



**Remarks for RADM Michael D. Weahkee
HHS Secretary's Tribal Advisory Committee
May 9, 2018 | 1:00 p.m. | Washington, D.C.**

Remarks as prepared

Good afternoon, 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. The conversations we have here, and the feedback you provide, are very important as we work to fulfill the IHS mission of raising the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level.

I want to start by sharing some personnel announcements with you.

- **Ms. Jennifer Cooper** is the new director of the Office of Tribal Self-Governance. Ms. Cooper, an enrolled member of the Seneca Nation of Indians, officially became the director on April 1, after serving as the acting director since October 2016. Her office provides policy analysis and development support to tribal governments and the IHS in the evolving area of self-governance and tribal and federal government relationships.

- **Ms. Roselyn Tso** is the new director of the Office of Direct Services and Contracting Tribes. Ms. Tso, an enrolled member of the Navajo Nation, officially became the director on March 4th, after serving as the acting director since August 2016. Her office is responsible for a wide range of agency functions that are critical to the working partnership between the IHS and federally recognized tribes. The ODCST is the focal point for Title I, Indian Self-Determination and Education Assistance Act activities and implementation for direct service tribes.
- **Ms. Athena S. Elliott** is now the director of the Office of Management Services effective April 1st. Ms. Elliott, an enrolled member of the Choctaw Nation of Oklahoma, served as the OMS director from 2005 to 2015. Since 2015, she has served as executive advisor to the IHS director, providing subject matter expertise and advice on administrative and financial issues that support the Agency's mission and program goals.
- **Dr. Beverly Cotton**, an enrolled member of the Mississippi Band of Choctaw Indians, is now the acting director of the Office of Clinical and Preventive Services. Her office aims to improve and promote wellness for American Indians and Alaska Natives by serving as the primary source of national advocacy, policy development, budget development and allocation for clinical, preventive, and public health programs for IHS, Area Offices, and Service Units.

As you know, building our workforce with the best health care professionals is important for all of us. Today, I want to share with you some of the exciting ways we are working to build our future workforce through innovative partnerships with universities.

The IHS Navajo Area is collaborating with the University of California, San Francisco on the Health, Equity, Action Leadership Program -- or HEAL -- which arranges placements of pairs of early-career clinicians, both physicians and nurse practitioners, who serve in alternating six-month clinical periods over a two-year period.

When not at their clinical site, fellows engage in global health delivery work at a second site of their choice, typically in a low-income country, while earning a distance learning Masters of Public Health degree. This partnership places clinical providers in the Navajo Area who would not otherwise serve in these locations. The costs are substantially lower than that of a contract physician. The program also allows a community member from each partner site to pair with each fellow to also obtain an MPH with the goal of increasing local workforce capacity.

Another way we are building the future workforce is through the University of Washington Global and Rural Health Fellowship, a two-year fellowship for internal medicine and emergency medicine physicians. During the first year of fellowship, fellows attend a one-month global health course at the University of Washington in Seattle and spend the remainder of the year at either the Pine Ridge IHS Hospital in South Dakota or at Alaska Native Tribal Health Consortium. The second

year is spent abroad, where internists engage in clinical education or research, and emergency physicians participate in rural health or humanitarian emergencies.

We are also partnering with Massachusetts General Hospital for a two-year Fellowship Program in Rural Health Leadership. Fellows spend six months engaged in primary care and hospital medicine at Rosebud Indian Hospital. In their non-clinical time, fellows participate in on-site coursework for an MPH, teach health professions students rotating through the site, and participate in community-driven projects.

And the IHS Oklahoma City Area has expanded its collaborative relationship with the Oklahoma State College of Medicine. This program sponsors medical residents in exchange for a service obligation.

We are continuing to partner with the Office of the Surgeon General to explore ways to improve the recruitment and retention of Commissioned Corps officers in the immediate future, including:

- A monthly pay incentive over and above current allowances, to attract qualified officers to assignments that are hard-to-fill or in isolated hardship locations.
- Credit that is applied towards a promotion that acknowledges the contributions of officers providing clinical care and encourages them to remain in clinical positions long-term to maintain continuity of care and establish trust with patients;

- Increasing the number of Corps officers that may be nominated for an early promotion to the next rank for exceptional proficiency; and
- Updating Commissioned Corps policy to ensure Corps officers do not transfer before they've met their long term service obligation.

IHS is also working closely with Department of Health and Human Services to address Secretary Alex Azar's priorities. One of the department's priorities that IHS is especially involved in is addressing the opioid crisis.

As part of the overall HHS strategy, IHS believes that addressing this critical issue requires a holistic approach that integrates the physical, mental, spiritual, and cultural components into a comprehensive strategy. This means that we are developing effective strategies to address substance use prevention, treatment and recovery. As with this plan and all other IHS initiatives around substance use, collaboration with tribes is fundamental. The IHS partners with tribes, in multiple forums, to address the overall effect that substance abuse has had on the health of tribal members in their communities. This feedback becomes a central driving component of the overall IHS strategy. Dr. Michael Toedt who is the IHS chief medical officer, will provide information on specific actions we have taken in a few minutes.

IHS is also working to address the Secretary's priority of transforming the nation's healthcare system to a value-based system. One of the areas of emphasis is giving patients greater control over health information through interoperable and accessible health information technology. The Indian Health Service has long been

a pioneer in using computer technology to capture clinical and public health data. IHS patients can register to use the Indian Health Service Personal Health Record, where they can access their health information, track medications and lab results, contact their health care provider, and much more - all from the privacy of their personal computer or mobile device.

Another point of emphasis for this priority is using alternative models to drive value and quality. In some of the locations IHS serves, the traditional hospital model is not efficiently meeting the health needs of the individuals, communities, and tribes we serve. There is a mismatch between the organization and delivery of care and the health needs of the community in the geographic and social context in which the care is provided. Innovation can offer opportunities for a system of care that can perform better in these circumstances.

Our facilities are predominately in rural locations with limited access to services for the population, or in urban areas where the services provided are duplicative of services available in larger, better funded private sector facilities. As a result, our hospitals tend to have low utilization of inpatient services with very low average daily census. To address this, for some sites, such as Rapid City, we can transition from full hospital services to an ambulatory care center with 24/7 urgent care, reallocating staffing and resources from the expensive and lightly used inpatient services to more cost-effective and heavily used primary care services.

For some facilities, conversion to Critical Access Hospitals may provide flexibility to better tailor services to meet each community's unique needs. IHS currently operates five Critical Access Hospitals:

- Hopi Health Center,
- Parker Indian Hospital,
- Cass Lake Indian Hospital,
- Fort Belknap Health Care Center,
- and Crow/Northern Cheyenne Indian Hospital.

The federal budget has been in the news a lot lately, and we heard an update on the HHS budget this morning. Our budget plays a critical role in providing for a healthier future for American Indian and Alaska Native people.

The fiscal year 2018 Omnibus provides federal appropriations through the end of September. I am pleased to report that the spending bill includes \$5.5 billion for the IHS, which is an increase of \$498 million over the fiscal year 2017 enacted funding level. Some of the increase highlights include: \$72 million for the Indian Health Care Improvement Fund, \$98 million for current services to cover the increasing cost of pay and medical inflation, nearly \$66 million for staffing of five newly-constructed health care facilities, an additional \$29 million for accreditation emergencies, and significant increases for our facilities budget lines totaling \$322 million.

We're also working closely with the Substance Abuse and Mental Health Services Administration, regarding \$50 million in their budget for tribes and tribal

organizations to address the opioid crisis by increasing access to treatment, reducing unmet treatment need, and reducing opioid overdose related deaths through the provision of prevention, treatment and recovery support activities for opioid use disorder.

Congress has also enacted legislation to provide \$150 million for each of fiscal years 2018 and 2019 for the Special Diabetes Program for Indians – or SDPI, which provides funding for diabetes treatment and prevention to 301 IHS, tribal, and Urban Indian health programs. I recently sent a letter to initiate tribal consultation on the distribution of SDPI funds for Fiscal Year 2019. SDPI is saving lives, improving quality of life, and reducing the cost of care across Indian Country.

The proposed Fiscal Year 2019 proposed budget reflects the Administration's strong commitment to Indian Country and helps us maintain the progress we have made over the years. Specifically, the budget protects direct clinical health care investments. In order to prioritize direct clinical health care services and the staffing of newly-constructed health care facilities, the budget discontinues the Health Education Program and Community Representatives Program.

I testified before the House Appropriations committee and the Senate Indian Affairs Committee last month on the budget, and I will appear before the Senate Appropriations Committee later this month. The proposed budget is a starting point, and discussions are ongoing. Congress will make the final determination.

The proposed budget supports self-determination by continuing the separate indefinite appropriation account for contract support costs. The budget includes an estimate of \$822 million to fully fund CSC, which is \$22 million above the FY 2018 Annualized Continuing Resolution estimate. Maintaining the flexible funding authority of an indefinite appropriation allows the IHS to guarantee full funding of CSC, as required by the law.

I wanted to also make you aware of an important workgroup that met for the first time in January, and has met several times since then. The Indian Health Care Improvement Fund Workgroup includes federal staff and tribal leaders from each IHS area. They are evaluating the formula used to determine funding needs for health care facilities operated by the IHS, tribes, and tribal organizations. The workgroup is accelerating its work to ensure \$72 million in recently appropriated funds can be distributed before the end of the fiscal year. The workgroup will meet next week in Denver to finalize their recommendations, which will be shared through tribal consultation before any decisions regarding potential changes to the existing formula are made.

Another important group is the Community Health Aide Program Tribal Advisory Group, which is providing input and feedback to the IHS on expanding the Community Health Aide Program to the lower 48 states. The group proposed several workgroups that will begin working over the next few months to continue our efforts in expanding CHAP to reduce health disparities and increase access to care.

I also want to mention that I understand how important Contract Support Costs are for our Tribal Partners that choose to operate their own health care programs in part or in their entirety, as well as for tribes and tribal organizations that are considering exercising rights under the Indian Self-Determination and Education Assistance Act.

On April 13, I sent a letter to initiate Tribal Consultation on the Contract Support Costs policy, specifically, the section commonly known as the “97/3 Method” or “97/3 Split.” The comment period is open through May 18, 2018 to gather input on a recommendation made by the IHS Contract Support Costs Workgroup, as well as other views or recommendations you may have to offer.

Before I wrap up, I want to thank everyone for their active involvement in the IHS strategic plan. The IHS received comments from 150 individual tribes, tribal organizations, urban Indian organizations, and federal employees.

The Federal-Tribal Workgroup met from November through February to review comments and provide feedback on the Mission and Vision statements and recommended 70 strategies across 3 goals and 8 objectives for the draft Strategic Plan. 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 an Urban Leader Call to share updates and provide a forum for additional comments on the draft strategic plan.

We all want Indian programs to be successful. We are 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 the tribes.

Thank you.