



Statement by

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**Oversight Hearing
“High Risk Indian Programs:
Progress and Efforts in Addressing GAO’s Recommendations”**

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Chairman and Members of the Committee:

Good afternoon, Chairman Hoeven, Vice-Chairman Udall, and Members of the Committee. I am RADM Michael D. Weahkee, Acting Director of the Indian Health Service (IHS). I am pleased to provide testimony before the Senate Committee on Indian Affairs on “High Risk Indian Programs: Progress and Efforts in Addressing GAO’s Recommendations”. I would like to thank you, Chairman Hoeven, Vice-Chairman Udall, and Members of the Committee for elevating the importance of delivering quality care through the IHS.

I am an enrolled member of the Zuni Tribe. Most recently, I served as the Chief Executive Officer (CEO) of the Phoenix Indian Medical Center, leading the largest federally-operated IHS hospital in the nation. I have previously served at IHS headquarters in a variety of posts. Before that, I served in leadership roles on behalf of the California Rural Indian Health Board. I am honored to be a veteran of the United States Air Force, where I served as a Public Health Specialist. I am also proud of the fact that I was born at the IHS hospital in Shiprock, New Mexico, and grew up as an active user of the IHS health care system. Essentially, Indian health care and public health have been my lifelong pursuits and are my passion.

IHS is a distinctive agency in the Department of Health and Human Services (HHS), established to carry out the responsibilities, authorities, and functions of the United States to provide health care services to American Indians and Alaska Natives. It is the only HHS agency whose primary function is direct delivery of health care. The mission of IHS, 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 (ISDEAA), and through contracts and grants awarded to urban Indian organizations authorized by the Indian Health Care Improvement Act.

IHS is steadfastly committed to overcoming the longstanding systemic problems that have hindered our efforts to provide quality health care to American Indians and Alaska Natives, and I am proud to report that our concerted efforts are producing results. As of September 1, the Rosebud IHS Hospital is no longer under a Centers for Medicare & Medicaid Services (CMS) Systems Improvement Agreement. CMS determined that the hospital had substantially met all of the Medicare Conditions of Participation. We are striving to achieve a similar result for Pine Ridge and Omaha Winnebago IHS Hospitals.

IHS is also committed to doing all that is necessary to be removed from GAO's High Risk list. The GAO's High Risk Report cited 14 recommendations that focus on IHS, derived from seven reports issued over a period of six years (2011 to 2017). Although all 14 recommendations remain open at this time, we have made substantial progress and are continuing to press forward. In July, IHS provided an update to GAO and requested closure of seven recommendations. GAO requested additional documentation concerning those requests that we are currently providing, and we will continue to submit additional responses to address the remaining GAO

recommendations. I will describe the actions we are taking to address the recommendations and strengthen the IHS' ability to ensure quality health care.

Ensuring Quality Care

GAO identified a number of challenges facing IHS in administering Indian health care programs that have hindered our ability to ensure quality of care to Indian communities. To overcome these challenges, IHS developed a Quality Framework – a plan to develop, implement and sustain quality-focused compliance programs at all of our hospitals and clinics. The Framework incorporates quality standards from national experts, including best practices and expertise from across the IHS system of care. Core elements of the Framework focus on strengthening our organizational capacity to improve quality of care and systems, meeting and maintaining accreditation for IHS Direct Service Facilities, aligning our service delivery processes to improve patient experience, ensuring patient safety, and improving transparency and communication about patient safety and quality to IHS stakeholders.

IHS has worked diligently to refine and operationalize the Quality Framework. In less than a year, we have updated Governing Board Bylaws, acquired a credentialing software system, developed a standard patient experience of care survey and an implementation strategy using electronic tablets, developed patient wait time standards for the primary care setting, developed a quality assurance accountability dashboard (the data reporting tool is currently undergoing functional testing), and are nearing award of a master contract for accreditation of hospitals. The Deputy Director for Quality Health Care provides senior leadership oversight of critical quality improvement strategies related to accreditation/certification, patient safety, and quality care.

IHS has made remarkable progress and will continue to pursue implementation of the Quality Framework at all levels of IHS and in partnership with Tribal/Urban Indian organization partners as a key priority. Our leadership team is focused on ensuring quality in all that we do as an agency, and I expect this perspective and commitment will continue to produce results.

We are strengthening the agency's use of standards by developing new policies that define the standards and implementing system level reporting and oversight through Agency-wide improvements. We are on course to address the four key GAO recommendations on improvement of agency oversight of quality of care, and requested closure of one of these four recommendations in July.

The first recommendation I would like to address concerns succession planning for key leadership personnel. In December 2016, IHS developed contingency and succession plans, including skills gap analyses and appropriate developmental programs for the replacement of key personnel, including Area Directors. The December 2016 succession plans are currently being updated and will continue to be updated on a semi-annual basis. In addition to the contingency and succession plans, IHS has developed leadership training academies for senior leaders. For example, the IHS Leadership Training program is designed to prepare selected IHS individuals to serve in leadership positions at the Service Unit, Area, and Headquarters levels. In addition, staff rotations through IHS Headquarters provide additional training for senior level positions, and a mentoring initiative for those who have recently been promoted to key leadership positions has been implemented. We have requested closure of this recommendation.

The second and third recommendations I would like to address concern patient wait times for appointments. Wait times are an important measure of the patient experience and IHS federally-operated service units have been collecting and tracking this data to improve patient services. On August 25, I signed the official Patient Wait Times policy formalizing the IHS wait times standards for outpatient primary care visits in direct care IHS facilities. This policy finalizes the interim standards initially established in July of this year. Under these new standards, the mean wait time for a primary care appointment will be 28 days or less and for urgent appointments it will be 48 hours or less. These mean appointment wait times are the core measures that will be collected in all primary care settings. The data collected across IHS' direct service sites will be used to continually improve patient wait times. In order to implement the agency-wide standards by December 31, 2017, the IHS Chief Medical Officer communicated the Patient Wait Time policy Circular to Area clinical leadership on September 1, 2017. As part of its implementation, IHS will monitor the outcome data and ensure corrective actions are taken if standards are not met.

The fourth quality-related recommendation I will address is the Agency-wide oversight of quality. IHS has developed a performance accountability dashboard and acquired a practitioner credentialing software system. The accountability dashboard incorporates the five dimensions of health: patient safety, care effectiveness, patient-centeredness, timeliness, and care efficiency. Dashboard metrics will allow oversight and management of compliance with policy and regulatory requirements that ensure quality and safety of care. The measure definitions are complete, the data collection tool is in testing, and the dashboard for visualization is under development. The IHS will have the system-wide dashboard of performance accountability

metrics in operation in the fall 2017. The dashboard is a powerful tool that will enable Headquarters and Area Offices to have real-time visibility across the IHS system. This will facilitate implementation and monitoring of quality measures throughout the system over time.

We are making other system-wide changes to ensure that quality improvements made by the federally-operated facilities are supported and sustained over time. IHS is modernizing the way provider credentialing and privileging, and facility accreditation preparedness is carried out within the federally-operated hospitals and clinics. Also, we strengthened the governance and oversight of the hospitals by implementing standard Hospital Governing Board requirements.

To facilitate the hiring of qualified providers and ensure patient safety, the IHS is implementing a national provider credentialing and privileging system. The system is being implemented first in four IHS Areas and then will be expanded to the remaining IHS Areas by the end of 2017. The national credentialing system standardizes and streamlines the credentialing process across the IHS. Privileging and performance evaluations of IHS practitioners will be key aspects tracked in the new system that help address quality and patient safety. The IHS credentialing and privileging policy is being updated to support the new system.

Additionally, IHS expects to award a contract to a single accrediting organization for IHS hospitals later this month. IHS' use of one accreditation body will support the Agency-wide approach to quality improvement in the IHS facilities to help maintain accreditation. IHS' existing partnership with CMS further supports best health care practices and other

organizational improvements for IHS federally-operated hospitals that participate in the Medicare program.

Lastly, since January 2017, IHS Hospital Governing Board (GB) Bylaws for inpatient acute care hospitals have been standardized across the Agency. We set minimum standards IHS-wide, while maintaining flexibility for the Areas and Service Units to accommodate needs specific to their locations and service populations. GB bylaws now specify minimum meeting frequency, agenda topics, and membership. Area Directors were instructed to immediately incorporate these changes into GB Bylaws for each hospital, communicate these new requirements to their Service Units and verify completion of these changes to IHS Headquarters (which was accomplished by February 2017).

Purchased/Referred Care Improvements

I can report that the agency has made progress in addressing the 10 key GAO recommendations on improvement of the Purchased/Referred Care (PRC) program. The IHS is improving and increasing access to care for our beneficiaries through outreach, education and enrollment activities, and requested closure of six recommendations in July. We are working to provide GAO with additional documentation of our progress.

The first GAO recommendations on the PRC program that I can report progress on address opportunities for improving the administration of the program. IHS places a high priority on timely processing of purchase orders, private provider claims, and payments for those services that cannot be provided by our facilities directly. Improving the data reporting and measurement

system is essential to assuring that PRC programs are efficient. To that end and to address the first of the three recommendations, IHS modified the data system that tracks PRC referrals and emergency self-referrals and expects to begin baseline reporting for calendar year (CY) 2017 that will be available in CY 2018. IHS is currently researching industry standards and expects to have separate payment timeframe targets for these two referral types. We will request closure of this recommendation when the work is completed on all the items. GAO's second recommendation was for PRC funds to be used to pay for program staff. Historically, IHS' internal policy was to use PRC funds solely for the purchase of health care services. Any change in the current use of PRC should be balanced with the continuing need to assure access to services we cannot provide in our facilities. As for the third recommendation, we provide patients with current information regarding opportunities for new coverage options and ability to access care without obtaining a PRC referral. The Agency has requested closure of these two recommendations.

I can report that the recommendation to cap payment rates for non-hospital services has been addressed. IHS issued a final rule with comment, which amended the IHS regulations at 42 CFR part 136 to add a new Subpart I. The new Subpart I applies Medicare payment methodologies to physician and other non-hospital services or items purchased through the PRC program. The additional savings realized enables IHS and Tribal providers to increase access to more health care services. After capping PRC payment rates for non-hospital services, IHS and Tribes that use the IHS fiscal intermediary for the processing of PRC claims have realized a savings of more than \$178 million so far this calendar year. All IHS PRC programs participate in the PRC payment rates; Tribes are not required to participate, but may opt in. To date, six Tribes have

opted in to participate. IHS also developed an online PRC Rates Provider Tracking tool to monitor the access to physician and other non-hospital care. This tool enables PRC programs to document providers that refuse to contract for their most favored customer rate or accept the PRC rates. IHS provided training on use of the tool to the Area PRC officers at a face-to-face meeting in December 2016. The tool went live in January 2017. IHS has requested closure of this recommendation.

I would like to address GAO's three recommendations on the allocation of PRC program resources by describing the federal-tribal administration of PRC funds and its implications for our response to the first and second recommendations. Approximately sixty percent of the PRC funds are distributed through Indian Self-Determination awards and are protected from unilateral reductions or reallocation by the agency, absent one of the circumstances set forth in 25 U.S.C. § 5325(b)(2) or 25 U.S.C. § 5388(d)(1)(C)(ii). IHS partners with tribal leaders in making PRC fund allocation decisions. Any future changes in PRC allocation methods, such as the two recommended by GAO, will undergo tribal consultation. The tribal-federal workgroup on improving PRC met in June of this year and recommended not changing the fund allocation methodology at a time when there is uncertainty in the future of federal health care financing and policy. IHS has requested closure of these two recommendations.

I would also like to report on actions we are taking to address the third recommendation related to the development of written PRC allocation policies and procedures. To assure transparency, IHS distributed guidance on PRC allocation of funds to Area Directors and PRC officers in

CY 2016. IHS routinely directs Area Directors through official PRC allocation-of-funds distribution memos. These memos are official procedural documents that become a part of the PRC policy chapter of the Indian Health Manual. The chapter is under final agency review. The Agency has requested closure of this recommendation.

We continue our work addressing the remaining recommendations not discussed above: one addressing improvement in the enrollment processes and two focused on oversight for estimating need. We expect to request closure for these three open recommendations when we complete all the steps necessary to document the changes and improvements the Agency has adopted since 2011.

IHS is committed to addressing all risks impacting our ability to carry out our Agency mission. We have incorporated the GAO's High Risk Report recommendations into the IHS risk management work plan for 2017. IHS has entrusted leadership at all levels of the organization to identify current controls and will review their effectiveness in our annual internal management assessments. Where controls are deemed insufficient, actions to strengthen them will be taken. This special focus on identifying and mapping internal controls will help to inform strategic planning and identify appropriate areas for resource allocation.

I am very proud of the dedication and commitment of IHS staff at all levels of the agency who have accomplished these objectives in the past year. And I think you will agree with me that 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 will be happy to answer any questions the Committee may have.