Statement by

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Where Are They Now: Indian Programs on the GAO High Risk List

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Good afternoon, Chairman Hoeven, Vice-Chairman Udall, and Members of the Senate Committee on Indian Affairs. I am RADM Michael D. Weahkee, Principal Deputy Director of the Indian Health Service (IHS). I am pleased to appear before this Committee again to provide testimony regarding IHS programs identified by the U.S. Government Accountability Office (GAO) High Risk Report recently released on March 6, 2019. Our continued priority and goal at IHS is to provide quality care.

IHS is a unique agency within the Department of Health and Human Services (HHS). It is the only HHS agency whose primary function is direct health care delivery. IHS was established to carry out the responsibilities, authorities, and functions of the United States in providing health care services to American Indians and Alaska Natives. The mission, in partnership with American Indian and Alaska Native people, is to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level. The IHS system consists of 12 area offices, which oversee 170 service units that provide care at the local level. Health services are provided through facilities managed by IHS, by Tribes and tribal organizations under authorities of the Indian Self-Determination and Education Assistance Act, and through contracts and grants awarded to urban Indian organizations authorized by the Indian Health Care Improvement Act.

Demonstrated Progress

IHS is committed to making improvements and ultimately to being removed from the GAO's High Risk list. The GAO released its most recent High Risk Report on March 6, 2019. Although IHS is still on the list, we have made significant progress since the GAO's High

Risk report published on February 15, 2017. Since that time, GAO has closed seven recommendations. Earlier this month, IHS requested closure of four recommendations after issuing updates to the Indian Health Manual, Purchased/Referred Care (PRC) chapter. The remaining two recommendations cited in the 2017 report require continued IHS monitoring of the actions implemented before we formally ask the GAO to close them. In the March 6, 2019 report, GAO cites one additional recommendation that was not cited in the 2017 report, and IHS is moving forward with actions to implement this recommendation.

Since June 2018, IHS has realized significant improvements to quality care for American Indians and Alaska Natives. These improvements include developing and implementing an IHS Strategic Plan for Fiscal Year 2019-2023, establishing an Office of Quality, implementing credentialing and privileging software agency-wide for all applicants, and awarding a new contract for an adverse events reporting and tracking system that replaces an older legacy system.

IHS also started work on modernizing our electronic health record system. In collaboration with the HHS Office of the Chief Technology Officer, we are completing a Health Information Technology (HIT) Modernization Research Project to inform IHS regarding options to replace or modernize our existing HIT infrastructure.

Leadership Commitment

IHS leadership is committed to making progress on addressing GAO's recommendations and continues to press forward in working partnership with GAO. Since last June, IHS has met four times with key GAO officials to describe action plans for closing-out the recommendations and to review our activities to meet the criteria to be removed from the High Risk list. IHS is focused on implementing change across the agency to strengthen our ability to ensure quality health care.

In February 2019, IHS released the Strategic Plan for Fiscal Years 2019-2023. The Strategic Plan will help guide ongoing efforts to provide health care for American Indians and Alaska Natives throughout the United States. The plan details how the IHS will achieve its mission through three strategic goals, which are each supported by objectives and strategies.

- **Goal 1:** To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people.
- **Goal 2:** To promote excellence and quality through innovation of the Indian health system into an optimally performing organization.
- **Goal 3:** To strengthen IHS program management and operations.

This Strategic Plan reflects the feedback received from Tribes, tribal organizations, urban Indian organizations, IHS staff, and other stakeholders. This plan continues to elevate and institutionalize the work previously included in the IHS Quality Improvement framework.

IHS leadership, along with HHS, seeks to innovate the delivery of care the IHS provides to meet the health needs of tribal communities not fully addressed by the traditional hospital model in some locations IHS serves. 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 those available in private sector facilities. As a result, our hospitals tend to have low utilization of inpatient services. To address this, we could transition from full hospital services to an ambulatory care center with 24/7 urgent care or to a critical access hospital where appropriate. Through this transition we could reallocate staff and resources from expensive and lightly used inpatient services to more cost-effective and heavily used primary care services.

Last month, I participated in the first HHS Intradepartmental Council on Native American Affairs meeting under the current administration. The council is comprised of HHS Operating Division and Staff Division senior officials. The council discusses strategies, priorities and recommendations on new partnerships and intradepartmental collaboration relating to American Indians and Alaska Natives. This is an exciting step in broadening our partnership throughout the Department and with other Federal agencies outside of HHS.

Progress on Improvements in Quality Care

IHS's new Office of Quality was formally established in January 2019 and our new Deputy Director for Quality Healthcare was selected and on-boarded in November 2018. The Office of Quality will include four divisions: Enterprise Risk Management (ERM), Quality Assurance, Innovation and Improvement, and Patient Safety and Clinical Risk Management. Six current staff in quality assurance, quality improvement, patient safety and clinical risk management roles

are transitioning to the new Office of Quality. ERM has begun transitioning to the new Office of Quality, which will be completed by the end of fiscal year 2019. Five new positions for the Office of Quality have been announced, and IHS plans to interview and hire within the next two months. During the transition of staff and ERM, IHS anticipates all current work will continue without disruption.

The Office of Quality supports IHS hospitals and health centers by providing resources and tools for quality assurance and improvement to attain and maintain compliance with Centers for Medicare & Medicaid Services (CMS) regulations and accreditation standards. Accreditation and Certification surveys have been conducted at 26 IHS facilities in nine IHS areas. As a result, in the third quarter of 2018, 96% of IHS hospitals were fully accredited or CMS certified, and 97% of IHS health centers were accredited.

Improving access to care is a top priority for the agency. Wait times are one component of access to care, and an important measure of the patient experience. In 2017, IHS published IHS Circular Number 17-11 establishing wait time standards for direct care IHS facilities. Facilities are already using data to drive measureable improvements in wait times. The published IHS Wait Time Standards are undergoing improvement to add wait time standards for emergency department settings. IHS is working toward further automating data collection and reporting capabilities to improve monitoring and accountability.

Monitoring

As mentioned in prior testimony to this Committee, IHS finalized the National Accountability Dashboard for Quality (NADQ) on February 20, 2018. Since finalization, we've completed a Fiscal Year (FY) 2018 Quarter 3 report that was released October 9, 2018. With the release of the 2018 Quarter 4 report in March 2019, the NADQ will have successfully completed a full year of reporting. The dashboard is a valuable reporting tool that enables IHS headquarters and area offices to have a near real-time view of health care hospitals and health centers functioning across the system. Over time, this will facilitate implementation and monitoring of quality care measures. As IHS continues to implement the NADQ, we anticipate the results will demonstrate sustained improvements in the nine key metrics tracked in the dashboard including accreditation and an active quality improvement program.

Organizational Capacity

IHS understands the importance of having permanent leadership in key positions throughout the agency. In the past year, IHS has filled eight Senior Executive Service positions, which includes two senior staff positions, two area director positions, and four headquarter office director positions. In addition, IHS continues its leadership training program designed to prepare selected IHS individuals to serve in leadership positions at the service unit, area, and headquarters levels. The leadership training program has had three cohorts since the summer of 2017 with nearly 100 total participants completing the training. The next cohort starts in March 2019.

Recruitment and retention of health care professionals is a challenge for IHS and other health care organizations serving rural locations. To meet these challenges, IHS offered legislative

proposals in the FY 2019 IHS Congressional Justification for discretionary use of all Title 38 personnel authorities, half-time obligations for loan repayment and scholarship recipients, and tax exemption for these recipients.

Purchased/Referred Care Improvements

IHS continues to improve and increase access to care for our beneficiaries through outreach, education, and enrollment activities. The national PRC program set targets for local programs to ensure that IHS is able to provide access to our patients in the most cost effective manner. All levels of PRC management frequently monitor progress towards meeting these targets, and IHS started doing internal quarterly monitoring in September 2018 to look at root causes for not meeting the targets. Initial analysis identified two caveats to the measure that are beyond IHS control: 1) the time it takes from authorization to appointment availability is significant, and 2) the time it takes for a provider to file a claim is significant.

Since implementation of the PRC rates regulations in October 2016, the PRC program has realized a $1.188 billion increase in purchasing power according to the fiscal intermediary. This purchasing power has allowed PRC programs to pay for additional services and fund more medical priority levels than ever before, which improves access to care for our patients.

In closing, there are a few updates regarding the Pine Ridge and Rosebud IHS Hospitals that are important to mention to this Committee. On February 26, 2019, The Joint Commission Resources was onsite at the Pine Ridge Hospital to conduct a review of compliance in preparation for an accreditation survey. IHS is preparing to send a request by the end of March

to CMS for a recertification survey of the Pine Ridge Hospital. There are a few recent key personnel changes at the Pine Ridge Hospital. We have hired a full time Clinical Director as of January 20, 2019. We have also put in place an acting Director of Nursing and an acting Administrative Officer in the past month.

At the Rosebud Hospital, we hired a new Chief Medical Officer, Chief Nurse Officer, Chief Quality Manager, and a Federal Emergency Department Nurse supervisor. We have two additional Nurse Case managers awaiting acceptance of employment offers, and three new Registered Nurses, an OB/GYN physician, and a psychologist on board. We have also made improvements in Outpatient Clinic access at the Rosebud Hospital, which include extending outpatient hours, a workflow redesign to gain efficiency, and tele-health for outpatient clinics including Emergency Department, Cardiology, Endocrinology, Behavioral Health, Rheumatology, and Neurology. Also, facility projects for improvements include the following: dental renovation, HVAC system replacement with a start date Summer 2019, and a 19 unit housing complex with a completion date projected for May 2019.

We have improved our tribal consultation at Rosebud with weekly meetings between the Rosebud Sioux Tribe (RST) Health Administrator, RST Health board members, and Rosebud Hospital leadership. The RST Council and health board attend hospital meetings monthly.

We have also continued to reach out and support our tribal partners in the Winnebago Tribe of Nebraska and the Omaha Tribe of Nebraska. IHS has offered the Winnebago Tribe technical assistance since it assumed control of the hospital in June 2018. In December 2018, I traveled

along with other senior IHS staff to meet with both Tribes for a tour of the Twelve Clans Unity Hospital.

I am very proud of the dedication and commitment of our IHS team at all levels of the agency; who have focused on and accomplished the objectives of the action plan during this past year. These actions demonstrate that IHS is taking its challenges seriously, and is continuing to take assertive and proactive steps to address them.

Thank you for your commitment to improving quality, safety, and access to health care for American Indians and Alaska Natives. I am happy to answer your questions.