & Annual Meeting
January 29, 2018 | 9:10 a.m. | Washington, D.C.

Remarks as Prepared

Good morning, I'm Rear Admiral Michael Weahkee, acting director of the Indian Health Service. I'm happy to be here today to speak with all of you and to provide updates on what we're working on at IHS.

Let me begin by thanking you all for inviting me to your Board of Directors meeting, and for the work you do to promote Native health. NIHB is a key partner, and I appreciate your continued dedication to supporting the IHS mission of raising the physical, mental, social and spiritual health of American Indians and Alaska Natives to the highest level.

I understand there are important topics that the Board of Directors would like to discuss with me this morning. Before we start our discussion, I would like to share a few updates about the ongoing work at IHS Headquarters and around the country.

Recruiting and retaining skilled, qualified people in positions throughout the Indian health system is vital to our success.

We are currently looking for Senior Executive leaders at IHS. We'd like your assistance. We're accepting applications for Area Director in the Great Plains Area and Navajo Area. In addition to job-specific qualifications, these positions require

- demonstrated leadership,
- professional integrity,
- a broad perspective,
- and a commitment to the highest ideals of public service.

Please help us spread the word. More information on these positons is available at USAjobs.gov.

We all know that retention of our employees requires competitive compensation. I'm happy to tell you that as part of ongoing efforts to provide competitive compensation and provide recruitment and retention tools to IHS managers, last year we implemented special salary rate pay tables for certified registered nurse anesthetists and certified nurse midwives.

A new special pay rate for nurse practitioners became effective this month. The Title 38 pay program uses special pay authorities to provide higher rates of pay to employees in certain health care occupations.

Another way we're addressing staffing challenges is through the use of telemedicine. You may remember that we launched tele-emergency services last year, which brings ED-qualified doctors and nurses virtually into some of our hospitals, where they can help monitor patients, document treatment, and advise

on-site staff. I'm happy to report that we have now also begun offering specialty care remotely through our contract with Avera Health's eCare system. The first patients were recently seen at the Rapid City IHS. Several sites in the Great Plains Area are now using this service. As we expand tele-specialty care, we will improve access to care, reduce patient wait times and bring additional resources to our rural health care providers.

Specialty services that can be delivered through telemedicine include behavioral health, cardiology, endocrinology, pain management, and rheumatology.

I'd also like to highlight our efforts to build future capacity through opportunities for students such as scholarships, externships, residencies, rotations, and even sponsoring students to attend medical school at the Uniformed Services University of the Health Sciences.

USUHS offers students a tuition-free education and the full salary and benefits of a junior-ranking Commissioned Corps officer while they earn their medical degree. These programs provide opportunities for the next generation of medical professionals, and bring them to both federal and tribal facilities.

I want to talk to you about an important meeting coming up. The newly formed Indian Health Care Improvement Fund Workgroup is meeting tomorrow and Wednesday in Washington DC at the Holiday Inn Washington-Central/White House. This meeting will focus on the purpose and history of the fund and the results of our recent work to update the data used in the current formula. We will

also begin discussions on recommendations for future improvement. We anticipate this will be the first of several meetings and we will provide updates throughout the process.

You may have seen my recent letter dated December 21, 2017 about an important policy update to the Contract Support Cost policy. I am happy to see Councilman Andrew Joseph, Jr. here at the meeting. He serves as the Tribal Co-chair to the CSC Workgroup. We have scheduled the next CSC workgroup meeting for March 6-7 in Albuquerque, New Mexico.

One of the CSC policy's guiding principles is that it will be reassessed on a regular basis. After a year of implementing the revised CSC policy, the IHS has found that in certain instances, the section of the policy relating to an alternative method for calculating indirect costs associated with recurring service unit shares – which many of you know as the 97-3 split or the 97-3 method – does not conform with the statutory authority of the ISDEAA. The 97-3 method potentially would provide more CSC funding in some cases than the statute would allow.

I want to thank Mr. Joseph for his leadership on the CSC workgroup. I received his letters on behalf of the Tribal Members to the CSC workgroup. I will be in attendance at the next CSC workgroup meeting in Albuquerque and look forward to continuing our work on CSC.

Last month, I participated in a high-level meeting with Deputy Secretary Hargan. Leaders from across the department joined in discussing strategies for addressing

the opioid crisis. I had the opportunity to bring our perspective on the effects of opioids on the American Indian and Alaska Native population and share the work we are doing to combat misuse.

Our native communities continue to wrestle daily with the opioid crisis. American Indians and Alaska Natives had the highest drug overdose death rates in 2015. The IHS National Committee on Heroin, Opioids, and Pain Efforts (HOPE), established in April 2017, was the successor of the Prescription Drug Abuse Workgroup, and works to promote appropriate and effective pain management, reduce overdose deaths from heroin and prescription opioid misuse, and improve access to culturally appropriate treatment.

We're also working to address mental health by establishing a chartered tribal advisory group to consult with IHS on the creation of a national Community Health Aide Program. Our goal is for the advisory group to meet in March to begin developing a policy and implementation plan for community health aide expansion in the lower 48, which could lead to greater numbers of behavioral health aides and dental health aide therapists. Behavioral health aides are trained paraprofessionals who provide crisis counseling, mental health first aid, and connect individuals to an appropriate level of care. Dental health aide therapists are trained to provide dental care and procedures. I will be sending out a letter with more information soon.

I appreciate NIHB inviting us to the upcoming 2018 National Tribal Public Health Summit on May 22-24 in Prior Lake, Minnesota. We look forward to hosting listening sessions on these important topic at the Summit.

I know there has been a lot of news about the federal budget lately. I'm sure you all know that we are operating under a continuing resolution that funds federal operations through February 8.

Previous continuing resolutions have included $75 million for the Special Diabetes Program for Indians – or SDPI – for Fiscal Year 2018.

We await congressional action on further funding bills for the fiscal year. Both the House and Senate have recommended increased funding over 2017 levels for the IHS.

I'd also like to mention the success of an effort to increase the reach of the funds we receive. Since the Purchased/Referred Care Rates regulation was approved, all IHS operated facilities have fully implemented PRC Rates and are six tribes have opted in. PRC Rates allow us to pay rates similar to other federal programs such as Medicare and Tricare for physician and other health care professional services to expand beneficiary access to medical care. Since the implementation of PRC Rates, IHS and Tribal programs have saved $388.6 million through the end of December 2017.

Tribes can opt in to the PRC rates at any point. Any tribe that is interested in PRC rates should contact their contract proposal liaison officer or area lead negotiator to modify or amend their funding agreement with appropriate language.

The Director's Workgroup on Improving Purchased/Referred Care will meet on March 8-9 in Albuquerque, New Mexico, immediately following the CSC Workgroup meeting.

Finally, I want to quickly give you an update on the IHS strategic plan. The IHS received comments from 137 individual tribes, tribal organizations, urban Indian organizations, and federal employees. The Strategic Planning Workgroup has met several times to develop the objectives, strategies and measures for each goal in the Strategic Plan. We anticipate the workgroup will complete a draft strategic plan by the end of January.

As a next step, we will initiate a 30-day public comment period on the draft Strategic Plan. During the comment period, the IHS will hold a National All Tribal and Urban Leader Call to share updates and provide a forum for comment on the draft strategic plan. We expect the final IHS Strategic Plan to be completed and published for use in April 2018.

As we begin a new year, I want to say I'm proud of what we accomplished in 2017. We could not have done it without our partners. We are steadfastly committed to overcoming the longstanding systemic challenges that have

hindered some of our efforts across the agency. I am pleased that our concerted efforts are producing results.

We all want Indian programs to be successful. I am extremely proud of the commitment and successes of the IHS team working to improve our agency. And I am also grateful for the partnerships we have with tribes and tribal organizations.

I look forward to our discussions here today. Thank you.