



**Remarks for RADM Weahkee  
Direct Service Tribes Advisory Committee  
February 13, 2018 | 9:00 am | Arlington, VA**

***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 being here, and for the work you do to promote Native health. Our partnerships with tribes, tribal and urban Indian organizations are critical to our success.

I would like to mention that we're excited to work with the six tribes in Virginia that were recently recognized. We look forward to building government-to-government relationships with the Chickahominy, Eastern Chickahominy, Upper Mattaponi, Rappahannock, Nansemond and Monacan tribes.

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. The conversations we have here, and the feedback you provide, are very important. I appreciate the opportunity to speak with all of you and to provide updates from the Department of Health and Human Services as well as the ongoing work at IHS Headquarters and around the country.

Alex Azar was recently sworn in as the 24th Secretary of Health and Human Services. He previously served at the department as General Counsel and then as Deputy Secretary. During his time as Deputy Secretary, he was involved in improving the department's operations; advancing its emergency preparedness and response capabilities as well as its global health affairs activities; and helping oversee the rollout of the Medicare Part D prescription drug program.

His priorities as Secretary include lowering drug prices while allowing for innovation, making healthcare more affordable and available, improving Medicare outcomes, and ending the opioids epidemic.

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. I recently participated in a high-level meeting with HHS Deputy Secretary Eric 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.

The IHS National Committee on Heroin, Opioids, and Pain Efforts (HOPE), established in April 2017 works to promote appropriate and effective pain management, reduce overdose deaths from heroin and prescription opioid misuse, and improve access to culturally appropriate treatment.

Building upon our current work and efforts to address mental health issues, the IHS will soon announce the establishment of a chartered tribal advisory group to

assist us further explore 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 outside of the state of Alaska, “in the lower 48,” which could lead to greater numbers of community health aide programs, such as 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.

We value our staff and seek ways to recruit and retain the best employees. 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, a new special pay rate for federal civilian nurse practitioners became effective last month.

Title 38 of the United States Code allows IHS to provide higher rates of pay to employees in certain health care occupations. During the past two years, we implemented special salary rate pay tables for certified registered nurse anesthetists and certified nurse midwives, and we have already seen a decrease in our vacancy rates for these critical occupations. Additional Title 38 pay tables are either under development or under discussion.

The IHS also recently obtained authority from the Office of Personnel Management to provide increased recruitment, relocation, and retention incentives for nurses in order to compete with private sector health care organizations.

The IHS continues the successful partnership with the Office of the Surgeon General to increase the recruitment and retention of U.S. Public Health Service Commissioned Corps officers. Most recently the IHS has been given priority access to new Commissioned Corps applicants. This allows IHS to make the first contact with these applicants in an effort to recruit them to fill health professional vacancies throughout IHS. These actions demonstrate that IHS is taking its challenges seriously, and is continuing to take assertive and proactive steps to address them.

We also 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, where they enjoy a tuition-free education and receive the full salary and benefits of a junior ranking Commissioned Corps officer while attending the four-year program to earn their MD. These programs provide opportunities for the next generation of medical professionals, and bring them into the Indian health system.

Of particular interest to the DSTAC, we're addressing staffing challenges through the use of telemedicine. We have begun offering specialty care remotely through our contract with Avera Health's eCare system. 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 health care providers. Specialty services that can be delivered through telemedicine include behavioral health, cardiology, endocrinology, pain management, and rheumatology.

The Indian Health Service seeks to provide trusted, high quality health care to American Indians and Alaska Natives by promoting practices and policies that improve health outcomes.

Some of our other recent accomplishments include:

- A new national provider credentialing and privileging system used to modernize the way provider credentialing and privileging is facilitated throughout the agency. I'm happy to report that all IHS Areas are now using this new system. This allows IHS to more easily track our providers and work across services units or areas to minimize duplication of credentialing.
- A master contract for accreditation for hospitals awarded to The Joint Commission. A single accrediting organization for all IHS hospitals means a uniform set of health, quality and safety standards across the organization.
- And a patient experience survey -- an important tool for gathering information about experience and also for determining perceptions of the quality of care received. IHS developed a standardized patient experience of care survey for uniform use across the agency.
- A National Accountability Dashboard for Quality that aids in evidence-based strategic decision making. The new dashboard will allow the IHS to monitor data to key performance indicators in a succinct and easily viewed display. It is the result of a collaborative process that reflects the input of a diverse group of subject matter experts from across IHS in the areas of clinical and public health care, quality improvement, and health informatics. We will be releasing the Dashboard on the IHS web site Thursday afternoon.

On December 21, 2017, I sent a letter to Tribal Leaders to inform them about an important policy update to the Contract Support Cost policy – a temporary rescission to a portion of policy that I will speak more about in a second, but I would like to say a few things first about the CSC policy.

In October 2016, the IHS approved a revised CSC Policy. This update was long overdue – 10 years to be exact. The revised policy was implemented with robust tribal consultation, including many meetings of the CSC Workgroup. The workgroup is comprised of federal staff and tribal leaders.

The revised policy aims to ensure efficient, accurate, and transparent CSC negotiations and provide a uniform and equitable system of determining, paying, and reconciling CSC funds for contracts and compacts. It is also our policy to preserve and support each awardee's right to contract or compact under the ISDEAA.

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 will be in attendance at the next CSC workgroup meeting in Albuquerque, New Mexico on March 6-7. I look forward to continuing our work on CSC.

Another important workgroup met for the first time recently - the Indian Health Care Improvement Fund Workgroup. I have heard several positive comments about their first meeting and understand they have agreed to an aggressive work agenda to complete their work to evaluate and recommend changes to the formula used to determine funding needs for health care facilities operated by the IHS, tribes, and tribal organizations. The workgroup includes federal staff and tribal leaders from each IHS area. I look forward to receiving their recommendations and engage nationally in tribal consultation prior to make a final decision.

We are all surrounded by news of the federal budget. The IHS currently operates under a continuing resolution that funds federal operations through March 23.

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

Tomorrow morning, Secretary Azar will testify at a House Ways and Means Committee hearing on the fiscal year 2019 proposed budget, which was released yesterday. Ann Church, acting director of the IHS Office of Finance and Accounting, will provide more information later this morning.

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 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.

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. I want to thank everyone for their active involvement. We are reviewing the recommendations from their work now to finalize a complete draft plan. In addition, we are considering recent input received on next steps of the consultation process that may result in making a few adjustments to our timeline.

One of the critical next steps includes 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 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.