



# Federal Indian Trust Responsibility: The Quest for Equitable and Quality Indian Healthcare

*The National Tribal Budget Formulation Workgroup's Recommendations  
on the Indian Health Service Fiscal Year 2018 Budget*

June 2016

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## *Executive Summary*

Tribal Leaders on the National Tribal Budget Formulation Workgroup (TBFWG), representing all twelve Indian Health Service (IHS) Areas, met on February 11-12, 2016, to develop the national Indian Health Service budget recommendations for the FY 2018 budget year. The budget priorities are highlighted below:

- ❖ Fully fund IHS at \$30.7 billion phased in over 12 years
- ❖ Increase the President's FY 2017 Budget Request for the IHS by a minimum of 37% (~\$7.1 billion) in FY 2018:
  - +\$169.1 million for full funding of current services
  - +\$145.8 million for binding fiscal obligations
  - +\$28.5 million for Contract Support Costs
  - +\$1.6 billion for program expansion increases
- ❖ Provide dedicated funding to begin implementing the following provisions of the Indian Healthcare Improvement Act (IHCA)
  - Section 205: Funding for Long-term Care Services (\$37 million)
  - Section 704: Comprehensive Behavioral Health Prevention and Treatment Program (\$20 million)
  - Section 204: Diabetes Prevention, Treatment, and Control (\$20 million)
  - Section 123: Health Professional Chronic Shortage Demonstration Project (\$15 million)
  - Section 705: Mental Health Technician Program (\$5 million)
- ❖ Advocate that Tribes and Tribal programs be permanently exempt from sequestration
- ❖ Support Advance Appropriations for the Indian Health Service

The federal Indian trust responsibility for health is a sacred promise, grounded in law, which our ancestors made with the United States. In exchange for land and peaceful co-existence, American Indians and Alaska Natives (AI/ANs) were promised access to benefits, including healthcare. Year after year, the federal government has failed American Indians and Alaska Natives by drastically underfunding the Indian Health Service (IHS) far below the demonstrated need. For example, in 2015, IHS spending for medical care per user was only \$3,136, while the national average spending per user was \$8,517 - an astonishing 63% difference. This correlates directly with the unacceptable higher rates of premature deaths and chronic illnesses suffered throughout Indian communities. While the average life expectancy is 4.2 years less for all AI/ANs than it is for other Americans, the disparity is much greater in certain Tribal communities. In Montana for example, the life expectancy of AI/ANs is actually 20 years less than the general state population. It is unacceptable to continue to knowingly allow the premature loss of a whole generation of American Indian and Alaska Native people. Resources to address modifiable risk factors leading to premature deaths are desperately needed to reverse this worsening health crisis facing Indian communities.

Unless sufficient funding is made available for Tribal health programs, health disparities will never be eliminated as called for in Healthy People 2020. It will take a more meaningful investment targeted toward primary and preventative health, including public health services, in order for Tribes to begin reversing the trend of rising premature death rates and early onset of chronic illnesses. Evidence has shown that disparities related

to the disadvantaged social, demographic, environmental, economic, and geographic realities of Indian reservations and Alaska Native villages creates additional challenging hurdles to overcome. During the last several years, bipartisan collaboration between Congress and the Administration has resulted in a noticeable overall increase for the total IHS budget of 53% since FY 2008, sadly however, this has only resulted in a slight increase in the IHS services portion of the budget. In reality, much of the increases in funding over the past eight years have supported population growth, rising medical inflation, staffing funding for specific new/expanded facilities, and the rightful funding of legal obligations such as Contract Support Costs (CSC). A more significant funding increase, including necessary investments in adequate facilities, modernized infrastructure, and a qualified workforce, is needed so that quality healthcare services can be delivered in a safe manner within all AI/AN communities. Only then will we expect to see a noticeable correlating improvement in health outcomes for our people.

FY 2018 represents a real opportunity for a new Administration to carry forward a bold budget to Congress; one which does not just sustain current services, but one which actually builds on the recent advances we have been able to secure for Indian healthcare. The TBFWG requests a minimum 37% increase for the IHS in FY 2018 so that our people can receive a level of care that is more in line with the healthcare taken for granted by other Americans. It will be a strong start in the quest for more equitable and quality healthcare for all of Indian Country.

During this Administration, Tribes have also strengthened relationships with federal officials which has led to more meaningful Tribal consultation, input and collaboration on how to improve Indian healthcare. It is important these successful efforts continue into the future. This new partnership respects federally recognized Tribes as sovereign nations, and has resulted in meaningful government-to-government consultations to construct culturally-viable solutions to address unacceptable health and other disparities which still persist within Indian Country.

However, we still have a lot of work to do. Recent findings by the Centers for Medicare and Medicaid Services (CMS) have exposed instances where care at several IHS-operated hospitals was substandard and resulted in dangerous patient environments, and even deaths. Additional funding must go toward the reform of the IHS to ensure that this does not continue. Tribes must no longer live with marginal healthcare options that put our children, elders and patients in danger. America is too great a nation to stand by while our people live with life-threatening realities. As one Tribal leader recently stated at a Senate hearing:

*“[IHS] is all we have to count on. We don't go there because they have superior health care. We go there because it is our treaty right. And we go there because many of us lack the resources to go elsewhere. We are at the mercy of IHS.”*

In an effort to further advance health outcomes, Tribes have also set forth priorities this year which will begin to fund the expanded authorities in provisions of the Indian Health Care Improvement Act (IHCIA). This historic law has opened up many new opportunities designed to improve the Indian health system, but few resources have been identified to allow them to be implemented – many view inaction as yet another broken promise to Indian Country. With the passage of the Patient Protection and Affordable Care Act (ACA), the American health care delivery system has been revolutionized, while the Indian health care system still waits for the full implementation of the IHCIA. For example, mainstream American has seen an increased focus on health promotion and disease prevention, and comprehensive behavioral health programs are now a standard of practice. The intent to replicate this same coordination of behavioral health, substance abuse, domestic violence,

and child abuse services for Tribes in the IHCA was a critical aspect of the reauthorization effort. Tribes fought for over a decade to renew IHCA authorities. It is critical that the full intentions of this law are realized with proper funding.

In summary, the TFWG calls on the next Administration to take decisive steps to accelerate health gains in American Indian and Alaska Native communities, while preserving the investments and health improvements achieved over these past several years. To do this, the department must propose a budget for IHS that is ***bold, effective, and which contains important policy reforms*** to ensure that AI/ANs experience the highest standard of care possible. Funding IHS \$7.1 billion in FY 2018 will instill trust in Indian leadership that the recent gains we have made are real, and that we are truly working together to build a more equitable and quality-driven Indian health system.

## Tables: FY 2018 Tribal Recommendations

<b>FY 2018 National Tribal Recommendation</b>	
<i>Planning Base – President's FY 2017 Budget</i>	<b>\$5,185,015,000</b>
<b>Current Services &amp; Binding Agreements</b>	<b>\$314,907,000</b>
<b>Current Services</b>	<b>\$169,074,000</b>
Federal Pay Costs	7,964,000
Tribal Pay Costs	11,946,000
Inflation (non-medical)	10,385,000
Inflation (medical)	70,068,000
Population Growth	68,711,000
<b>Binding Agreements</b>	<b>\$145,833,000</b>
New Staffing for New & Replacement Facilities	62,500,000
Health Care Facilities Construction (Planned)	83,333,000
<b>Program Expansion Increases - Services</b>	<b>\$1,395,544,027</b>
Hospitals & Health Clinics	422,536,330
Dental Services	80,433,813
Mental Health	186,849,208
Alcohol and Substance Abuse	155,882,258
Purchased / Referred Care ( <i>formerly CHS</i> )	422,454,388
Public Health Nursing	14,295,199
Health Education	9,019,524
Community Health Representatives	26,948,771
Alaska Immunization	7,373
Urban Indian Health	46,630,329
Indian Health Professions	22,320,781
Tribal Management Grants	23,964
Direct Operations	2,847,980
Self-Governance	5,294,109
<b>Contract Support Costs</b>	<b>\$28,531,659</b>
Contract Support Costs - Estimated Need	\$26,080,000
Contract Support Costs - New and Expanded	\$2,451,659
<b>Program Expansion Increases - Facilities</b>	<b>\$172,772,564</b>
Maintenance & Improvement	43,750,655
Sanitation Facilities Construction	51,726,449
Health Care Facilities Construction-Other Authorities	49,302,308
Facilities & Environmental Health Support	19,292,528
Equipment	8,700,624
<b>GRAND TOTAL</b>	<b>\$7,096,770,250</b>
\$ Change over Planning Base	\$1,911,755,250
% Change over Planning Base	36.9%

Detail of Changes		
FY 2018 National Tribal Recommendation		
(Dollars in thousands)		

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# Federal Indian Trust Responsibility: The Quest for Equitable and Quality Indian Healthcare

During the last seven years, Indian health funding has benefited from a strong bipartisan cooperation between Congress and the Administration. In both the legislative and executive branches, Tribal communities have been prioritized in funding requests and appropriations measures, leading to an increase in total IHS spending of 35% in the total Indian Health Service (IHS) budget from FY 2009 to the FY 2017 President's Budget Request. Tribes are grateful that increases have helped address long-standing funding gaps to address population growth, inflation and to pay for binding agreements related to staffing for new/expanded facilities and legally-mandated Contract Support Costs. For the first time in years, these increases have also allowed Tribes to take the first steps toward making marked improvements in health delivery and priority health measure targets (*see GPRA Performance Results GY2008-2015, Appendix A*). While a 35% increase may appear significant, after calculating for inflation, population growth, and the rightful funding of staffing and Contract Support Costs, the amount leftover to address decades of health disparities has been minimal and more is needed to reverse high cost chronic diseases and historical trauma-induced behavioral health conditions. The FY 2018 IHS Tribal Budget Formulation Workgroup's budget recommendations presented in this document represent what we believe to be a bold, but achievable and necessary FY2018 funding goal for Indian health. We request that the Administration proposes a 12-year phased in budget plan for Indian Health that will do justice to the federal trust responsibility so that more AI/ANs are able to access quality healthcare and accelerate health gains for the next generation.

As noted above, many of the increases over the last several years, while important, have not allowed for program expansion. For instance, the FY 2017 President's budget request proposes an increase of \$377 million for IHS over the FY 2016 enacted level. Of this increase, \$159 million (57%) is for federal and Tribal pay costs; non-medical and medical inflation; and population growth. This is just what is needed to keep even. Contract Support Costs comprise another \$82 million (21%) of this increase, which are mandated to be paid in full. While the Administration has proposed important

**The National Tribal Budget Formulation Workgroup** members include Tribal representatives from each of the 12 IHS Service Areas who are tasked with consolidating budget recommendations developed by Tribal leadership and program staff of the 12 IHS Areas (regions) into a national set of budget and health priorities for a given fiscal year. The Workgroup provides input and guidance to the IHS Headquarters budget formulation team throughout the remainder of the budget formulation cycle for that fiscal year.

*"And I've said that while we couldn't change the past, working together, nation-to-nation, we could build a better future. I believed this not only because America has a moral obligation to do right by the tribes and treaty obligations, but because the success of our tribal communities is tied up with the success of America as a whole. And over the past seven years, with tribal leaders and federal officials working together, we've made a lot of progress."*

**President Barack Obama**  
November 5, 2015



new programs on the mandatory side, the likelihood of these being enacted by Congress remains slim. The FY 2018 TBFWG's request for IHS takes these factors into account and goes beyond so that we can finally see a world where the first Americans are not last when it comes to health.

FY 2018 represents an opportunity for a new President and Administration to continue to build on the gains of the last several years. This budget is also chance to fully break with the travesties of the past that have been suffered (and continue to be suffered) by the First Peoples of the nation and move towards solidifying the commitments made to Tribes. The budget presented in FY 2018 is a chance for the new President to make a mark to say that we will no longer tolerate substandard healthcare for AI/ANs. We can not only reduce, but *eliminate* the health disparities suffered by so many of our people. The target for the IHS budget is **\$30.8 billion** over 12 years. Embarking on a pathway toward full funding will change the conversation on Indian Health and will bring a measure of hope for a better life for the next generation of our indigenous peoples.

Tribal Leaders on the national Tribal Budget Formulation Workgroup (TBFWG), representing all twelve Indian Health Service (IHS) Areas, met on February 11-12, 2016, to develop the national Indian Health Service budget recommendations for the FY 2018 budget year. The budget priorities are highlighted below:

- ❖ Fully fund IHS at \$30.7 billion phased in over 12 years
- ❖ Increase the President's FY 2017 Budget Request for the IHS by a minimum of 37% (~**\$7.1 billion**) in FY 2018:
  - +\$169.1 million for full funding of current services
  - +\$145.8 million for binding fiscal obligations
  - +\$28.5 million for Contract Support Costs
  - +\$1.6 billion for program expansion increases. Top priorities for program expansion include:
    - Hospitals & Health Clinics                   +\$422.5 million
    - Purchased / Referred Care                   +\$422.5 million
    - Mental Health                                   +\$186.8 million
    - Alcohol & Substance Abuse                   +\$155.9 million
    - Dental Health                                   +\$80.4 million
    - Facilities Program Increases (all)           +\$172.7 million
- ❖ Provide dedicated funding to begin implementing the following provisions of the Indian Healthcare Improvement Act (IHCA)
  - Section 205: Funding for Long-term Care Services (\$37 million)
  - Section 704: Comprehensive Behavioral Health Prevention and Treatment Program (\$20 million)
  - Section 204: Diabetes Prevention, Treatment, and Control (\$20 million)
  - Section 123: Health Professional Chronic Shortage Demonstration Project (\$15 million)
  - Section 705: Mental Health Technician Program (\$5 million)
- ❖ Advocate that Tribes and Tribal programs be permanently exempt from sequestration
- ❖ Support Advance Appropriations for the Indian Health Service

## The Quest for Equitable Healthcare

The federal budget for AI/AN health is not just a fiscal document between sovereign Nations. It is indeed, the execution of a moral, ethical, and legal commitment. The U.S. federal government recognizes Tribal nations as “domestic dependent nations” and Congress has long recognized the sovereignty of Native Nations, citing treaties, made between sovereign nations, as the Supreme Law of the Land. These early treaties, reaffirmed by Executive Orders, Congressional actions and two centuries of Supreme Court case law, provide the basis for Congress to apportion funds for Indian Health care services for the benefit of all AI/ANs. Tribes are the only citizen group allowed to have formal consultation into the federal budget formulation process. The annual budget request reflects the extent to which the United States chooses to honor its promises of justice, health, and prosperity to Indian people. When national budget requests for Indian health care fall short of providing even the most basic level of services equitably to all Tribal members, Tribal communities suffer. It is no wonder that visitors to remote Tribal reservations or villages are moved to describe Tribal living conditions as comparable to the developing world. Sadly, many developing nations receive healthcare support far easier than our own “domestic dependent nations”. It is tragically still a truth that many families are forced to make tough decisions between seeking health care or to pay for food or living expenses. This is unconscionable in a country promising equality and justice for all its citizens. As recently as 2010, Congress passed the permanent reauthorization of the Indian Healthcare Improvement Act, but many, if not most, of these provisions remain unfunded, representing yet another broken agreement between Tribes and the United States.

For generations, Tribal communities have called on Washington to fulfill its promise by providing equitable and quality healthcare services to Indian Country. Yet, time and again, the treaties that we signed are an afterthought of federal funding, jammed into other appropriations bills with thousands of other competing priorities. Now is the time, to reverse this trend. Now is the time to take bold action as a progressive new Administration to fully support equitable healthcare so that our people no longer live sicker and die younger than other Americans.

### About the Indian healthcare delivery system:

The Indian healthcare delivery system consists of services and programs provided directly by IHS; Indian Tribes and Tribal organizations who are exercising their rights of self-determination and self-governance; and services provided through urban organizations that receive IHS grants and contracts (collectively, the “Indian healthcare system” or I/T/U). The Indian healthcare system has a user population of 2.2 million individuals. Currently, the IHS FY 2016 budget is \$4.8 billion. That is only (on average, system wide) 54% of the level of need.

*“I think we have a moral responsibility to fund Indian Health Care services, contract services. We have a moral responsibility to our Native Americans, so that's a high priority that we keep that commitment.”*

**– Congressman Ken Calvert, Chairman  
of the House Appropriations  
Subcommittee on Interior, Environment  
and Related Agencies, March 21, 2016**

## The Quest for Quality Health Care

Perhaps even more disturbing than the severe lack of resources at IHS, is recent findings by the Centers of Medicare and Medicaid Services (CMS) that Great Plains Tribes are receiving substandard care that is dangerous to patients. This is despite the fact that a report detailing many of the same atrocities was released by the Senate Committee on Indian Affairs in 2010. Six years later, we are here again and the quest for quality health reaches a more critically urgent level of crisis. It is time for leadership to radically change the regular course of business at IHS. Clearly, the current system is broken.

In the last year, four hospitals serving Tribes in the Great Plains region have lost (or received threats of revocation) their ability to bill CMS. This becomes a double blow, as it not only severely hampers the ability to capture critical third party revenue on which these facilities depend, but more importantly, these findings raise serious questions about the quality of health care provided at IHS facilities. At the Winnebago Indian Hospital, Pine Ridge Indian Hospital, Sioux San Indian Hospital and the Rosebud Indian Hospital the deficiencies in question are simply unacceptable and more must be done to reform the system to ensure that IHS management never allows this to happen again.

While it is our understanding that the agency has recently reached an agreement with CMS to work through many of these findings, we continue to be highly troubled by issues occurring on the ground. IHS should certainly be held to task by Congress for the breakdown in management of these facilities, but it is also incumbent on the Administration and Congress to provide IHS with sufficient funding so that the Service is able to safely and effectively carry out its mission. We cannot continue to starve the IHS and expect different results.

## Continuing the Quest for our Next Generations

Devastating consequences from historical trauma, poverty, and a lack of adequate treatment resources continue to plague Tribal communities. American Indian and Alaska Natives have an average life expectancy 4.2 years less than other Americans, but in some areas, the life expectancy is far worse. For instance, “white men in Montana lived 19 years longer than American Indian men, and white women lived 20 years longer than American Indian women.”<sup>1</sup> In South Dakota, in 2014, “for white residents the median age was 81, compared to 58 for American Indians.”<sup>2</sup> AI/ANs also suffer significantly higher mortality rates from suicide, type 2 diabetes, and heart disease than other Americans. According to CDC data, 45.9 % of Native women experience intimate partner violence, the highest rate of any ethnic group in the United States. American Indian / Alaska Native children have an average of six decayed teeth, when other US children have only one. These health statistics are no surprise when you compare the per capita spending of the IHS and other federal health care programs. Across almost all diseases, AI/ANs are at greater risk than other Americans. For example, AI/ANs are 520 % more likely to suffer from alcohol-related deaths; 450 % more likely to die from tuberculosis; 368 % more likely to die from chronic liver disease and cirrhosis; 207 % greater to die in motor vehicle crashes; and 177 % more likely to die from complications due to diabetes.<sup>3</sup> Infant mortality rates for AI/ANs is 8.3 per 1,000 live births, a decrease of 67 % since 1974. However, AI/ANs still have a higher rate than the U.S. all rates rate of 6.6.

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<sup>1</sup> “The State of the State’s Health: A Report on the Health of Montanans.” Montana Department of Public Health and Human Services. 2013. p. 11.

<sup>2</sup> “2014 South Dakota Vital Statistics Report: A State and County Comparison of Leading Health Indicators.” South Dakota Department of Health. 2014. P. 62.

<sup>3</sup> *Ibid*, p 5.

Additionally, public health risks related to alcohol and substance abuse are widespread in many Tribal communities, leading to other health and socio-economic disparities such as poverty, mental illness, and increased mortality from liver disease, unintentional injuries and suicide. Dental health concerns also continue to affect AI/ANs at higher rates than other Americans do. Ninety percent of AI/AN children suffer from dental caries by the age of eight, compared with 50 % for the same age in the US all races population. Our children ages 2 to 5 have an average of six decayed teeth, when children in the U.S. all races population have only one.

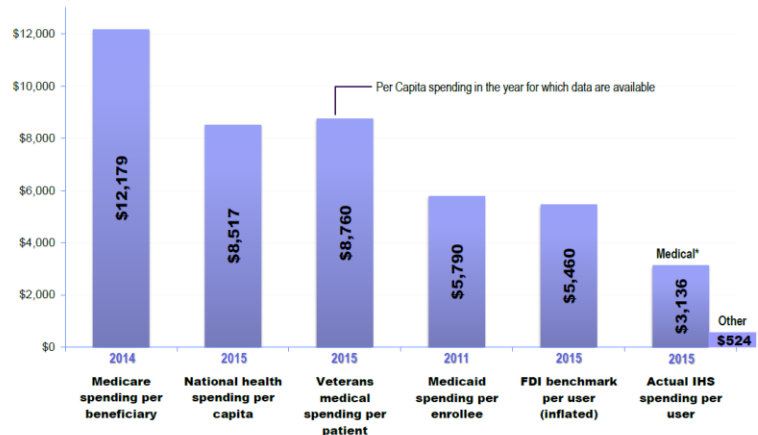
Perhaps these statistics are not surprising when you consider the level of funding provided to Tribal communities. In 2015, per capita spending for medical care at the IHS was only \$3,136 compared with \$8,760 for the national average. With such low spending rates, coupled with higher acuity of medical care needs, it is clear that Tribal communities are not going to be part of the conversation. Overall, IHS funded at only about 50% of total need. Some areas, it is far lower. While new health care insurance opportunities beginning in 2014 and expanded Medicaid in some states may expand health care resources available to American Indians and Alaska Natives, these new resource opportunities come with a cost for billing, collections and

compliance and are no substitute for the fulfillment of the federal trust responsibility. Tribes often have a difficult time recruiting qualified billing and compliance staff who don't want to work on remote reservations or villages, making them vulnerable to audit compliance. Furthermore, healthcare coverage varies widely by state, with some states seeing up to 37% reduction in uninsured AI/ANs since 2011, and others not seeing any changes at all. This, not surprisingly, is correlated with whether or not the state expanded Medicaid.<sup>4</sup> Tribes should not be held hostage to whether or not their state has made a decision to expand Medicaid, or as in some cases to adjust statewide Medicaid services due to budget constraints. That's contrary to the federal trust responsibility and only results in Tribal communities with unequal shares of healthcare dollars.

The following budget proposal will provide additional details on the IHS budget for FY 2018 and justify where Tribes' believe that funding should be concentrated. As you read through this document, we urge you to hear the stories that our people tell and imagine if your family members were living with a health system that was grossly under resourced and poorly managed but provided the only option for health access. Now is the time to change. Now is the time for a new Administration to institutionalize the gains of the previous years and take bold future steps to resource and reform the system so that America can move beyond the past and work in concert with Tribes to achieve a brighter, healthier future for the next generations of American Indian and Alaska Natives.



## 2015 IHS Expenditures Per Capita and Other Federal Health Care Expenditures Per Capita



See page 2 notes on reverse for sources. \*Payments by other sources for medical services provided to AI/ANs outside IHS is unknown. 12/29/2015

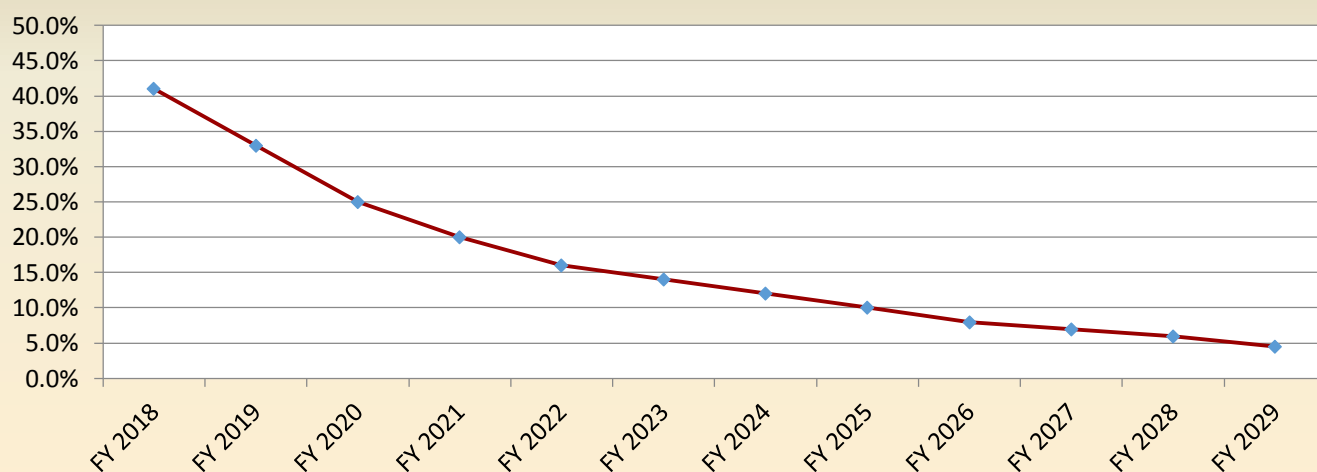
<sup>4</sup> Ibid, p. 3.

## ***FY 2018 Tribal Budget Recommendations and Priorities***

### **1ST RECOMMENDATION: FULLY FUND IHS AT \$30.7 BILLION PHASED IN OVER 12 YEARS**

Early in 2003, the Workgroup met to develop the national Tribal budget recommendations for FY 2005. Tribal leaders were dismayed that the planning base for the IHS budget was \$2.85 billion, less than 15% of the total funding required to meeting the health care needs for AI/ANs. This level of funding was not even sufficient to maintain current services in the face of inflation and increases in the Indian population. Tribal leaders warned that continued under-funding would thwart the Tribes and IHS's efforts to address the serious health disparities experienced by our AI/AN people. To address this shortfall, IHS, Tribal and Urban programs worked together to develop the first true Needs Based Budget (NBB) for FY 2005, and proposed an IHS NBB totaling \$19.5 billion. This includes amounts for personal health services, wrap-around community health services and facility investments.

**FY 2018 Tribal Needs Based Budget % of Increases Needed to Achieve  
Full Funding in 12 Years - \$30.7 billion**



The FY 2005 Budget Formulation Workgroup responsibly proposed a 10-year phase-in plan, with substantial increases in the first two years to build facilities and start-up services, with more moderate increases in the following years as this Workgroup understood that meeting the NBB of \$19.5 billion in one fiscal year was unlikely, due to the importance of balancing the Federal budget and respecting other national priorities. Furthermore, IHS and Tribal health programs lacked the health infrastructure to accommodate such a large program expansion at one time. The most significant aspect of the 10-year plan was that it would require a multi-year commitment by Congress and Administration to improve the health status of American Indians and Alaska Natives.

That work was done thirteen years ago. Over the years and with failure to produce necessary funding to fulfill the initial 10-year plan, the per capita health funding and health disparities between AI/ANs and other populations have continued to widen, and the cost and amount of time required to close this funding disparity gap has grown. The NBB has been updated every year, using the most current available population and per capita health care cost information. The *IHS need-based funding aggregate cost estimate for FY 2018* is now **\$30.8 billion**, based on the FY 2015 estimate of [2.2 million eligible] AI/ANs served by IHS, Tribal and Urban health programs. Given the lack of adequate budget increases over the past thirteen years, the amount of time to reasonably phase-in the NBB of \$30.8 billion has been extended to twelve years.

# FY 2018 AI/AN Needs Based Funding

## Aggregate Cost Estimate

### GROSS COST ESTIMATES

Source of Funding is not estimated

Need Based on FY 2015 Existing Users at I/T Sites	Need based on FY 2015 Expanded for Eligible AIAN at I/T/U Sites*
1,594,229	2,710,893

SERVICES	\$ Per Capita	Billions	Billions
<b>Medical Services</b>	\$6,069	<b>\$9.68</b>	<b>\$16.45</b>
Medical services and supplies provided by health care professionals; Surgical and anesthesia services provided by health care professionals; Services provided by a hospital or other facility, and ambulance services; Emergency services/accidents; Mental health and substance abuse benefits; Prescription drug benefits.			
	Based on 2008 FDI benchmark (\$4,100) inflated to 2013 @4% per year	\$ Per Capita * Users	\$ Per Capita * Eligible AIAN
<b>Dental &amp; Vision Services</b>	\$635	<b>\$1.01</b>	<b>\$1.72</b>
Dental and Vision services and supplies as covered in the Federal Employees Dental and Vision Insurance Program			
	2008 BC/BS PPO Vision (\$87) and Dental benchmarks (\$342) inflated to 2012 @4% per year		
<b>Community &amp; Public Health</b>	\$1,424	<b>\$2.27</b>	<b>\$3.86</b>
Public health nursing, community health representatives, environmental health services, sanitation facilities, and supplemental services such as exercise hearing, infant car seats, and traditional healing.			
	19% of IHS \$ is spent on Public Health. Applying this ratio, \$1,316 per capita = (.19/.81*\$6611).		
<b>Total Annualized Services</b>	<b>\$8,128</b>	<b>\$12.96</b>	<b>\$22.03</b>
FACILITIES	\$ Per Capita	Billions	Billions
<b>Facility Upgrades Upfront Costs</b>		<b>\$6.51</b>	<b>\$8.77</b>
<b>Annualized for 30 year useful Life</b>		<b>\$0.38</b>	<b>\$0.51</b>
IHS assessed facilities condition (old, outdated, inadequate) and has estimated a one-time cost of \$6.5b to upgrade and modernize. A 30 year useful life assumption is used to estimate the annualized cost (assuming 4% interest) of the upgrades.			
<b>TOTAL</b>			
<b>Total Annualized Services + One-time Upfront Facilities Upgrades</b>		<b>\$19.47</b>	<b>\$30.80</b>

Gross costs for mainstream health care to AIAN and facilities upgrades are based on typical cost factors. The actual costs that would be experienced among I/T/U sites would vary. Gross costs are estimated expenses without specifying sources of payment. Under current law, a portion of gross costs would be paid by Medicare, Medicaid, and private insurance depending on the number of AIAN eligible—which varies place-to-place and time-to-time. The extent that gross costs would be offset is not precisely known. For certain planning assumptions, IHS assumes a crude 25% nation-wide.

\*Crudely—AIANs residing in service areas, including urban areas, discounted for AIAN already partially served by I/T sites.



## **2ND RECOMMENDATION: INCREASE THE PRESIDENT’S FY 2017 BUDGET REQUEST FOR THE INDIAN HEALTH SERVICE BY A MINIMUM OF 37% (~7.1 BILLION) IN FY 2018**

### ***CURRENT SERVICES & BINDING AGREEMENTS***

Tribal Leaders are adamant that the FY 2018 budget request, as a starting point, provides an increase of \$314.9 million to cover Current Services and all other binding obligated requirements. Tribes have long insisted that the annual request must transparently disclose all known expected cost obligations in order to demonstrate the true funding base required to sustain current services and meet obligated fiscal requirements. Deliberately understating the amount necessary to meet the entire fiscal obligation for binding agreements beyond Current Services creates a false expectation that a slight funding increase is available to expand needed program services. In fact, in past years, a 2-3% funding increase has not even been sufficient to maintain the status quo, effectively resulting in an actual decrease from the prior year. These real cost obligations include actual federal & Tribal pay costs, true medical and non-medical inflation, population increases, planned increases in staffing for new and replacement facilities, facilities construction project requirements, and all expected off-the-top mandatory assessments. The workgroup strongly recommends that full funding for Current Services and other “binding” fiscal requirements at the true projected costs of \$314.9 million be requested as reflected in this section.

### **CURRENT SERVICES (Fixed Costs) +\$169.1 MILLION**

The FY 2017 President’s Budget request included an increase of \$159 million for direct and tribally provided health care services to cover increased costs associated with population growth, pay cost increases for workers, medical and non-medical inflation, and ensure continued levels of health care services. Unfortunately, the proposed \$159 million falls short of actual need, specifically in population growth, only covering \$43.2 million of the total population growth need of \$73.3 million. Population growth estimates are determined by a 1.8% increase.

The FY 2018 Tribal Budget Request for Current Services of \$169.1 million includes an increase of \$7.9 million for Federal Pay Costs and \$11.9 million for Tribal Pay Costs. Tribal and federal facilities cannot continue to offer salaries below the competitive market. As demonstrated most recently in testimony heard from the Great Plains Area, the ability to provide safe, quality care at Indian Health facilities is severely compromised when the IHS and Tribes are unable to fill vacancies or retain qualified staff. Indeed, as testified, it is a matter of life and death. Further, the Workgroup feels strongly that commissioned officers, civil service, and Tribal employees should be exempt from any federal pay freeze that may be imposed in FY 2018. We cannot allow pay scales for our health professional to be so substandard that they are forced to look elsewhere to seek a fair wage.

The Current Services request also includes \$10.4 million for Non-Medical Inflation and \$70 million for Medical Inflation. This is the minimum amount necessary to inflation-proof services as the actual inflation rate for different components of the IHS health care delivery system is much greater. As a component of the Consumer Price Index (CPI), the index for all items less food and energy increased 2.3% over the past 12 months, a figure that has been slowly rising since it was 1.7% for the 12 months ending May 2015. The medical care index has increased 3.5 %, its largest rise since October 2012. The Workgroup asserts that the rates of inflation applied to H&C, Dental Health, Mental Health, and PRC in developing the IHS budget should correspond to the appropriate components in the CPI to reflect the true level of funding needed to maintain current services. Another \$68.7 million in Current Services funding is requested for Population Growth to address increased



services needs arising from the increase in the AI/AN population, which in recent years has been growing at an average rate of 1.8% annually.

While the budget has received upward adjustments since 2008, these increases have done little to address the huge disparities in funding for Tribal health care compared to similar expenditures for the rest of the U. S. population. With the total funding need now estimated at \$30.8 billion, the Indian Health system remains severely underfunded at \$5 billion. The FY 2013 sequestration cuts were pure disaster for hospitals and clinics across Indian Country. Losing dollars to this as well as the 2014 federal government shutdown, has effectively nullified many of the funding gains of the last seven years. When compounded with rising medical inflation and population growth, and new unfunded mandates resulting from the CMS Meaningful Use and ICD-10 conversion requirements, Indian Health budgets are, in real dollars, trending backwards.

### **BINDING AGREEMENTS (Fixed Costs) +\$145.8 MILLION**

#### **Health Care Facilities Construction (Planned) +\$83.3 million**

In FY 2018, \$83.3 million is requested for previously approved health facility construction projects in accordance with the IHS health care facilities 5-year plan. HCFC budget line is historically underfunded and it will be years for the IHS to catch up on its backlog of health facilities projects. This binding agreement budget amount only provides the ability to advance a small percentage of its identified construction needs for projects which are already started, and does not address any of the backlog.

#### **Total FY 2018 Request for Fixed Costs:**

##### **Current Services \$169,074,000**

- Federal Pay Costs \$7,964,000
- Tribal Pay Costs \$11,946,000
- Inflation (non-medical) \$10,385,000
- Inflation (medical) \$70,068,000
- Population Growth \$68,711,000

##### **Binding Agreements \$145,833,000**

- New Staffing for New & Replacement Facilities \$62,500,000 \*
- Health Care Facilities Construction (Planned) \$83,333,000
- Newly Recognized Tribe Funding \$ 0\*

\*these placeholders are estimates only and are subject to adjustment based on actual requirements

### **CONTRACT SUPPORT COSTS (Estimate) +\$28.532 MILLION**

The Work group has identified an estimated budget increase of \$28.532 million over the FY2017 President's budget will be required as a program increase to address legally obligated Contract Support Cost (CSC) for new and expanded programs. The workgroup recognizes that this amount is subject to change based on the actual CSC obligation to be estimated based on the new pending CSC policy. As written, this draft policy references CSC Budget Projections as follows: Each Area Director or his or her designee shall survey Tribes and Tribal organizations within that Area to develop accurate projections of CSC need at the end of the second and fourth quarter. This will include identification of the amounts required for any new and expanded projects as well as projections for the total ongoing CSC requirement for the following FY and estimates for the next two FYs. The

information will be consolidated by the IHS Headquarters OFA and provided to Tribes and Tribal organizations as expeditiously as possible. The information will also be generated in the “Contract Support Costs Budget Projections (for the appropriate FY),” and submitted to the Director, Headquarters OFA, on or before September 30 of each FY and will be used by the IHS in conjunction with the Agency’s budget formulation process.

The estimated \$28.532 million increase over the FY2017 President’s budget of \$800 million, is requested for reasonable costs for activities that Tribes/Tribal Organizations must carry out to support health programs and for which resources were not otherwise provided.<sup>5</sup> The total FY2108 CSC request is estimated to be \$828.532 million. The Indian Self-Determination and Education Assistance Act requires that 100% of these costs be paid, and is therefore this budget line is considered to be a legally mandated requirement. In FY2016, over 60 percent of the IHS budget is operated by tribes with authority provided by the Indian Self-Determination and Education Assistance Act, under which tribes may assume the administration of programs and functions previously carried out by the federal government. IHS transfers operational costs for administering health programs to tribes through the "Secretarial amount," which is the amount IHS would otherwise have spent to administer the health programs. In addition, tribes are authorized to receive an amount for Contract Support Costs that meet the statutory definition and criteria.

The proposed fiscal year 2017 budget fully funds estimated Contract Support Costs at \$800 million, an increase of +\$82 million above fiscal year 2016. The proposed budget maintains the indefinite appropriation for Contract Support Costs provided by Congress in fiscal year 2016. This funding approach continues the policy to fully fund Contract Support Costs and guarantees reliability of funding for the activities covered by Contract Support Costs under the statute.

In fiscal year 2018 and beyond, The Tribes universally supports the Administration proposal to reclassify Contract Support Costs as a mandatory, three-year appropriation with sufficient increases year over year to fully fund the estimated need for such costs.

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<sup>5</sup> After the Tribal Budget Formulation Workgroup completed its national Budget Recommendations for IHS, the President’s Budget was submitted for Fiscal Year 2016, identifying CSC requirements for a three-year period, FY 2017-2019. In doing so, the IHS identified \$800 million as required to fund all CSC requirements in FY 2017. As this line item is identified as a Binding Agreement, and notwithstanding the estimated funding level by IHS, the appropriation should include such sums that are necessary to fully fund this contractual requirement, realizing that the exact amount will not be known until closer to the appropriated fiscal year.

## PROGRAM EXPANSION INCREASES – SERVICES BUDGET

### **HOSPITALS & CLINICS +\$422.5 MILLION**

The Workgroup recommends the FY 2018 Budget Program Increases outlined in this section. These national priorities agreed to by Tribal leaders build upon the progress made by the Administration over the past eight years to bring American Indians and Alaska Natives into parity with other citizens of the United States.

Adequate funding for the Hospitals & Clinics (H&C) line item is the top priority for FY 2018, as it provides the base funding for the 650 hospitals, clinics, and health programs that operate on Indian reservations, predominantly in rural and frontier settings. This is the core budget line item that makes available medical care services to AI/ANs. IHS and Tribal managed facilities continue to grapple with inadequate funding. Increasing H&C funding is necessary as it supports the following; all primary medical care services, including inpatient care, routine ambulatory care, and medical support services, such as laboratory, pharmacy, medical records, information technology and other ancillary services. In addition, H&C funds provide the greatest flexibility to support community health initiatives targeting health conditions disproportionately affecting AI/ANs such as diabetes, maternal and child health, and communicable diseases including influenza, HIV/AIDS, and hepatitis. In 2017, for example Tribes supported the IHS requests for program increases in the H&C line item to address Health Information Technology, the Domestic Violence Prevention Program, IHS Quality Consortium for Federal Hospitals, Tribal Clinic Lease, Operations & Maintenance and Tribal Epidemiology Centers. These efforts will require continued support in FY 2018.

The demands on the IHS H&C are continuously challenged. In our facilities we experience constant and increased demand for services due to the significant population growth and the increased rate of chronic diseases that result in overwhelming patient workloads. Adding rising medical inflation, difficulty in recruiting and retaining providers in rural health care settings, and the lack of adequate facilities and equipment, these resources are stretched. As a result, any underfunding of H&C equates to limited health care access, especially for patients that are not eligible for or who do not meet the medical criteria for referrals through Purchased Referred Care that shall be discussed in another section of this report. For many in Indian Country, there are no alternatives other than the care provided directly at an IHS or Tribal facility.

An example of health outcomes which will benefit from additional H&C funding is the crisis Indian Country is facing with Hepatitis C (*see news publication in Appendix B*). The American Indian/Native Alaska population is disproportionately affected by hepatitis C virus (HCV). The most recent national data show American Indian/Alaska Native people with both the highest rate of acute HCV infection and the highest HCV-related mortality rate of any US racial/ethnic group. In 2013, the latest national data available, rates of acute HCV infection were 1.7 per 100 000 American Indian/Alaska Native persons. From 2009 through 2013, their HCV-related mortality rate increased by 23.2%, accounting for 324 deaths in 2013. The American Indian/Alaska Native mortality rate of 12.2 deaths per 100 000 population is more than double the national rate of 5.0 per 100 000. Although prevalence data are limited, one national study estimates 120 000 persons living on Indian reservations are positive for the HCV antibody. Another study has shown American Indian/Alaska Native veterans born from 1945 to 1965 have an antibody-positive seroprevalence of 10%. While funding has been provided to the VA for the HCV treatment, the IHS has not received supplemental funding for this same HCV treatment and does not have HCV drugs on its National Core Formulary. New H&C funding is necessary to address both urgent health crises as well as basic primary and specialty high cost care needs.

Tribes are determined and seek the commitment of HHS to make meaningful impacts in terms of improved health outcomes. This will be difficult to achieve if we continue to receive limited resources to address basic primary and urgent care needs. Our communities suffer from significantly higher mortality rates from cancer, diabetes, heart disease, suicide, injury and substance abuse. Preventative and primary care programs deter costly medical burdens. Yet, with funds primarily directed to cover fixed and inflationary costs, there is little left over to make significant, long-term progress toward improving the health of AI/ANs. This Administration can make a difference as well by targeting some of the funding increases to give them an opportunity for Tribes to develop and implement their own preventative programs through culturally appropriate approaches.

A critical component to achieve the full potential of H&C is funding new authorities under the Indian Health Care Improvement Act (IHCIA). The provisions in this law represent a promise made by the federal government to significantly improve the health of our people, *yet six years after the IHCIA was reauthorized, most of the new programs remain unfunded*. For Tribes, this is a huge disappointment. We renew our request to the federal government to keep its promise by funding IHCIA authorities. Tribes are especially interested in full funding of Section 124 - Other Authority for Provision of Services (25 U.S.C. § 1621d) as it would provide our elders hospice care, assisted living, long-term care, home-and community- based care and convenient care services. These are services that IHS has never funded. FY 2018 should be the year where the Administration commits to funding this new authority and other priority sections of the IHCIA that are further identified in this report. We must begin to see the impacts of a law that was over 20 years in the making. Tribes also request that funding new authorities should be in addition to the base-level H&C funding.

## ***Public Health Infrastructure Support***

IHS services are largely limited to direct patient care, leaving little, if any, funding available for public health initiatives such as disease prevention, education, research for disease, injury prevention, and promotion of healthy lifestyles. This means that Indian Country continues to lag behind other communities in resources and services. Our communities are therefore more vulnerable to increased health risks and sickness.

As independent, sovereign nations, Tribal governments do not operate within the state regulatory structure, and often compete with their own state governments for resources. Tribes are regularly left out of statewide public health plans and federal funding decisions for public health programs.

Tribal communities must cobble together public health funding from a variety of federal, state, local, and private funding sources. State governments receive base operational and programmatic funding through the large flagship federal grants, while Tribes are either not eligible to compete for the funding or are woefully underrepresented in the grantee pool. This leads to rampant unpredictability and inconsistency among Tribal public health initiatives.

We request that HHS work together with IHS, the Centers for Disease Control and Prevention, the Substance Abuse and Mental Health Services Administration and other agencies to support Tribal public health infrastructure development so that our communities can experience comprehensive health system and AI/AN health disparities become a thing of the past.

## **DENTAL SERVICES +\$80.4 MILLION**

It is no secret that oral health care access is one of the greatest health challenges Tribal communities face. In the general U.S. population, there is one dentist for every 1,500 people, but in Indian Country, there is only one dentist for every 2,800 people.

*"If you don't have a car that can drive on the highway for a few hours or gas money, then accessing the dental clinic is next to impossible."*  
- Elizabeth, 24  
North Fork Rancheria of Mono Indians

Within Great Plains Area alone, American Indian preschool children have the highest rate of tooth decay than any population group in the country. On the Pine Ridge Reservation, the W.K. Kellogg Foundation found 40% of children and 60% of adults suffer from moderate to urgent dental needs, including infections and other problems that could become life-threatening.

It is not uncommon to hear stories of elderly patients waiting out in the cold for one of just a few dental appointments available in one day. Or, for patients to wait for months to get an appointment. Patients get frustrated with this system and often abandon the search for care altogether. This delayed or deferred care has long-term impacts over a patient's overall health and wellbeing.

The IHS Dental program supports the provision of dental care through clinic-based treatment and prevention services, oral health promotion, and disease prevention activities, including topical fluoride application and dental sealants. The demand for dental treatment remains high due to the significant dental caries rate among AI/AN children. Funds are used for staff salaries and benefits, contracts to support dental services, dental lab services, training, supplies, and equipment. These funds are needed primarily to improve preventive and basic dental care services, as over 90% of the dental services provided by I/T/Us are used to provide basic and emergency care services. More complex rehabilitative care (such as root canals, crown and bridge, dentures, and surgical extractions) is extremely limited, but may be provided where resources allow.

It is clear why the TBFWG has prioritized increased access to dental care year after year. Yet, we continue to not see substantial improvements in the state of oral health for American Indian and Alaska Natives. But Tribal communities have pioneered a solution. In Alaska, the use of **Dental Health Aide Therapists (DHATs)** over the last decade have filled a gap where dentists not available. DHATs live and work in communities they serve providing routine care to patients so that the need for emergency services is minimized and patients are experiencing greater overall oral health outcomes. Alaska's DHATs have expanded dental care to over 40,000

*"In my community, the only time we can be seen by a dentist is to stand in line before the sun comes up on Monday mornings, and even then we are not guaranteed care."*

- Alayna, 25  
Standing Rock Sioux

Alaska Natives and now, there are whole elementary school classes without any cavities. In 2015, several Tribes in Washington and Oregon have announced that they will use DHATs as part of their dental team. Two tribes in Oregon are working through a state program, and the Swinomish Indian Tribal Community has created its own licensing board to license medical professionals at the Tribe, including a DHAT.

While these are remarkably positive steps for the tribes involved, the TBFWG continues to request that IHS use its dental services funds to expand DHATs to tribes in the lower 48 within the existing law. In guidance issued by the agency in January 2014, IHS erroneously notes that any DHAT expansion in Tribal communities can only occur if a state legislature approves. However, Tribes believe, that the IHCA's restrictive language on DHATs only applies to the Community Health Aide Program (CHAP). IHS should revise, update and re-issue guidance on the use of Dental Health Aide Therapists (DHATs) in Tribal communities. The revised guidance

should clarify that the limitation in IHClA applies only to the proposed national expansion of the CHAP, and does not otherwise prevent Tribal health care programs from providing DHAT and other dental midlevel services in their communities. IHS should issue formal support for the efforts undertaken by the Swinomish Indian Tribal Community to license and add DHATs and other dental midlevel practitioners to the Community's dental team.

## **Mental Health +\$186.8 MILLION**

Tribal leaders report Mental Health as a significant priority for FY 2018 and recommend a **\$189.9 million** increase above the FY 2017 budget request. This increase would mean a 171% increase in funding for behavioral health services in Indian Country. This significant increase is needed to increase the ability of Tribal communities to develop innovative and culturally appropriate prevention programs that are so greatly needed in Tribal communities.

American Indian/Alaska Native (AI/AN) people continue to demonstrate alarming rates of psychological distress throughout the nation. However, tribal health continues to receive inadequate funding resources to address these issues. Without a significant increase in funds for FY 2018, Indian Health Services (IHS) and tribal programs will continue to experience difficulty with properly staffing outpatient community based mental health treatment facilities. Likewise, despite the need for mental health services throughout AI/AN communities, limited resources restrict the ability to hire qualified, culturally competent and licensed providers to relocate to rural areas.

Research has demonstrated that AI/ANs do not prefer to seek Mental Health services through Western models of care due to lack of cultural sensitivity; furthermore, suggesting that American Indians and Alaska Natives are not receiving the services they need to help reduce these alarming statistics.<sup>6</sup> Moreover, added resources will ensure

### **PSYCHOLOGICAL IMPACTS OF HISTORICAL TRAUMA**

"The decades of colonialism and oppression experienced by the Alaska Native Peoples has been devastating and its impact has adversely affected the peoples in every capacity of mind, body, and spirit (Napoleon, 1996). The trauma experienced by this group including oppression of cultural traditions and values have displaced multiple generations from the culture (Roderick, 2008). The loss of culture is also related to mass numbers of lives lost during the 1900 influenza epidemic, also known as the "Great Death," during which approximately 74,000 Alaska Native Peoples died (Boraas, 1991)."

"Such experiences of colonialism and oppression, along with immense cultural loss that many often refer to as "historical trauma," has been argued to be the root of many psychological and behavioral health concerns among Alaska Native Peoples today (e.g., Napoleon, 1996; Roderick, 2008). Indeed, Alaska Natives have some of the most disproportionate numbers of psychological and behavioral health issues in comparison to all other ethnic groups (Napoleon, 1996; Roderick, 2008; Walls, Johnson, Whitbeck, & Hoyt, 2006)."

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<sup>6</sup> Beals, J., Novins, D.K., Whitesell, N.R., Spicer, P., & Mitchell, C.M., & Manson, S.M. (2005). Prevalence of mental disorders and utilization of mental health services in two American Indian reservation populations: Mental Health disparities in a national context. *American Journal of Psychiatry*, 162, 1723-1732.

Heilbron, C. L., & Guttman, M. A. J. (2000). Traditional healing methods with first nations women in group counseling. *Canadian Journal of Counseling*, 34, 3-13.



that in-patient psychiatric services for youth and adults will be available locally within the tribal health system while offering culturally responsive treatment and increasing service utilization. Additionally, increased funding will offer an expansion of services promoting wellness and prevention to help reduce the astonishing rates of mental health issues we continue to observe today. The geographical remoteness of most American Indian reservations and Alaska Native villages demand unique and innovative treatment options to address comprehensive mental health, substance abuse and psychiatric services. Furthermore, aftercare including case management, outreach and prevention are critical in reducing mental health issues. Use of innovative technology is critical to help support an expansion of services to the most remote communities.

**Suicide continues to plague American Indians and Alaska Natives throughout Indian Country.** Suicidality is often in combination with other behavioral and mental health issues including depression, feelings of hopelessness, history of trauma, substance abuse, domestic violence, sexual abuse and other negative social issues. Moreover, American Indian and Alaska Native people experience high rates of depression and psychological distress and higher suicide rates across the national average. Furthermore, one of the main risk factors known to contribute to such psychological distress and behavioral health concerns is historical trauma which continues to manifest through this population and specifically today's generations through intergenerational trauma.

**Intergenerational effects of historical trauma on long-term health have been documented among American Indian and Alaska Native populations through adverse childhood events (ACEs) studies.** These studies assess prevalence of personal experiences —physical abuse, verbal abuse, sexual abuse, physical neglect, and emotional neglect and family experiences--an alcoholic parent; a mother who has been a victim of domestic violence; a family member in jail; a family member with a mental illness; and the loss of a parent through divorce, death or abandonment. Higher scores are correlated with poorer long-term outcomes. As generations of families transmit the damage of trauma throughout the years it becomes a cumulative, collective exposure to traumatic events that not only affect the individual exposed, but continue to affect the following generations, thus compounding the trauma even further.

The Attorney General's Advisory Committee on AI/AN Children Exposed to Violence, comprised of experts in the area of AI/AN children exposed to violence recently released its report. It describes the foundation that must be put in place to treat and heal AI/AN children who have experienced trauma: "We must transform the broken systems that re-traumatize children into systems where Tribes are empowered with authority and resources to prevent exposure to violence and to respond to and promote healing of their children who have been exposed."<sup>6</sup>

Another significant factor reinforcing these mental health concerns is economic. The poverty rate among American Indian and Alaska Natives was 29.1% in 2012, compared with 43% for whites. On many reservations, economic development is much lower than in surrounding cities. There are far fewer jobs, and unemployment is much higher in the reservation communities. On some reservations, unemployment is as high as 80 or 90%, leading to a sense of hopelessness and despair. The inability to provide for one's family often leads to a sense of loss of identity, despair, depression, anxiety and ultimately substance abuse or other social ills such as domestic violence.

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Walls, M. L., Johnson, K. D., Whitbeck, L. B., & Hoyt, D. R. (2006). Mental health and substance abuse services preferences among American Indian people of the northern Midwest. *Community Mental Health Journal*, 42, 521-535.

But access to behavioral health services is limited. In a study of 514 IHS and Tribal facilities, 82% report providing some type of mental health service such as psychiatric services, behavioral health services, substance abuse treatment, or traditional healing practices, and to improve access 17% (87) have implemented telemedicine for mental health services. However, none provide inpatient psychiatric services. Without access to care, persons in psychiatric distress often end up at the hospital emergency room.

Obtaining services for mental health also forces patients to travel a long distance from home and family as they receive treatment. An adolescent from the Oglala Lakota Tribe recently said in a Congressional briefing that after several suicide attempts, *“They sent me to a facility 6 hours away from home that was not targeted for native youth, like myself. While I was there, I attempted working on myself. I didn’t have one visitor while I was there. It was too far away from my family. Family sessions were over the phone, but my dad was not engaged in any of the sessions. I was there for almost 2 months.”* It was not until she moved in with another family member, and attended a Lakota Cultural Healing Camp that she was able to make positive change in her life. She now is a youth mentor for others and committed to conducting outreach to highlight the struggles so many Native youth when it comes to accessing behavioral health services.

With behavioral health issues nearing the crisis point in many Tribal communities, as evidenced by testimonials at local, regional and national meetings, the TBFWG has made behavioral health services a major budget priority for FY 2018. While programs currently in place such as the IHS Methamphetamine and Suicide Prevention Initiative (MSPI) have provided important funding, Tribal communities are still grappling with co-dependent complex health issues. More must be done to provide resources to local and community support systems so that individuals dealing with serious behavioral health crises have a place to turn. We, therefore, encourage the Secretary to find creative ways to fund innovative programs that will allow for access to more mental health resources within Tribal communities.

One example, is the funding of the Mental Health Technician Program (*as described on page 54*).

### ***The Role of NTAC***

The IHS National Tribal Advisory Committee on Behavioral Health was established in 2008. The Committee has provided technical support to the IHS Behavioral Health Work Group, composed of Tribal and urban Indian health representatives who are providers and experts in the field of behavioral health. The Committee and the Work Group advises IHS on how to effectively deliver behavioral health services integrated into local tribal health care delivery systems. The committee offers positive community, cultural approaches and traditional practices balanced with western approaches to be implemented in addressing urgent, short term and longer term needs including some of the prevailing and serious issues such as depression, suicide, domestic violence and co-occurring mental health and substance abuse disorders

### **ALCOHOL & SUBSTANCE ABUSE +\$155.8 MILLION**

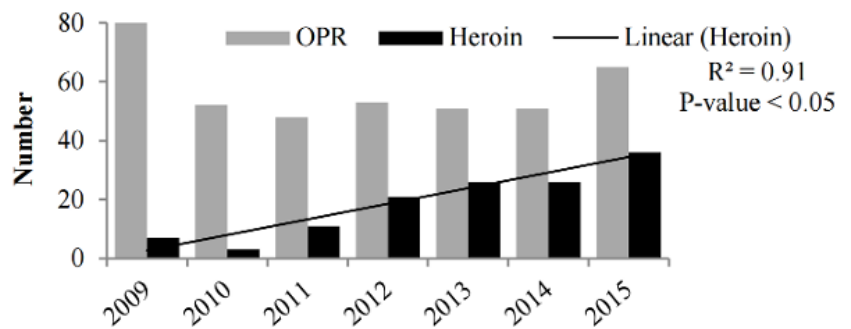
Closely linked with the issue of mental health is that of alcohol and substance abuse in Tribal communities. Indeed AI/AN communities and people continue to be afflicted with the epidemic of alcohol and other drug abuse. Tribal leaders agree that this topic remains a high priority for FY 2018. The Workgroup recommends a program increase of **\$70.5 million** above the FY 2017 budget request.



Tribal leaders recognize that AI/AN people will continue to be over represented in statistics relating to alcohol and substance abuse disorders unless new culturally adapted strategies and targeted funding are identified. For instance, in 2012, drug overdose deaths in Alaska were astonishingly higher than the national rate for heroin related overdose deaths (3.0 vs 1.9 per 100,000 individuals).

Furthermore, in comparison to the rest of the United States, Alaskan drug overdoses by prescription opioid pain relievers was more than double the rate (10.5 vs 5.1 per 100,000 individuals).<sup>7</sup> The increase in use of more lethal drugs is consistent with the reports throughout Indian Country. Also, with more stringent regulations around prescription opioids, more people are turning to heroin as a relatively cheap and apparently easy accessible alternative. Several hospitals are reporting an alarming increase of infants born in 2014 addicted to heroin and Tribal leaders are testifying about the devastation heroin, meth and opioids are causing in their communities. The growing use of heroin in particular has spurred a resurgence of public health issues like Hepatitis and other sexually transmitted diseases.

**Figure. Overdose Deaths Associated with OPR or Heroin — Alaska, 2009–2015**



Again, effects from historical trauma, poverty, lack of opportunity, and lack of patient resources compound this problem. AI/ANs have consistently higher rates relating to alcohol and substance abuse disorders, deaths (including suicide and alcohol/substance related homicides), family involvement with social and child protective services, co-occurring mental health disorders, infant morbidity and mortality relating to substance exposure, the diagnosis of Fetal Alcohol Syndrome (FAS) and other Fetal Alcohol Spectrum Disorders (FASD), partner violence, diabetes complications and early onset as a result of alcohol abuse, and other related issues.

According to a study in 2009-2010 American Indian and Alaska Natives were almost twice as likely to need treatment for alcohol and illicit drugs as non-Native people. The study found that AI/ANs needed treatment at a rate of 17.5% compared to the national average of 9.3%. A health study conducted by the New Mexico Department of Health in 2013 indicated that Alcohol-related Death Rates is the highest for Native Americans in the State of New Mexico and is 4 times higher than the US rate for alcohol-related deaths.

Current alcohol and substance abuse treatment approaches (offered by both the IHS and Tribal facilities) employ a variety of treatment strategies consistent with evidenced-based approaches to the treatment of substance abuse disorders and addictions (such as outpatient group and individual counseling, peer counseling, and inpatient/residential placements, etc.) as well as traditional healing techniques designed to improve outcomes and align the services provided with valuable cultural practices and individual and community identity. IHS-funded alcohol and substance abuse programs continue to focus on integrating primary care, behavioral health, and alcohol/substance abuse treatment services and programming through the exploration and development of partnerships with stakeholder agencies and by establishing and supporting community alliances. Adult and youth residential facilities and placement contracts with third party agencies are funded through the IHS budget

<sup>7</sup> Hull-Jilly, D., & Gibson, D. (2016). Drug Overdose Deaths in Alaska. State of Alaska Epidemiology Bulletin, 6 (1).

for alcohol and substance abuse treatment. However, as a result of diminishing resources, placement and treatment decisions are often attributed more to funding availability than to clinical findings. Providing this treatment is costly to the community. Gaps in funding mean that treatment is often inconsistent from year to year across Indian Country. Because funding is never guaranteed, vulnerable people and communities can slip through the cracks and back into drug habits when grant resources run out. For example, the Fort Peck Tribes of the Assiniboine and Sioux created a drug task force on their remote reservation in northeastern Montana in order to employ a cross-jurisdictional strategy for treating and preventing substance abuse. The task force was funded through a state-funded program. Councilman Vice Chairman, Charles Headdress, noted that the program was making progress, but when the funding ran out, the gains the task force made diminished and methamphetamine dealers were able to increase their presence on the reservation.

It is well known that the Alcohol and Substance Abuse prevention budget line has been severely underfunded due to more urgent primary and specialty medical health care needs of AI/ANs. Funding the expansion of additional wide-spread prevention, outreach and education services is a high priority. Efforts have been made to “target” solutions for smaller initiatives or to address an immediate crisis. For example, there is currently an IHS initiative to reduce the abuse and misuse of controlled substances in Indian Country. This “legal” form of substance abuse is becoming widely recognized as a form of substance abuse that negatively impacts our patient population.

However, we now know that inadequate funding for alcohol and substance abuse services has a ripple effect on other funding sources, such as overloading the agency’s outpatient clinics, urgent care departments, and emergency departments with unnecessary visits (typically funded by Hospitals and Health Clinic funds and third party collections). The increased number of patient visits to private sector emergency departments also puts an increased burden on Purchased/Referred Care Services.

At the Jicarilla Service Unit in the Alba, many clients are sent away from the reservation for long term treatment programs but when they return to the community, there is not a place they can go to for transitional services back to the environment of the reservation. Some return to the habits of alcohol and substance abuse. This is true in most Indian communities. Tribes are requesting options to mitigate these cases by the establishment of a safe house, detox and aftercare facilities, and juvenile/family treatment centers.

A number of Tribes have been successful in finding grants and other non-IHS resources to manage alcohol and substance abuse outpatient programs. Although the long-term sustainability of these programs are questionable, IHS is in a unique position to assist the Tribes plan, develop and implement a variety of culturally responsive treatment options to help individuals sober and prevent from relapse. Programs with treatment approaches that include traditional healing and cultural practices have been reportedly more successful. However, due to lack of funding availability several culturally responsive in-patient treatment centers have had to close their doors leaving a major gap in service availability and more specifically availability of detox beds with the rising number of heroin and opioid addictions.

IHS funding supports the operation of six youth residential treatment facilities and services for women with children up to age 24, but as in all health care, third party reimbursement has become increasingly relied upon by these facilities. Medicaid reimbursement is an important resource, however not fully accessible and always contingent on state policies with regard to the level of reimbursement for covered and optional services if adopted in a State Medicaid Plan. The Youth Regional Treatment Centers, for example, serve tribal youth from multiple states and youth do not obtain residential status for at least 30 days. Limited funding often results in placement decisions based on the availability of alternate resources and the providers' clinical recommendations.

Smoking and smokeless tobacco is often the first drug which individuals experiment; furthermore, research has demonstrated that it increases risk to using illegal drugs. Smoking rates are significantly higher among American Indian and Alaska Natives when compared to non-AI/AN populations. Moreover, cigarette smoking is linked to approximately 90% of all lung cancers in the U.S. and it is a leading cause of death among AI/AN people. Such chronic illnesses exacerbate individuals' mental well-being and overall health and wellness. Increased funding will support the need for prevention and education on this topic and particularly targeting youth while promoting non-tobacco using adults as role models for establishing social norms in Indian communities.

As noted in the FY 2017 report, domestic violence rates are alarming, with 39% of AI/AN women experiencing intimate partner violence - the highest rate in the U.S. Furthermore, congress and this administration highlighted the need to address issues of violence and sexual and domestic abuse against AI/AN women in the re-authorization of the Violence Against Women Act (VAWA) (Public Law 113-4) and the Tribal Law and Order Act (TLOA) (Public Law 111-211). Furthermore, it is worth highlighting the alarming statistics among Alaska Native children regarding witness to violence and the serious implications from this exposure in relationship to children's cognitive development.



### ***Health Impacts of Alcohol in Alaska:***

A review of medical records in Alaska from 2002 -2011 indicated that alcohol was documented as being associated with 63.2% of all intentional injury hospitalizations and 32.2% of all unintentional injury hospitalizations among AI/AN, based on blood alcohol and breathalyzer tests and other notes in the patient's medical record. Almost three out of five (57.5%) suicide attempt and self-harm hospitalizations among Alaska Native people were reported as alcohol-related.

Moreover, alcohol and other substance abuse is often a precursor to these serious issues in Tribal communities. In addition, Section 714 of the Indian Health Care Improvement Act Provisions Passed in the *Patient Protection and Affordable Care Act* (P.L. 111-148), authorizing the establishment of a culturally appropriate program, in each IHS area, to prevent and treat Indian victims of domestic and sexual violence and perpetrators of domestic and sexual violence in Indian households.

These authorities will enhance efforts and provide potential funding and coordination of effort among agencies in the area of alcohol and substance abuse prevention, treatment, data analysis and community based research.

The National American Indian/Alaska Native Behavioral Health Strategic Plan provides a comprehensive approach to address alcohol and substance abuse and its tragic consequences, including death, disabilities, families in crisis and multi-generational impacts. IHS, Tribal and urban Indian health alcohol and substance abuse programs continue to focus on integrating primary care and behavioral health services, being more responsive to emerging trends and the instituting best and promising practices that align with culture based prevention and treatment.

January 27, 2016

To Whom It May Concern:

My name is Eugene Little Coyote, a proud Northern Cheyenne and a proud American. I am a working single father, pay my taxes and I am bless to be able to take care of my five school-aged children plus a little three year old daughter "Baby Mae," who is the focus of this letter.

Baby Mae's mother was a fair haired beautiful religious woman. We went to Alcoholics Anonymous together and we were clean & sober for at least three years. So it was completely shocking and near inconceivable when the hospital and social workers told me that she and our 2 month premature newborn daughter tested positive for meth! But that devastating blow paled in comparison to the very real horror of watching helplessly as Baby Mae struggled to live and breathe in her early hours of life. Have you witness a helpless newborn – a tiny bundle of humanity – fight for life because the mother chose to take meth while pregnant? Baby Mae could not breathe on her own so she was put on a respirator and fed by a tube through her nose. She shook and trembled uncontrollably, unnaturally, suffering through meth withdrawals that were not her fault. When she was able to breathe on her own and after 8 hours, Baby Mae's feeble cries of agony broke my heart.

A few weeks later Baby Mae left the hospital while her mother left for treatment. I went to work in the day and then in the evening I cared for Baby Mae and slept with her beside me. She cried to no end, often inconsolable because of the meth withdrawals. Baby Mae's little arms and legs always shook violently, and her little jaw never stopped trembling whether she was crying or feeding on her bottle. We held Baby Mae as much as lovingly as possible but we were as helpless as she was to ease her never-ending suffering. Describing what Baby Mae went through doesn't really give a brutally honest impression of the torture the poor little soul had to endure every day and every night. All through that nightmarish month I lived in constant terror that I would wake up to find Baby Mae might have lost her fight for life. But Baby Mae is now three. She is happy, beautiful little should but her mother (eventually) went to jail, we divorced and I have sole custody – but not before a lot more meth-caused misery and tragedy took place that included a horrific miscarriage and a differently baby's death (partly related to RSV).

It's a deeply personal, traumatic effort to relive and share my story on the record, but it's more important we bring these things to light to you because, tragically, "meth babies" are becoming more and more common among the Northern Cheyenne Tribe. There has been a drug problem on Northern Cheyenne, there continues to be a drug problem, and we need far more resources than what's available to seriously address it, because in the wake of my ex-wife's meth abuse I and Baby Mae are left with life-long scars on our hearts, in our minds and in Baby Mae's case she could be left with permanent cognitive development problems. But I tell you here and now that meth abuse just doesn't affect one or two in our large extended tribal families – it effects everybody. Baby Mae's siblings, who lover her unconditionally, care the trauma of witnessing their little sister near death. They carry the emotional trauma of seeing me go through the bitter conflicts with their drug-addicted stepmother, our divorce and severe depression from it all. The services available on the reservation weren't helpful to my needs nor to my family (there is no family counseling through the Tribe or Indian Health Service) and there was no help to save my marriage.

Please consider my painful and truthful story, and hear my tribal representatives' words to assist you in the budget process to appropriate the severely needed resources to Indian Country and to Northern Cheyenne for substance abuse prevention, treatment, education and mental health services."

Sincerely,



Eugene Little Coyote

## **PURCHASE/REFERRED CARE +\$422.5 MILLION**

The AI/AN population experiences some of the most significant health disparities of any population in the United States. Improvements in the health of AI/AN cannot be achieved with the current or projected level of health services from IHS and the tribes. The resources available and approach to care historically used are insufficient to meet the current need within communities. With the continued and increasing shortage of providers and services directly available within IHS and tribal health facilities the demand for Purchase/Referred Care continues to remain a critical priority for all tribes.

Direct Care is identified as medical and dental care that is provided at an IHS or tribal health care facility. Purchased/Referred Care is for medical and dental care provided away from an IHS or tribal health care facility. PRC funds are used to supplement and complement other health care resources available to eligible Indian people. The funds is used in situations where: (1) no IHS direct care facility exists, (2) the direct care element is incapable of providing required emergency and/or specialty care, (3) the direct care element has an overflow of medical care workload, and (4) supplementation of alternate resources (i.e., Medicare, private insurance) is required to provide comprehensive care to eligible Indian people.

Because IHS programs are not fully funded, the PRC program must rely on specific regulations relating to eligibility, notification, residency, and a medical priority rating system. The IHS is designated as the payer of last resort meaning that all other available alternate resources including IHS facilities must first be used before payment is expected. These mechanisms enhance the IHS to stretch the limited PRC dollars and were designed to extend services to more Indians. This renders the PRC program to authorize care at restricted levels and results in a rationed health care system.

As with the rest of the IHS budget, PRC funds have not kept pace with the health needs of tribal members, the cost of health care and the growth of Tribal populations. As a result PRC funds, which are managed by the IHS, are typically reserved for emergency and specialty services following a priority schedule used by the IHS.

- A. **Medical Priority Level I-** Emergent or acutely urgent care services are diagnostic or therapeutic services that are necessary to prevent the immediate death or serious impairment of the health of the individual, and which, because of the threat to the life or health of the individual necessitate the use of the most accessible health care available and capable of furnishing such services. Diagnosis and treatment of injuries or medical conditions that if left untreated, would result in uncertain but potentially grave outcomes.
- B. **Medical Priority Level II-**Preventive Services are distinguished from emergency care, sophisticated diagnostic procedures, treatment of acute conditions, and care primarily intended for symptomatic relief or chronic maintenance. Most services listed as Priority Level II are available at IHS direct care facilities. If no direct care capabilities are available at the IHS or Tribal direct care facility, preventative services can be purchased using PRC funds
- C. **Medical Priority Level III-**Primary and Secondary Care Services include inpatient and outpatient care services. The inpatient and outpatient services involve the treatment of prevalent illnesses or conditions that have a significant impact on morbidity and mortality. This involves treatment for conditions that may be delayed without progressive loss of function or risk of life, limb, or senses. It also includes services that may not be available at many IHS facilities and/or may require specialty consultation.

Typically, only Priority I conditions are covered or approved through PRC. To ensure that committed PRC funds are available throughout a fiscal year, each IHS Service Unit or Tribal Program must make a 52 week budget plan, limiting the amount of PRC funds that can be obligated in a given week.

As mentioned in above priorities, underfunding for PRC in addition to antiquated information technology systems result in consequences that affect quality of care. An emerging issue in Indian Country is the growing burden of uncompensated care on the major contracted providers.

Along with the administrative costs, there are undesirable consequences through the existing IHS PRC process. Payments for private sector care are often denied due to appropriation or budget limits and medical priority determinations. When payments are denied, it is possible an individual tribal member will be responsible for the payment of provided services, which generates a financial burden for the individual and the provider.

In addition to the current lack of funding for PRC-eligible services under the current PRC policies, a major concern for Tribal leadership is that these policies have not been updated in years. The current policies were written during a time when the IHS had to restrict access to services by creating limits to eligibility and scope of services provided. Tribes have asked the IHS to update these policies and bring them up to today's standard of quality care in order to have a better picture of what the true funding need is for PRC services. The truth is that these needs have been understated for at least 40 years.

### **PUBLIC HEALTH NURSING +\$14.3 MILLION**

Public Health Nursing (PHN) is a community health-nursing program that focuses on promoting health and quality of life and preventing disease and disability. The PHN program provides quality, culturally sensitive primary, secondary, and tertiary health promotion and disease prevention nursing services to individuals, families and community groups. Home-based services are most often related to chronic disease management, safety and health maintenance care for elders, investigation and treatment of communicable disease, breastfeeding promotion, pre/postnatal education, parenting education, and screening for early diagnosis of developmental problems. However, PHN also offers traditional food programs that focus on food choices that are not only culturally appropriate but consider health challenges for AI/ANs, health system patient navigator assistance programs, tobacco cessation programs, cancer screening programs, onsite emergency care assistance, and community mental health support, education, and programs. The request includes inflation plus \$584,000 in expanded services.

### **HEALTH EDUCATION: +\$9 MILLION**

The Health Education program supports the provision of community, school, and worksite health promotion, patient and professional education, and the development of educational materials for staff, patients, families, and communities. Current focus areas include health literacy, patient-provider communications, and the use of electronic health information by and for patients. The need for health education activities is important in order to empower AI/AN patients to become better informed about their own personal health and the wellness of their Tribal communities. The request includes inflation over the FY 2016 base plus \$457,000 in program expansion.

### **COMMUNITY HEALTH REPRESENTATIVES (CHR): +\$26.9 MILLION**

The CHR program helps to bridge the gap between AI/AN individuals and health care resources through outreach by specially trained members of the Tribal community. CHRs integrate basic medical knowledge about health promotion and disease prevention with local community knowledge. They often play a key role in follow-up care and patient education in Native languages and assist health educators implement prevention initiatives. Their role is crucial in Indian country. They are considered an integral member of the health care team. With the opportunity provided under the IHCIA, which expands the permissible uses of appropriated funds to include community-based care, additional resources are needed to increase CHR trainings and increase the CHR workforce. The request includes inflation plus \$557,000 in expanded services.

## **ALASKA IMMUNIZATION +\$7.373**

*Hepatitis B Program:* Viral hepatitis, including hepatitis B, and other liver diseases continue to be a health disparity for AI/ANs in Alaska. The Alaska Native Tribal Health Consortium (ANTHC) Hepatitis B Program continues to prevent and monitor hepatitis B infection, as well as hepatitis A and hepatitis C infections, throughout the state of Alaska. With respect to hepatitis C, we have identified a 127% increase in new cases from FY14 to FY15. In FY15, immunizations maintained high vaccine coverage rates; hepatitis A vaccination coverage was 93% and hepatitis B vaccination coverage was 97%.

*Immunization (Hib) Program:* Immunization is a fundamental health prevention activity for Alaska Native people. In 1990, elevated rates of *Haemophilus Influenzae B (Hib)* among Alaska Native children prompted an immediate call to action for increased vaccination coverage, especially in Alaska Native communities with limited access to care. High vaccination coverage rates have resulted in a 99% reduction in *Hib* meningitis and vaccination coverage rates amongst Alaska Native children continue to be the highest in Alaska. The ANTHC Immunization Program maximizes the prevention of vaccine-preventable disease by providing directed resources, staff training, and coordination to tribes in Alaska. Support services also include site visits and consultation for the varying electronic health records (EHR) systems within each tribal health organization to facilitate immediate access to complete vaccine records. Dedicated immunization funding has ensured continued access to vaccines in Alaska Native communities and high vaccine coverage for Alaska Native children and adults.

## **URBAN INDIAN HEALTH +\$46.6 MILLION**

Thirty-four Urban Indian Health Programs provide health care and substance abuse services in fulfillment of the federal trust responsibility to more than 100,000 AI/ANs and from nearly 500 tribes, each year. Operating in 21 states, these programs are funded from an IHS line item of only \$43.6 million, which is less than 1% of the total IHS budget. Urban Indian Health Programs are unable to access PRC funding and other resources from the general IHS budget, and consequently have become adept at leveraging their modest base funding with additional health care dollars from other federal agencies, states, and foundations.

Indian Health Programs offer services to all AI/ANs. Urban Indian Health Programs are excluded from laws intended to benefit American Indians and improve their quality of health, because of a lack of the understanding of the history of urban Indian communities and complexity of the Indian Health Services, Tribal and Urban (I/T/U) Indian health system. Lack of information and bureaucratic complexity has led to the exclusion of Urban Indian Health Programs participation from a number of critical protections enjoyed by IHS and Tribal health providers. The most urgent of these provisions would be the inclusion of urban programs in 100% federal match for Medicaid services - a protection already enjoyed by IHS and Tribal facilities. This protection – known as 100% FMAP- would provide states with 100% of the cost of payments made to urban Indian health providers for service provided to American Indian Medicaid patients, rather than requiring the states to assume a %age of the cost of Indian health care.

For example, as required by the Veterans Access, Choice, and Accountability Act of 2014, IHS and the Department of Veterans Affairs (VA) worked jointly to submit a report to Congress on the feasibility and advisability of entering into and expanding certain reimbursement agreements for costs of direct care services provided to eligible Veterans who are not American Indian or Alaska Native. According to the “Report on Enhancement of Collaboration Between the Department of Veterans Affairs and the Indian Health Service” a national Reimbursement Agreement for Direct Health Care Services was signed on December 5, 2012 between IHS and the Veterans Health Administration. Under this national agreement, VA reimburses IHS facilities for



direct health care services provided to eligible AI/AN Veterans. As of January 2015, the national agreement between IHS and VA covers 108 IHS facilities, and VA has successfully negotiated 81 direct care services reimbursement agreements with Tribal Health Programs (THPs). Total reimbursements since December 5, 2012, exceeded \$24 million covering over 5,500 eligible Veterans. VA does not currently have separate reimbursement agreements with UIHPs.

Urban Indian Health Programs have had a difficult time being included at the forefront of these and other types of consultations. For instance, UIHPs, unlike IHS and THPs are not under the protections of the Federal Tort Claims Act. Consequently, Urban Indian Health Programs are required to spend thousands of program dollars each year to purchase malpractice insurance for their providers. Extending this coverage to Urban Indian Health Programs would also require a legislative change.

## **INDIAN HEALTH PROFESSIONS +\$22.3 MILLION**

**The Indian Health Professions program has seen much success throughout the years including, but not limited to, the following:**

- Enabling AI/ANs to enter the health care professions through a carefully designed system of preparatory, professional, and continuing educational assistance programs.
- Serving as a catalyst in developing AI/AN communities by providing educational opportunities and enabling AI/AN health care professionals to further Indian Self Determination in the delivery of health care.
- Developing and maintaining American Indian psychology career recruitment programs as a means of encouraging AI/ANs to enter the mental health field.
- Assisting AI/AN health programs to recruit and retain qualified health professionals.

The FY 2018 budget request for an additional \$23.114 million to fund Indian Health Professions will be a bold step to stop additional experiences like the Great Plains crisis from reoccurring. Of this, \$793,000 is for inflation proofing plus an additional \$22.321 million to expand funding to address an urgent unmet need. Safe, quality care cannot be provided if provider vacancies cannot be filled or if staff is not adequately trained. Tribes and the Department of Health & Human Services unanimously agree that much more needs to be done to address quality of care issues within the IHS.

The Indian Health Care Improvement Act (IHCIA) P.L. 94-437, as amended, authorizes the Indian Health Service (IHS) Indian Health Professions (IHP) Program which manages the Scholarship program, Loan Repayment program (LRP), health professions training related grants, and recruitment and retention activities for IHS. The IHS made its first Scholarship program awards in 1978 when Congress appropriated funds for the IHP program. The IHP programs work synergistically to recruit and retain health professionals to provide high quality primary care and clinical preventive services to AI/AN communities.

The IHP Scholarship program includes the preparatory and pre-graduate scholarship programs that prepare students for health professions training programs (Section 103). It also includes the Health Professions Scholarship program (Section 104), which provides

financial support consisting of tuition, fees and a monthly stipend for AI/AN students from federally recognized Tribes enrolled in health profession or allied health profession programs. Students accepting funding for

programs under Section 104 incur a service obligation and payback requirement. In FY 2015, there were 990 new online scholarship applications submitted to the IHS Scholarship program. A total of 289 of these new scholarship applications were considered eligible for funding. The IHS Scholarship program was able to fund 149 new awards. An additional \$3.3 million in scholarship funding would have been needed to fund all qualified scholarship applicants.

The Loan Repayment Program (LRP) is an invaluable tool for recruiting and retaining healthcare professionals by offering health care professionals the opportunity to reduce their student loan debts through service to Indian health programs with critical staffing needs. Applicants agree to serve two years at an Indian health program in exchange for up to \$20,000 per year in loan repayment funding and up to an additional \$5,000 per year to offset tax liability. Loan repayment recipients can extend their initial two-year contract on an annual basis until their original approved educational loan debt is paid. In FY 2015, a total of 1,211 health professionals were receiving IHS loan repayment. However, IHS was still not able to fund an additional 613 who had requested it. The inability to fund these health professional applicants is a significant challenge for the recruitment efforts of the agency. It is estimated that an additional \$30.39 million would be needed to fund the 613 unfunded health professional applicants from FY 2015. Generally, individuals who come to IHS on the student loan repayment program stay with IHS for eight years, providing a much needed stable continuum of care for our people. Therefore, the Workgroup continues to support the legislative request to ensure that LRP payments are exempt, so that more appropriated dollars can be reaching medical providers.

The IHP Extern Program (Section 105 of the IHCA) is designed to give IHS scholars and other health professions students the opportunity to gain clinical experience with IHS and Tribal health professionals in their chosen discipline. Students are employed up to 120 days annually, with most students working during the summer months. In FY 2015, the Extern Program funded a total of 124 student externs. A total of 120 students were health professions students, and 25 (20%) were American Indian/Alaska Native.

It is indisputable that adequate staffing levels and capabilities, as well as state of the art equipment, are essential for quality care. Emergency medicine physicians, RNs, APNs, and other highly trained staff are essential for crisis and disaster management and to improve patient outcomes.

Nursing represents the largest category of health care providers in the Indian health system and has a major impact on patient safety and health care outcomes. According to the 2015 IHS Nurse Position Report, there are 2,484 RNs and 427 Licensed Practical Nurses (LPNs) employed with the I/T/U programs. The FY 2015 IHS Nurse Position Report identified a RN/Advanced Practice Nurse (APN) vacancy rate of 18 % and a LPN vacancy rate of 11 %. Nurses are actively engaged in the transformation of the health care system by placing more emphasis on prevention, wellness, and coordination of care.

Tribes continue to support efforts by the agency to engage in creative recruitment and retention practices for physicians and dentists, including allowing scholarships to be tax-exempt from income, shortening hiring times for medical professionals, and allowing fulfillment of service obligations through half-time clinical practice. Like most rural health providers, IHS has difficulty recruiting and retaining medical staff at many of its sites. As a result, patients experience very long wait times, and serious illness is often left untreated. Alternative solutions include: increasing funding to build staff housing on reservations and Alaskan Native villages, creating specialized residency programs within IHS to attract a service provider corps with more diversified professional expertise, allowing active military-service providers to fulfil their service obligations at an I/T/U health facility, and increasing professional development opportunities for existing staff. This, and more, needs to be done to effectively improve recruitment and retention of medical and health professionals at the Indian Health Service.

Overall, physician vacancy rates continue in the 20% range due to a shortage of physicians, particularly in primary care specialties. IHS is at a disadvantage to compete successfully with physician and dentist private sector salaries. Some IHS Areas experience vacancies for medical professionals up to five years. In the long-term, this means that clinics close, thereby denying care to AI/ANs. With a nation-wide physician shortage, this problem is growing. The I/T/U has seen a sharp rise in its reliance of itinerant providers to provide coverage. Use of itinerant providers can double, or even triple the cost outlay for providers as they usually demand a higher salary and rotate in and out on a monthly basis, costing more to cover temporary relocation expenses. While this is an adequate short-term solution for urgent coverage, the long-term impact on the quality of care and patient continuity of care affecting successful health outcomes is undeniable. Because IHS focuses on primary and community based care, the need to recruit *and retain* professional providers is key to successful disease prevention and treatment for AI/ANs. It is vital that the Administration work with Congress to be able to offer competitive pay rates and better working environments to ensure that providers are seeking out the IHS as a desirable place to work.

“The renewed focus on direct health care services comes at a crucial time for the agency's Great Plains Area. IHS is taking a number of actions, both in the short- and the long-term, to address these issues. The federal response includes deployment of needed staff from other IHS Areas and HHS operating divisions; strategies for long-term recruitment and retention of clinical staff; efforts by our IHS Quality Consortium and the HHS Executive Council on Quality; and training for personnel in the Great Plains Area.”

*Mary Smith, enrolled member of the Cherokee Nation, Newly appointed Principal Deputy Director for the IHS*

### **TRIBAL MANAGEMENT GRANTS +\$23,964**

The purpose of the Tribal Management Grant (TMG) Program is to assist federally recognized Tribes and Tribal organizations in assuming all or part of existing IHS programs, services, functions, and activities (PSFAs) under self-determination and operate these programs at the Tribal level. There has been a resurgence of interest in Tribes and Tribal consortia in exploring their option to exercise self-determination rights to assume management of health PSFAs, in part due to the ability to now recover Contract Support Costs. The Workgroup recommends an increase of \$24,000 to expand the grant offerings to Tribes, in addition to providing inflationary increases of \$46,000 for a total increase over the FY2017 President's Budget of \$70,000.

TMG also assists established self-determination contractors and self-governance compactors to further develop and improve their management capability and conduct health program planning.

The Tribal Management Grant Program provides discretionary, competitive grants to Tribes and Tribal organizations to conduct planning and evaluation, including the development of any management systems necessary for contract/compact management and the development of cost allocation plans for indirect cost rates; and to plan, design, and evaluate Federal health programs serving the Tribe, including Federal administrative functions. The program provides resources to allow Tribes to analyze PSFAs to determine if management by a Tribe or Tribal organization is practicable and develop the accompanying organizational and governmental infrastructure, as well as internal management systems needed to carry out effectively these PSFAs. This grant opportunity is an important resource for Tribal capacity-building and technical assistance needed to empower Tribes and Tribal organizations to exercise rights under the Self-Determination and Education Assistance Act. All federally-recognized Tribes and Tribal organizations are eligible to apply for Tribal Management Grants. Priority is given to newly recognized Tribes and Tribes and Tribal organizations addressing material audit weaknesses.

## **DIRECT OPERATIONS +\$2.8 MILLION**

The Direct Operations budget supports the leadership and overall management of IHS. This includes oversight of employees, facilities, finances, information, and administrative support resources and systems. Funding is allocated to IHS Headquarters, Area Offices, and Tribal shares. These funds ensure that the IHS is able to perform its essential residual functions in support of the I/T/U. In addition, it provides management support for direct service Tribes and system-wide administrative functions, contributing to better health outcomes for AI/ANs. The request includes \$544,000 for federal and tribal pay costs, \$527,000 for inflation, plus an additional \$2.8 million for program expansion. This additional funding is needed because in the President's FY 2017 budget request eliminates \$2.7 million from the Direct Operations budget. The Request explains that this funding was transferred to the H&C account to continue the intended purpose of the funds, however the Direct Operations program continues to be underfunded given its importance to other administrative functions within the Agency.

Another essential function of IHS' Direct Operations is Tribal Consultation. The agency is continually, and rightfully, consulting with Tribes and their representatives in Workgroups, advisory committees, and other negotiations. These meetings require not only support for basic meeting functions such as travel and facility space, but also technical support for Tribal leaders to engage in meaningful consultation. All of these functions are essential to maintaining the government-to-government relationship and the federal trust responsibility. Funds should be specifically allocated in FY 2018 to support technical advisors and meeting travel for these consultations.

## **SELF-GOVERNANCE +\$5.3 MILLION**

The Self-Governance budget supports negotiations of Self-Governance compacts and funding agreements, oversight and coordination of the Agency Lead Negotiators (ALN), technical assistance on Tribal consultation activities, analysis of new authorities in the IHCA, Self-Governance Planning and Negotiation Cooperative Agreements, and funding to support the activities of the Tribal Self-Governance Advisory Committee, which advises the IHS Director on Self-Governance policy issues. The request includes \$86,000 for inflation plus \$5.3 million to expand Self-Governance training and technical support in FY 2018. The total increase above the FY2017 President's Budget is \$5.4 million. With Tribes and Tribal consortia becoming more interested in understanding P. L. 93-638 and the detailed process involved if they are to exercise their option to assume management of health PSFAs, there has been a need to increase OTSG staffing to provide Self Governance 101 and advanced training nationwide.

Title V of the ISDEAA provides the IHS statutory authority to enter Planning and Negotiation Cooperative Agreements to assist Tribes in planning and negotiation activities associated with Self-Governance. Cooperative Agreement awards involve much more substantive Federal program-specific involvement than a grant, which is key to a successful Self-Governance planning and negotiation process. For those Tribes wanting to advance their efforts to enter into Planning and Negotiation Cooperative Agreements, more staff are required to respond to technical assistance requests.

These Cooperative Agreements provide resources to Tribes first entering self-governance as well as existing Self-Governance Tribes interested in expanding their current PSFAs. Title V of the ISDEAA requires that a Tribe or Tribal Organization complete a planning phase to the satisfaction of the Tribe. The planning phase must include legal and budgetary research and internal Tribal government planning and organization preparation relating to the administration of health care programs. The planning phase helps Tribes to make informed decisions about which PSFAs to assume and what organizational changes will be necessary to support those PSFAs. These Cooperative Agreements also provide resources to Tribes to help defray the costs related to

preparing for and conducting Self-Governance negotiations. This enables a Tribe to set its own priorities when assuming responsibility for IHS PSFAs and assist the Tribe during the negotiation of a self-governance compact and funding agreement. Self-Governance formalizes and recognizes the government-to-government relationship between the United States and each Tribe, and empowers Tribes to plan, design and carry out programs and activities that are most responsive to the health care needs of their communities. Also, additional staff time is required to participate in contract and compact negotiations for an increased number of Self Governance Tribes and Tribal consortia.

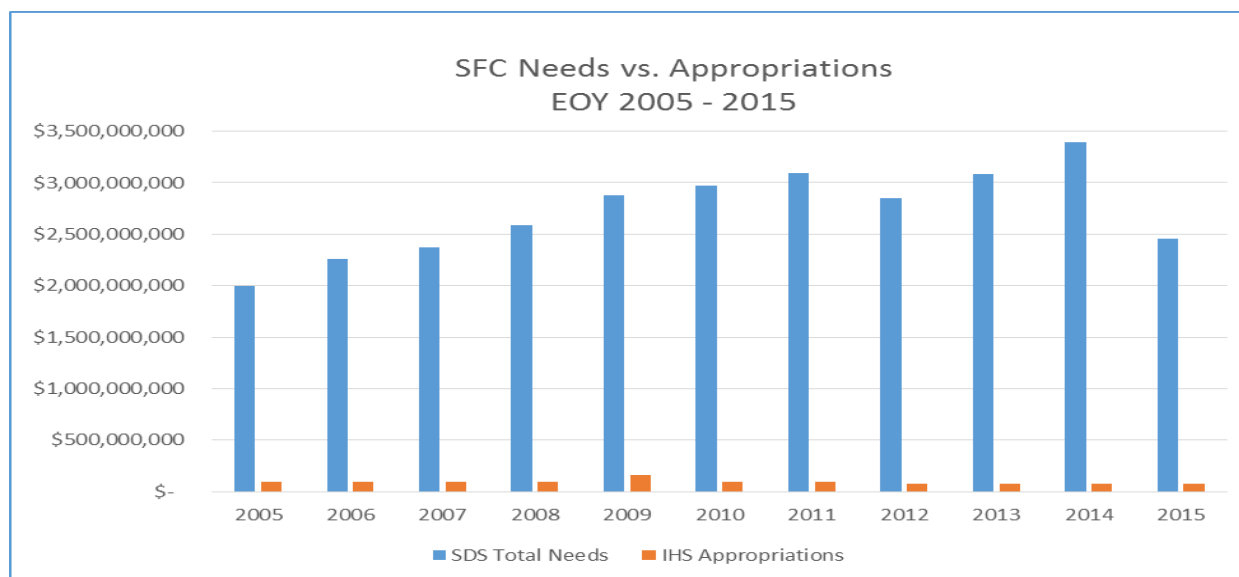
## **FACILITIES** *(See Appendix C)*

### **MAINTENANCE & IMPROVEMENT +\$43.7 MILLION**

The recommended increase for Maintenance and improvement (M&I) funds is \$45.842 million over the President's FY 2017 budget (included \$2.091 in inflation-proofing under current services and \$43.752 in program increases). M&I are the primary source for maintenance, repair, and improvements for facilities which house IHS funded programs, whether provided directly or through P.L. 93-638 contracts/compacts. The FY 2016 Maintenance and Improvement (M&I) funding is \$73.6 million which for the first time since 2010 fully funds sustainment and provides some funding for major repair projects. Tribes are appreciative of this additional funding to help sustain existing facilities and urge that these levels be maintained in FY 2018 and beyond.

### **SANITATION FACILITIES CONSTRUCTION +\$51.7 MILLION**

The recommended amount represents a \$54.739 million increase (\$3.011 million in current services for binding agreements + \$51.726 million in program expansion) above the FY 2017 President's Budget of \$103.036 million for the SFC line item. Due to the remoteness of Tribal communities and lack of infrastructure, the need for improvements and maintenance of water supply, sewer systems and solid waste facilities remain substantial. The Sanitation Facilities and Construction (SFC) program is an important Indian health disease prevention



program. It yields positive results by directly improving environmental conditions making a positive impact on the health of individuals on a day-to-day basis thereby reducing medical care costs. IHS estimates that about 47% of AI/AN homes were in need of improvements to sanitation in FY 2015. While 1% of the U.S. general population lacks access to safe water, 9% of Indian homes lack access to safe water.

Currently the SFC program has a backlog of over \$2.5 billion. With inflation, new environmental requirements, and population growth, the current sanitation appropriations are not reducing the backlog.

It has been proven that as the number of homes using available clean, safe water has climbed; the incidence of death due to intestinal disease in childhood has fallen. Decreased disease rates reduce medical costs. Therefore, increased funding to address this severe disparity, is requested. The additional resources would help to reduce the backlog of sanitation facilities needed to serve existing homes and would also address the need for sanitation facilities for eligible new homes being constructed annually.

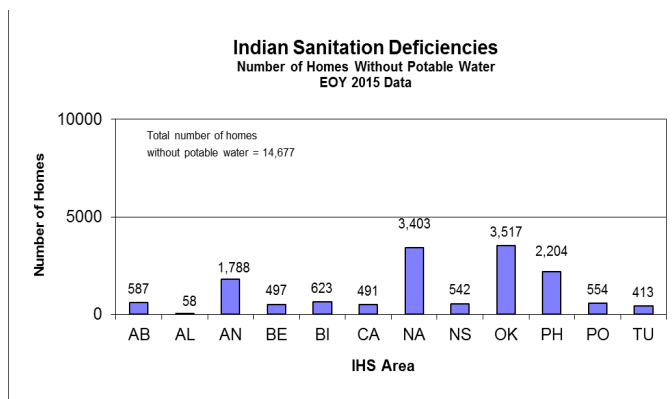
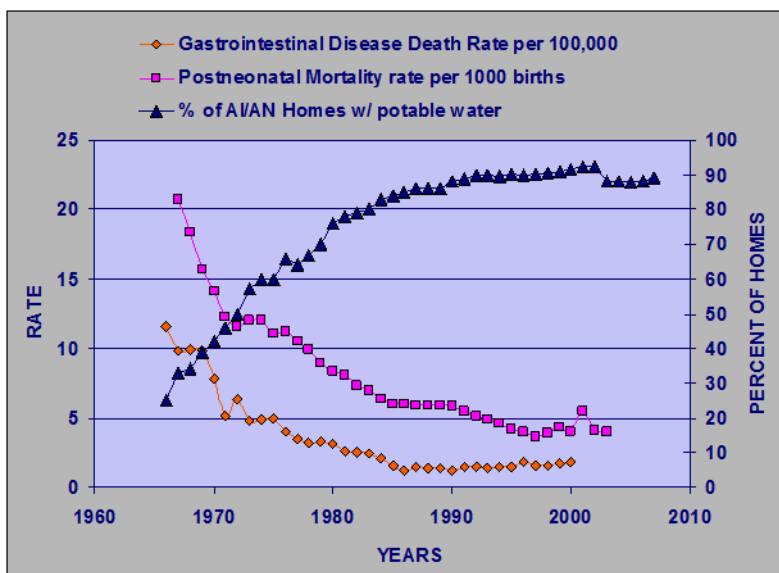
The provision of sanitation facilities is an extension of primary health care delivery. The availability of essential sanitation facilities can

be a major factor in breaking the chain of waterborne communicable disease episodes but by no means is their value limited to disease intervention. Safe drinking water supplies and adequate waste disposal facilities are essential preconditions for most health promotion and disease prevention efforts. Efforts by other public health workers are much more effective when safe water and adequate wastewater disposal systems are in place.

Patients admitted to the hospital have longer lengths of stay due to lack of sanitation facilities at home. An example of this is an elderly patient with a broken hip that should be discharged home but has no indoor water and sewer facilities and typically uses an outhouse located a long distance from the home. Many of these patients end up being admitted to nursing homes where exposure to nosocomial infections may worsen the chance of good outcome and return home.

The provision of sanitation facilities also has other far-reaching, positive effects. The availability of such facilities is of fundamental importance to social and economic development. In turn, such development leads to an improved quality of life and an improved sense of well-being.

A recent cost benefit analysis indicated that for every dollar IHS spends on sanitation facilities to serve eligible existing homes, at least a twentyfold return in health benefits is achieved. The IHS Sanitation Facilities Construction Program has been the primary provider of these services since 1960.



## **HEALTHCARE FACILITIES CONSTRUCTION +\$49.3 MILLION**

The Workgroup recommends a program increase of **\$49.3 million** for Indian Health Facilities over the FY 2017 President's Budget.

Tribes are keenly aware that the lack of facilities is a major barrier to access to adequate health care in Indian Country. As reported in the Facilities Appropriations Information Package (*see full report attached as Appendix B*) developed for the recently reactivated 2016 IHS Facilities Appropriations Advisory Board (FAAB), the number, location, layout, design, capacity and other physical features of healthcare facilities are **essential** for:

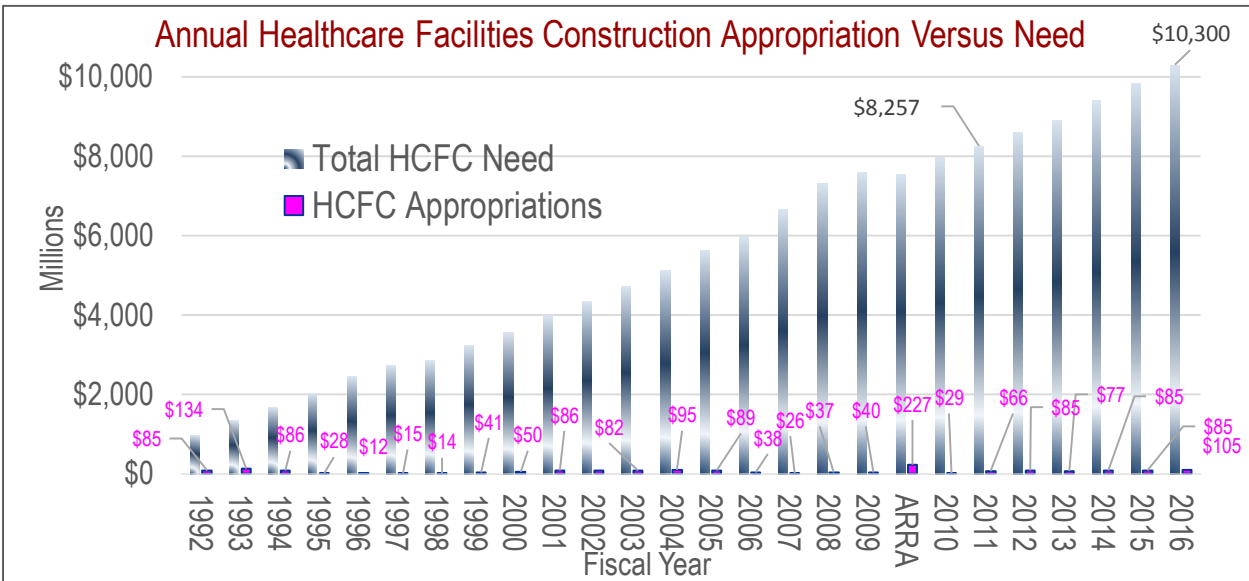
- Eliminating health disparities
- Increasing Access
- Improving patient outcomes
- Reducing O&M costs
- Improving staff satisfaction, morale, recruitment and retention
- Reducing medical errors and facility-acquired infection rates
- Improving staff and operational efficiency
- Increasing patient and staff safety

The IHS must provide funds necessary to begin construction of projects listed for decades on the IHS HCFC priority list and, additionally, by advancing partnerships with Tribes to implement a new national health care facility planning and construction system models.

Without a sufficient, consistent, and re-occurring HCFC appropriation the entire IHS system is unsustainable. The existing facilities are very dated with an average age of 47 years and have surpassed their useful lives. The facilities are grossly undersized for the identified user populations, which has created crowded conditions among staff, patients, and visitors. In many cases, the management of existing facilities have relocated ancillary services outside the main health facility; often times to modular office units, to provide additional space for primary health care services. Such displacement of programs and services creates difficulties for staff and patients, increases wait times, and create numerous inefficiencies within the health care system.

The report highlights that to replace IHS facilities every 60 years (twice a 30 year design life), would need HCFC appropriations of about \$500 million annually. Appropriations of \$1 billion annually is needed if we are to reduce the need by 95% by 2040. To match the comparable U.S. expenditure in healthcare facility construction, HCFC appropriations would need to be approximately \$750 million annually. In reality the average \$85 million current appropriate levels will mean that a new facility built in 2016 would not be replaced for 400 years! This is truly a disaster in the making if something is not done soon to make the proper investments in facilities needed to provide safe, quality care to American Indians and Alaska Natives.





### **FACILITIES & ENVIRONMENT SUPPORT +\$19.3 MILLION**

Facilities and Environment Support FY 2018 increased request is \$19.3 million over the FY 2017 President's request (includes \$8.697million in inflation and \$19.233 million in increases).

The Facilities and Environmental Health Support (FEHS) budget line item provides resources to staff and support its headquarters, regional, area, district, and service unit activities. The three major cost categories are:

#### **Facilities Support**

- O&M Staff for facilities and quarters
- Some utilities, and building supplies
- National IT maintenance management
- Construction management support

#### **Environmental Health Support**

- Staff and Operating costs at the IHS Area, District, and Service Unit levels for:
  - Environmental Health Services,
  - Injury Prevention,
  - Institutional Environmental Health, and
  - Sanitation Facilities Construction Staff

#### **OEHE Support**

- IHS Headquarters OEHE staff
- Engineering Services staff
- Direct support/management of overall Facilities appropriation services and activities.

The FEHS staff provides important levels of support to operate and maintain the real property and buildings in the Indian health care system. In addition, these professionals plan and design new and replacement facilities projects and support sanitation facilities construction and environmental health services activities.

Accurate clinical diagnosis and effective medical treatment depend in large part on health care providers using modern and effective medical equipment/systems to assure the best possible health outcomes. As the existing health care facilities continue to age, the associated building equipment and components deteriorate to a point of failure and the decreasing availability of replacement parts on this aged equipment ultimately disrupt the already limited health care services. For example, piping systems providing potable water for health services frequently experience failures, which require the systems to be shut down for extended periods of time and patient care discontinued until appropriate repairs can be made. The rural and often isolated conditions



associated with many IHS health facilities complicates the repair of failed systems and extends the time required to make needed repairs. The constant system failures deplete designated maintenance and improvement funds and require the use of third party collections or other funding sources that would otherwise be used for direct patient care. Furthermore, operating in these dilapidated facilities means that the Indian health system cannot take advantage of new healthcare technologies such as telemedicine or electronic health records in the same way as mainstream medicine.

A new health facility improves access to care and the quality of care by improving the design (functionality) and increasing the size of facilities to better support existing and new health services. When new IHS health facilities are approved for construction, the subsequent staffing packages provide additional providers and improved access to basic and expanded health care services. In addition, new IHS funded health facilities in remote and isolated areas typically include the construction of government quarters to provide suitable housing to support the recruitment and retention of medical professionals and ancillary staff.

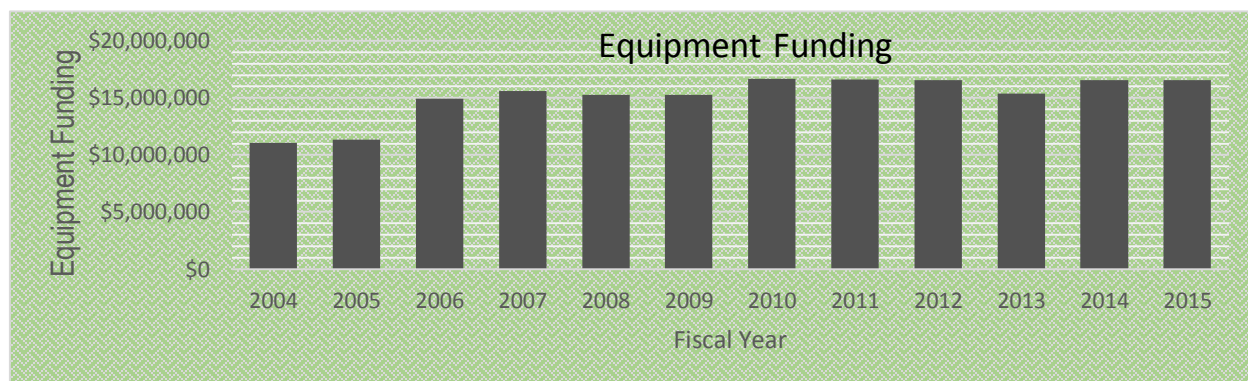
FEHS staff ensures that the IHS continues to demonstrate its commitment toward quality health care by maintaining their facility accreditation/certifications, undertaking quality improvement initiatives, and meeting established quality performance targets. A number of facilities seek The Joint Commission accreditation or Centers for Medicare and Medicaid Services (CMS) certification.

### **EQUIPMENT +\$8.7 MILLION**

The Workgroup recommends FY 2017 Equipment President's Appropriation is \$8.7 million which includes:

- \$17.3 million medical equipment funds to support existing IHS and tribal programs;
- \$5 million to support the initial purchase of equipment for tribally-constructed healthcare facilities;
- \$500,000 to acquire excess medical equipment from DoD or other sources through the TRANSAM program; and
- \$500,000 to procure ambulances for IHS and Tribal emergency medical services programs.

The IHS' medical equipment inventory is approximately 90,000 devices valued at approximately \$500 million. Below is the funding history from 2004 to 2015.



To replace the equipment on a 6 year cycle requires \$80 million annually or almost 4 times more than is currently provided. Tribes have put forward our urgent FY 2018 budget request which must prioritize the need for sufficient funds to address this looming crisis.

The current, yet antiquated, Health Facilities Construction Priority list contains over \$2.2 billion in unmet funding need for projects historically already on the list. New facilities needs are not reflected as this list has been closed for several year due to its severe backlog. While some Tribes have been successful in obtaining Joint Venture agreements with the IHS, this is not a substitute for the obligation to provide adequate facilities. The Joint Venture Construction program is an innovative partnership where the Tribe will build a facility with non-IHS resources upon agreement for a 20 year staffing package; not all Tribes have access to these alternative sources which creates another inequity in the system. Tribes clearly recognize that the current HFC Priority list is severely outdated and that the facilities needs issues needs serious analysis and updating. The FAAB must be tasked with accomplishing this in order to modernize the Indian healthcare delivery system and ensure that access to safe, quality care is a priority.

### **HEALTH INFORMATION TECHNOLOGY +\$46 MILLION**

The IHS/Tribal/Urban (I/T/U) Indian health system must use secure information technology (IT) to improve health care quality, enhance access to specialty care, reduce medical errors, and modernize administrative functions consistent with the Department of Health and Human Services (HHS) enterprise initiatives. A total of \$46 million is being requested for Health Information Technology: \$20 million will fund the improvement of the delivery of healthcare and the security of patient data through enhancement and modernization of the IHS Resource Patient Management System (RPMS); development, operations, and maintenance of capabilities for the Electronic Health Record; and support of technologies to meet healthcare quality reporting for the new Medicare Access and CHIP Reauthorization Act (MACRA) law and other initiatives. An additional \$20 million will fund the on-going cost for non-RPMS Commercial Health IT systems which numerous Tribes have deployed as a result of the lack RPMS capacity to support their health system needs. \$6 million will fund Clinical Application and Tech Support Workforce Development, as well as necessary research and development to leverage emerging technological advances to improve the delivery of healthcare and the security of patient data through the enhancement and modernization of the IHS RPMS.

The FY 2018 increase will support the new level of Operation and Maintenance costs and will allow the IHS to address continued improvements to the IT infrastructure and additional initiatives such as:

- **Enterprise Services** - Management and operations costs for enterprise systems that have been developed to upgrade for Medicare Access and CHIP Reauthorization Act (MACRA) and other initiatives, including at a minimum: Health Information Exchange (HIE), Master Patient Index, the Personal Health Record (PHR) patient portal, Electronic Prescribing, Terminology Services, centralized Pharmacy order checks, Practice Management Application suite and others.
- **Quality Reporting** - Analytical and technical work to accomplish alignment of measurement and reporting processes for various clinical quality reporting mandates including Government Performance and Results Act (GPRA), Medicare Access and CHIP Reauthorization Act (MACRA) Clinical Quality Measures. MACRA is a transformative law that builds a new, fast-speed highway to take the health care system away from the fee-for-service system and toward new risk-bearing, coordinated care models. Under the new law, quality reporting will be a significant for advanced alternative payment models (APMs) as well as the alternative Merit-Based Incentive Payment System (MIPS). Broadly, MIPS will build upon existing quality measure sets from the Physician Quality Reporting System (PQRS), Value-based Payment Modifier (VM), and Medicare EHR Incentive Program for Eligible Professionals. MACRA repealed the previous Sustainable Growth Rate (SGR) formula for PFS updates, and IHS must develop RPMS software which will meet the new requirements as they continue to develop.

Preparing for MACRA: As required by the statute, the proposed rule addresses measures, activities, reporting and data submission standards across the four performance categories. Key takeaways for each performance category include:

- **Quality:** CMS proposes that most MIPS-eligible clinicians would be required to report on at least six quality measures, including at least one cross-cutting measure (for patient-facing MIPS-eligible clinicians) and an outcome measure if available.
- **Resource use:** The proposed rule suggests continuing two measures from the current Value-based Modifier program: total costs per capita for all attributed beneficiaries and Medicare spending per beneficiary (MSPB) with minor technical adjustments. The Administration also proposes including measures based on episodes of care, as applicable to a MIPS-eligible clinician.
- **CPIA:** In the proposed rule, CMS regulators say they “generally encourage but are not requiring a minimum number of CPIAs.” Clinicians may select activities that match their practices’ goals from a list of more than ninety options, including activities focused on care coordination, beneficiary engagement, and patient safety.
- **Advancing care information (a change in terminology from meaningful use of certified electronic health record (EHR) technology):** The proposed rule indicates that MIPS-eligible clinicians would choose to report customizable measures, with a particular emphasis on interoperability and information exchange. Unlike the existing Meaningful Use program, this category would not require all-or-nothing EHR measurement and is intended to eliminate redundant quality reporting.

- **Process Improvement** – IHS will reengineer and retool its software development practice and custom support practice to be more agile, user-centric, and customer-focused to capitalize on the lessons learned from Meaningful Use Stage 2. This re-tooling is also necessary to keep pace with rapidly changing health IT environment.
- **Interoperability** – IHS will expand on its interoperability capabilities to support improved interoperability at the local facility level and to support the objectives of the ONC 10-Year Interoperability Roadmap.
- **Electronic Prescribing for Controlled Substances and Prescription Drug Monitoring** – IHS will implement solutions to align with standards and best practices for electronic prescribing and prescription drug monitoring for controlled substances.
- **Telemedicine and Mobile Health** – IHS will lead the development of an Indian health system telemedicine and mobile health strategy.
- **Identity and Access Management** – IHS will develop an integrated Identity and Access Management (IAM) strategy to facilitate adoption of mobile health and cloud computing technologies in a secure, user-friendly manner.
- **Data Quality and Governance** – IHS will begin formulation of a national data quality strategy to improve on performance reporting, quality reporting, and patient care.

- **Data Center Consolidation** - IHS seeks to reduce data center footprints and share technical expertise in the field. Although this should save long term maintenance costs, there will be a start-up investment for these transitions especially with the move of IHS to 5600 Fishers Lane in FY 2016.
- **Security Threats** - IHS HIT will be expected to continue to respond in a timely way to new security threats, regulatory mandates for government IT systems, and industry standards and best practices.
- **Affordable Care Act** - IHS HIT will be expected to support provisions of the Affordable Care Act (ACA) Arc #2 that calls for new data or data systems to implement new business processes or reporting requirements. Many of these requirements are still evolving in the regulatory process so their impacts on IHS HIT are not fully known.
- **Network Reliability** - IHS network will continue to require upgrades in order to achieve the necessary bandwidth and reliability recommended by the Federal Communications Commission (FCC) in order to support robust health information exchange required by MU and expanding telehealth initiatives.
- **Internet Protocol version 6 (IPv6)** - Network Operations Support Center (NOSC) in coordination with Area IT staff will continue to make progress with the implementation of IPv6.

Adding to the base OIT funding will ensure progress made in the past several years by keeping infrastructure costs as low as possible and maintaining a high level of productivity and commitment by both federal and contractor staff supporting the IHS-developed health information solutions. IHS uses open source tools where possible to minimize acquisition costs and is reducing use of more costly assisted acquisition providers such as the General Services Administration. This small investment is necessary to deter migration to Commercial Off-the-Shelf Systems (COTS) which has the potential to unnecessarily increase costs at Tribal facilities.

It is well understood within Indian Country that the rising digital divide between the IHS/Tribal/Urban (I/T/U) and other U. S. Health providers will continue to persist without appropriated financial resources, resulting in real impact on patient care quality and safety. While the successful application of health IT has the potential to transform how health providers collect, manage, store, use, and share health information, the significant lack of IT investments to support the Indian Health care system has created a health IT crisis for Indian Country. Health IT helps remote communities coordinate care, improve disease surveillance, target health education, and compile regional data, all activities that improve health (National Advisory Committee on Rural Health and Human Services, 2008). EHRs and other health IT tools facilitate a culture of health data management and sharing which can create a tremendous impact on patient care and health outcomes, particularly in primary care settings. The lack of overall health resources in the I/T/U sharpens the degree to which these IT disparities are experienced and assuaged.

## OIT RPMS Great Plains: Case Study of Elbowoods Memorial Health Center

One of the largest issues is the centralized approach to RPMS support and training at the Area level. Tribes have often kept their IT shares at Area but are not receiving the necessary support or training on how to use the various different business and clinic applications. This has led to huge gaps in the delivery of services. Elbowoods has no Site Manager or Clinical Applications Specialist; although they are actively seeking to hire these staff they have yet to be trained by Area or IHS. Because of this, not only does the staff suffer and fall under duress, but it directly affects the patient.



The staff at Elbowoods are not trained on how to use the third party billing and accounts receivable packages, because of this they have not billed out in over a year. To compound the issue, due to the fact that they had no RPMS knowledge staff (site manager and CAC) they struggled with simple tasks such as adding a location of a clinic or service for billing, table maintenance of insurance files, Medicaid and Medicare set up, and fee schedules.

This created a dependency on the Area Office, consultants and IHS. The Service Level Agreements were not comprehensible and expectations were not being met. Simply put, they didn't have the support needed to learn the system (EXAMPLE: there are no IHS Basic Site Manager classes being offered in the next year nor was there any Great Plains Basic Site Manager Classes being offered).

This scenario was exacerbated with repeated attempts to hire a CAC; after not being able to hire, they sought training opportunities for existing staff. Because IHS and Area Staff were too overwhelmed, six months ago they moved to the hiring of consultants to avoid catastrophe.

Some of the major RPMS/EHR issues are:

- Lack of training and knowledge of the RPMS EHR at the local area
- Lack of timely area support
- Lack of IHS general support
- Improper use of TIU note templates
- Non Use of Clinical reminders and decision support tools
- iCare Population Health Management tools not being installed on any of the machines, nor knowledge of what it even was
- Little to no onboarding of the Clinical Information System
- Issues with Pharmacy and Scriptpro interface
- Lab configuration
- GPRA taxonomies where in many cases blank, therefore affecting their GPRA scores

At the local level, the site wasn't even able to add a user, provider, printer or patch to RPMS and since they were on the D1 network, they had to go through the Area just to add a user profile.

In the last 6 months Elbowoods has made great leaps and strides. Staff have been trained on EHRs, workflow, access, Clinical Reminders, iCare, and case management approaches. They have also had help recently with business office functions and look to begin back billing. With more training these sites can soon become independent and self-sufficient.

Internally, the I/T/U have identified four key system-wide challenges which create barriers if not addressed: 1. Significant regulatory and legal barriers to interoperability to be able to serve customers and potential customers from over 567 tribes at federal and non-federal tribal and urban entities across 35 states with differing specifications and requirements. 2. Serve a predominantly rural population in areas without reliable high-bandwidth internet. 3. Develop and maintain affordable HIT solutions that meet ever increasing customer and stakeholder expectations in environment of increasing labor and technology costs. 4. Financial resources in environment of relatively flat recurring funding and reduced incentives for adoption and utilization of HIT.

The American Recovery and Reinvestment Act of 2009 (ARRA) set forth a plan for the advancement of a nationwide health information network to improve the quality and efficiency of care. Central to this vision is the widespread adoption of electronic health records (EHR) including how to manage the unique financial, structural and human resources that affect the successful implementation of health IT. Simply put, there has not been the resources available within existing appropriations to meet the growing unfunded requirements to fully transition all I/T/U providers and hospitals to a certified

EHR, nor to continue to support sites to meet the CMS EHR Incentive Programs Objectives and Measures for Eligible Providers and Eligible Hospitals and Critical Access Hospitals (CAHs) through 2017 and beyond.

#### **Benefits of Health IT**

- Decrease medication errors
- Reduce redundant tests
- Better utilization and compliance of evidence based practices
- Improve access to critical information
- Improve documentation
- Improve chronic disease management

While IHS OIT limited resources have been necessarily devoted in the short term toward developing the certified-EHR and writing CMS Meaningful Use standards, it is critical to take a strategic approach that does not continue to ignore the day-to-day operational management and maintenance of both RPMS and non-RPMS systems. Limited IT resources were directed in FY2014-16 to meet new unfunded mandates to transition I/T/U facilities to ICD 10 and to address Stage 1 and 2 of the CMS Meaningful Use requirements. This has forced the IHS to forego other software development upgrades and user-requested “fixes” which have direct impact on patient care and revenue capture, creating another digital divide for Tribal health programs. Many Tribal facilities have had to divert funding to pay for Commercial Off-the-Shelf (COTS) solutions in order to keep their operations going. The industry recognizes that Health IT is no longer just a business solution but has evolved to become a necessary extension of patient care; it is imperative that current investments in IT be managed with dedicated resources and stable funding for on-going capital planning and investment. Quality integrated wellness is highly dependent on comprehensive, user friendly, and modern electronic health record (EHR) systems. Health Information Technology (HIT) is a vital component in the healthcare delivery system, especially with the progression of comprehensive healthcare with the patient at the center of all decisions and coordinated care. Capital Planning and Investment Control (CPIC) makes sure that IT investments line up with the IHS mission, goals, objectives, and supports business needs, while minimizing risks and maximizing returns throughout the investment's life cycle.

The future of I/T/U quality reporting is twofold: centralization of national, clinical performance reporting from all available data sources and alignment of clinical measures with national standard measures, where appropriate. To support this effort, IHS has been building a national reporting system that will produce aggregated, clinical performance measure results from the new centralized Integrated Data Collection System Data Mart (IDCS DM) housed within IHS’ National Data Warehouse (NDW). Measure results will be calculated using any data (RPMS, non-RPMS or Purchased/Referred Care) submitted to the NDW. IHS will generate national results from IDCS DM beginning in FY 2017 for internal tracking and report exclusively from the IDCS DM in FY 2018. During FY 2016, IHS will consult with Tribes and confer with Urban

programs on the transition to this new performance reporting system. Since 2002, IHS has reported population level, electronic performance results for GPRA/GPRAMA clinical measures. IHS's current clinical performance reporting is from the Resource and Patient Management System (RPMS) Clinical Reporting System (CRS) and Tribes have long advocated that non-RPMS data included.

Using a new enhanced reporting system provides IHS with the ability to report on performance results for the I/T/U system by allowing Tribes and Urban programs with commercial Electronic Health Records (EHRs) to include their data in national results. This means IHS might be able to increase national performance data collection since performance results will expand to represent data submissions from the IHS I/T/U User Population. Until the IDCS DM is live in FY 2018, measure results will continue to be electronically calculated on local RPMS servers and aggregated nationally to produce two interim reports and one final report annually, and IHS results will include federal sites and tribal sites reporting from RPMS only.

Since the IDCS DM will use all data exported to the NDW including non-RPMS tribal and urban data, budget measures previously reported from CRS will be revised for the following reasons:

- **Updated Data Source:** IHS's clinical performance calculations will be from IDCS DM;
- **User Population Estimates:** The IDCS DM will standardize the use of the User Population estimates as the denominator for the clinical GPRA/GPRAMA measures;
- **Reporting Year:** The GPRA/GPRAMA year of July 1-June 30 will change to match the User Population estimates year of October 1-September 30.

IHS users will be able to access secure, web-based reports. Compared to three aggregated CRS reports annually, IDCS DM reports will be as current as the last weekly data refresh in the NDW. This direction aligns with the Affordable Care Act's *National Strategy for Quality Improvement in Health Care* as well as the HHS Measurement Policy Council's (MPC) efforts to align core performance measures. More frequent measure results will inform program decision making and provide opportunities for course correction during the report year.

While Tribes remain optimistic that the IDCS DM will address current health information exchange gaps within the I/T/U system, Tribal consultation is still ongoing to ensure that Tribal concerns are addressed through this new system. Specifically, that Tribal data ownership, access and use are protected by policies which respect Tribal sovereignty and allow access to data to run local reports; that policies be streamlined to eliminate barriers which make it difficult for Tribes to voluntarily report national GPRA and other performance reporting; and that measures be aligned with HRSA and other nationally accepted industry standard measures which allow for self-validated information to be accepted and incorporated.



Investments in IT enhance organizational performance. When carefully managed, IT can improve business processes, make information widely available, and reduce the cost of providing essential Government services. As IT rapidly evolves, the challenge of realizing its potential benefits also becomes much greater. It is imperative that the I/T/U health system is not left behind as the rest of the country advances its use of technology to improve health care outcomes.

**A Tribal Testimonial on the Urgent Need for IT Modernization & Investment**

The Resource and Patient Management System (RPMS) is the program used by a majority of Indian health programs. RPMS, which was previously used by the Veterans Administration (VA), is considered archaic by some users. The VA's decision to switch systems supports this belief. This program is still in use by many Indian health programs as a result of federal funding allocated to the Office of Information Technology (OIT) and the Government Performance Reporting Act (GPRA) which requires specific healthcare measures captured in RPMS to be reported. The very essence of HIT is "to improve health care delivery and quality, enhance access to care, reduce medical errors, and modernize administrative functions" (Department of Health and Human Services FY 2017 Indian Health Services Performance Budget Submission to Congress).

***A system that plays such a vital role in health care should receive dedicated funding and attention. However, the current funding that is allotted to RPMS is seemingly an afterthought.***

One specific challenge is the referrals system within RPMS. When a referral is made from a primary care provider, this process takes several steps and is difficult to track, creating time delays, missed opportunities, and a challenge in ensuring follow-up care. For a country that has put various resources and time into improving health care access and quality, the Indian health system certainly doesn't evidence that commitment. Other experiences include a California Area Indian Health Program spending almost \$22,000 out of their own revenue to support a bi-directional interface with a second lab. This price does not include the buyback that was needed for additional services from IHS which was charged at just short of \$23,000. These financial figures do not capture the time and almost two years that have been spent on the project with still no resolution. This hindrance absolutely impacts the quality and continuity of care for patients. Additionally, letters have been written in the past to respective Area Offices to express frustration due to the timeliness of updates. For example, Patch 13 was rolled out with a lack of timely information and full understanding of the contents, the impact that the rollout has on patient services, and the lack of resources allocated to this new initiative. In previous meetings it has been made clear that IHS Headquarters has not been allocated sufficient funds to allow the Area Offices to improve IT. IT funding is a backbone to delivering quality patient care. With the recent change to ICD-10, the lack of readiness in the system has been greatly emphasized. The insufficient dollars of the system takes away from health care delivery, the very heart and purpose of Indian Health Services. Employees are committed to providing quality and continuity in health care and the system to support these personal commitments is a critical element in achievement.

### ***3RD RECOMMENDATION: PROVIDE DEDICATED FUNDING TO BEGIN IMPLEMENTING PROVISIONS OF THE INDIAN HEALTHCARE IMPROVEMENT ACT***

Indian Healthcare Improvement Act was permanently reauthorized as part of the ACA in 2010. This historic law has opened up many new opportunities for the Indian health system, but not all provisions have been equally implemented - representing yet another broken promise to Indian Country. With the passage of the Patient Protection and ACA, the American health care delivery system has been revolutionized while the Indian healthcare system still waits for the full implementation of the IHCA. For example, mainstream American healthcare increased its focus on prevention as a priority and coordinated mental health, substance abuse, domestic violence, and child abuse services into comprehensive behavioral health programs and is now a standard of practice. Replicating these same improvements for Tribes in the IHCA was a critical aspect of the reauthorization effort. Tribes fought for over a decade to renew IHCA and it is critical for Congress and the Administration to ensure that the full intentions of the law are realized.

To provide context for how much of the law has not been implemented, the follow represent several categories of programs that have not been implemented and funded:

**1) Health and Manpower – 67% of provisions not yet fully implemented.**

- Includes: establishment of national Community Health Aide Program; demonstration programs for chronic health professions shortages

**2) Health Services – 47% of provisions not yet fully implemented**

- Includes: authorization of dialysis programs; authorization hospice care, long term care, and home /community based care; new grants for prevention, control and elimination of communicable and infectious diseases; and establishment an office of men's health.

**3) Health Facilities – 43% of provisions not yet fully implemented**

- Includes: demonstration program with at least 3 mobile health station projects; demonstration projects to test new models/ means of health care delivery

**4) Access to Health Services – 11% of provisions not yet fully implemented**

- Includes: Grants to provide assistance for Tribes to encourage enrollment in the Social Security Act or other health benefit programs

**5) Urban Indians – 67% of provisions not yet fully implemented**

- Includes: funds for construction or expansion of urban facilities; authorization of programs for urban Indian organizations regarding communicable disease and behavioral health

**6) Behavioral Health – 57% of provisions not yet fully implemented**

- Authorization of programs to create a comprehensive continuum of care; establishment of mental health technician program; grants to for innovative community-based behavioral health programs; demonstration projects to develop tele-mental health approaches to youth suicide; grants to research Indian behavioral health issues, including causes of youth suicides

**7) Miscellaneous – 9% of provisions not yet fully implemented**

- Includes: Provision that North and South Dakota shall be designed as a contract health service delivery area

Clearly, a plan must be put in place to ensure that the intended benefits of this law are actually realized. For FY 2018, the TBFWG has prioritized five provisions of the IHCA for additional funding on top of regularly-appropriated IHS base funding. It is critical that additional funds be allocated so the full implementation of these

programs can continue without compromising other critically needed services. We urge the Administration to add appropriations to the FY 2018 request so that the dream of the IHCI can finally become a reality.

### **SECTION 205: LONG TERM CARE SERVICES [25 U.S.C. § 1621D] + \$37 MILLION**

The treatment and medication management that is unique to the elder population requires the development of specialized geriatric capabilities within the I/T/U health care system. The care of elders is a culturally inherent trait that provides an important part of maintaining our cultural knowledge and wisdom to strengthen our families and communities. It was the consensus of the TBFWG that with the expanded authority of Long Term Care under the Indian Health Care Improvement Act, this needs to be fully supported and funded.

- Elder care accounts for approximately 18% of ambulatory visits for acute complaints, chronic disease follow-up or hospitalization.
- There is a need for expanded inpatient and outpatient clinical services. Including basic primary and secondary tertiary care, increased recruitment and retention for gerontology specialists, nurse practitioners, and social workers with specialized training in elder care.
- The growth of the elder population has increased and will continue to grow as the baby boomers age.
- Long-term care is not funded nor is it a service that IHS currently provides.

### **SECTION 204: DIABETES PREVENTION, TREATMENT AND CONTROL [25 U.S.C. § 1621C] +\$20 MILLION**

Diabetes continues to be prevalent in Tribal Nations across the U.S. with prevalence rates as high as 24.1% in some IHS areas. The IHS continues to work with Tribal Nations in providing resources and best practices to Tribes in an attempt to reduce diabetes rates and the complications that go along with a diagnosis of diabetes. Additionally, the Special Diabetes Program for Indians has provided Tribal Nations with resources to fight diabetes at the local level, with funding being used for the prevention and treatment of diabetes, however, additional work is needed.

According to 2013 data extracted from United States Renal Data System, 67% of incident ESRD cases among Native Americans had diabetes listed as the primary cause.<sup>8</sup> This correlation is troublesome to Tribal Nations and the Tribal citizens they serve given the high diabetes prevalence rates within their Nations. In a guidance document that was produced by the Indian Health Service in September of 2014, IHS reported that, “American Indians/Alaska Natives (AI/AN) experience high rates of End Stage Renal Disease (ESRD), severe kidney disease which results in a need for renal replacement therapy (dialysis or transplant) to sustain life.”<sup>9</sup>

Section 204(d) DIALYSIS PROGRAMS: “authorizes the Secretary to provide, through the Service, Indian Tribes, and Tribal organizations, dialysis programs, including the purchase of dialysis equipment and the provision of necessary staffing.”

Through the FY 2018 National Tribal Budget formulation process, Tribal Nations identified section 204(d) as a funding priority due to the high rates of Diabetes and ESRD throughout Indian Country. Because of the

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<sup>8</sup> Personal communication with Dr. Ann Bullock, IHS Division of Diabetes and Treatment, Director/Clinical Consultant

<sup>9</sup> Guide to the Development of Reservation-Based Dialysis Services

complexity in establishing dialysis centers, Tribal Leaders requests that funding be provided in the FY 2018 appropriation to the Indian Health Service/Tribally Operated Facilities/Urban Facilities (I/T/U) that desire to conduct needs assessments that will assess in part or fully the need for an I/T/U dialysis center. The needs assessment will consider the following:

- Environmental and Community Health Factors to consider in the establishment of a center
- Population Served
- Services offered (i.e. in-center hemodialysis, chronic ambulatory peritoneal dialysis, etc.)
- Quality of life difference by providing dialysis services locally
- Facility needs (i.e. personnel, land, water supply, etc.).

#### **SECTION 704: COMPREHENSIVE BEHAVIORAL HEALTH PREVENTION AND TREATMENT PROGRAMS [25 U.S.C. § 1665C] +\$20 MILLION**

Chronic underfunding, lack of sufficient services, limited access, and mismatched application of knowledge methods of healing have plagued Indian Country and Indigenous peoples for generations. The cumulative effects have become more apparent and devastating, as highlighted in recent visits by President Obama with Indian youth. Indian youth are more likely to attempt and complete suicide, be victims of interpersonal violence, use alcohol and drugs, drop out of school, and be over-represented in the justice systems. The burden of behavioral health problems (mental illness, substance abuse, and trauma) continue to erode the foundation of American Indian/Alaska Native (AI/AN) families, communities, and tend to overshadow the contributions of Native peoples to the strength of the United States. Many great culturally-appropriate programs have started only to be lost due to grant structures and barriers, limited timeframe for funding, and changes in political priorities and administrative attitudes. This cycle of support and then loss, compound the historical trauma of loss and marginalization that forms the foundation of much of the damaging behavioral and health indices in Indian Country.

While recognition of trauma as the organizing aspect of individual victim(S) in general behavioral health is an accepted truth, this same understanding hasn't fully penetrated the conceptualization of how Trauma (historical) affects AI/AN Peoples as a whole or their community structures and relationships. With a historical trauma foundation punctuated with ongoing existential and personal trauma, the introduction and implementation of successful Trauma Specific and Trauma Informed Care (TIC) principles and tools must be planned, resourced, executed, and sustained. Evidence is broad and compelling that such global and local trauma informed transformation, done with cultural sensitivity, would positively impact the behavioral and physical health of AI/AN Peoples and communities. While some tribes have embraced TIC, a concerted and consistent approach using Implementation Science has been too limited and locally-contained. TIC is a model which demonstrates an approach which can significantly impact the youth while helping parents, Elders, and communities. Collaboration within a TIC framework for all health services, incorporating the cultural holistic worldview of Native Peoples, would address this injured Identity foundation. Wellbeing follows relief and ultimately resolution of trauma.

Access to innovative evidence based practices within the TIC framework requires the use of IT services and electronic tools. Within the use of IHS' IT framework should be adoption of proven IT based tools increasing retention, engagement and outcome in behavioral health and associated health services. One such unanimous evidence-based-process gaining successful results is called Feedback Informed Treatment (FIT). A real-time, quick cycle of feedback focused on the immediate therapeutic relationship, FIT can bridge known barriers. Specifically, known barriers include a mismatched understanding of wellbeing, cultural mismatch due to cross-

culture service providers, and the nature of behavioral health issues cycles in Native communities. It is proposed that innovative, successful programs like the FIT model be expanded as pilot projects within the IHS IT capacity building. It is important that we seek new successful models to break the cycles of BH crisis within our AI/AN communities.

***A Provider's Story:***

***I worked in the Aleutian Islands of Alaska for 10 years in Unalaska and the smaller villages of Atka and Nikolski. I loved my job working with the Unangan people of the area. I felt like I was making a difference in people's lives and found the work very rewarding. As a medical professional, there were many challenges that came with the job. The challenges included working as a sole provider, cost of travel for CME and family visits, and lack of coverage...It would be my desire that the Indian Health Service and Tribal health system could find a better staffing solution which prevents burnout and provides support for providers working in remote sites. I know recruiting for permanent staff would be easier if this were the case.***

***Sincerely,***

***Annette Siemens***

***Annette Siemens, FNP, MSN, MPH, PhD***

Equally underfunded is the formation of and collaborative informing of a local system of supports. The importance of peers, paraprofessionals, and local supportive adults and others in the recovery of substance abuse, trauma, and severe mental illness is well-known. While AI/AN cultures have these naturally, too little universal emphasis with training, support, and interdependence with Western science has been resourced. Without this vital aspect of intervention, the cycle is only temporarily interrupted. Programs like the RWJF Health Nations, where support was over ten years and local program autonomy was nudged with science and trainings, should serve as an example. Practice based evidences should be the vision of outcomes and efficiencies.

The effects of underserved behavioral health issues are not restricted to the tribal homeland. The cascade of cost, both human and tax payer, reach adjacent communities, state systems, and the health measures of the US. Outside the obligations of treaties, the human toll and impact of the soul of America should spur greater funding and more foundational infrastructure and culturally-effective interventions. Funding for Indian Country behavioral health should parallel the analogy of immunities, a big, universal dose early and upfront of the rising epidemic, with a consistent follow-up and boosters as regular intervals. The epidemic is here, known, and worsening.

**SECTION 123: HEALTH PROFESSIONAL CHRONIC SHORTAGE DEMONSTRATION PROJECT [25 U.S.C. § 1616P] + \$15 MILLION**

The IHCIA authorizes the Secretary, acting through the Indian Health Service, to fund urgently needed demonstration programs for Indian health programs to address the extreme chronic shortages of health professionals. This will allow IHS and Tribes to provide direct clinical and practical experience within an Indian health program to health profession students and residents from medical schools. Tribal hospitals that have had the opportunity to add small residency programs have demonstrated that this is an effective way to introduce

potential providers to the health delivery system, making it easier to recruit. It also provides a teaching opportunity for physicians who are transitioning out, thereby reinforcing continuity of care for patients being served.

As noted in the health professions section of this budget document, the vacancy rates for medical and behavioral health providers is very high, especially on remote Indian reservations and rural Alaskan villages. Many sites find bandage relief for coverage by hiring locums; however, this comes at a much higher cost in part due to the market shortage pricing but also due to the added costs of transporting providers in and out of communities for 1 week to 3 month assignments. The unavailability of adequate temporary housing has also been cited as being an issue for so innovative solutions need to be found through these demonstration projects. We have seen some providers get right back on the plane once they see that where they will work and live is below their personal standards. It is no surprise that rural communities must compete with better equipped and supported urban centers for providers. In some cases, Community Health Aide/Practitioners, midlevel and physician primary care providers have to provide 24/7 coverage without immediate access to the necessary equipment and facilities to adequately address emergencies. Transferring to the next level of care is often not immediate due to access issues including geographic distances, weather delays, and facility availability. This creates immediate burn-out and stress, making it difficult to retain staff for any length of time. Having additional staff to fill on-call shift rotations and coverage for trauma emergencies is urgently needed in most rural facilities. Demonstration programs might address ways to alleviate burn out situations by offering incentives and rotation assignment partnerships with other more desirable located sites.

Providing sustainable solutions to address chronic shortages will also be a major step forward to improve the quality of health care for Indians by ensuring routine access to qualified health professionals. Continuity of care and care coordination easily fall through the cracks for patients when they do not have access to a model of care such as a patient centered care team. While IHS and the Tribes are making great progress in promoting the concept of an Indian Patient Medical Home and Improving Patient Care model within its system, chronic shortages creates enormous challenges to sustain improvements.

The Indian Health System has had tremendous success with developing alternative provider models which address provider shortages with limited resources. The Community Health Representative program and Community Health Aide/Practitioner programs are excellent provider-extender models which have been successfully implemented in remote communities for decades. IHCA new demonstration projects will provide academic and scholarly opportunities for health professionals serving Indians by identifying all academic and scholarly resources of the region; and will reinforce the ability to Tribes and the IHS to provide necessary training and support to promote the expansion of alternative provider types. It will build the capacity and skill levels for community health representatives, and community health aides, and develop training models and incentives to create more behavioral health aides and dental health aide therapists to fill service gaps across Indian country. Obtaining timely training is a current urgent issue facing many existing training centers. Lack of funding for training staff and facilities forces some new hires to wait up to 1 year to obtain their first certification training session. Others wait up to 5 years before they are sufficiently trained and certified to work independently without direct supervision. We must act to build the capacity for these alternative programs in order to ensure that current staff is supported and to make it an attractive career option for those interested in working in health professions but are unable to commit to medical school. This highly cost-effective alternative program has the added benefit of creating job opportunities in economically distressed rural communities and contributes to the holistic well-being of the community when providers are trained from the local workforce.

We urge the immediate formation of a program advisory board for the chronic shortage demonstration program, as called for in the Act, to be composed of representatives of tribal governments, Indian health programs, and Indian communities in the areas to be served by the demonstration programs. The advisory board will be instrumental to help guide the design of innovative chronic health professions solutions and will accelerate the spread best practice solutions throughout the Indian health system.

#### **SECTION 705: MENTAL HEALTH TECHNICIAN PROGRAM [25 U.S.C. § 1665D] +\$5 MILLION**

As noted above, mental health and provider shortages continue to be one of the most acute problems for Tribal communities. This provision would allow AI/ANs to be trained as mental health technicians to provide community-based mental health care to include identification, prevention, education, referral, and treatment services. According to the law, the Secretary shall provide high-standard paraprofessional training in mental health care and shall ensure that the program involves the use/promotion of traditional health care practices of Indian tribes to be served.

With behavioral health shortages experienced around the country, Tribes believe that this is an innovative solution to improve the ability for our people to get access to adequate care. In many remote areas of Indian Country, medical professionals are simply not available, so youth and other experiencing mental health crises have nowhere to turn. One young girl living on the Pine Ridge reservation recently reported at a Congressional briefing in the Senate Committee on Indian Affairs, that her family could have benefited from family counseling but no one knew where to turn. The youth in the community report feeling hopeless, ignored, and fall through the system, which can ultimately result in suicide attempts. Funding of the Mental Health Technician Program at IHS will provide this important lifeline for so many native youth throughout the system.

#### ***4TH RECOMMENDATION: ADVOCATE THAT TRIBES AND TRIBAL PROGRAMS BE PERMANENTLY EXEMPT FROM SEQUESTRATION***

In FY 2013, Indian health programs were subject to a 5.1 % automatic, across the board cut. This means a staggering \$220 million left the IHS, which already is under funded by an average of 41%. Several Members of Congress publicly stated that this was clearly an oversight, and that IHS should not have been held to the full sequester. Nevertheless, Tribes and federally run IHS direct service programs were left with an impossible choice – either deny services or subsidize the federal trust responsibility. In fact, many did close their doors for several days per month and forced others to deliver only PRC for Priority I. The Indian Health Service is one of only four federally funded services providing direct patient care; however, it was the only one of the four, not exempted from sequestration. This oversight, which created an unsafe hardship for Indian patients seeking care, must be permanently corrected.

“We can put forth the best words that we want... but unless we back it up with money, it is just that – its bologna. In the end, we’re never going to be successful if we don’t deal with what it costs to treat people in medicine – you can’t do it with half.”

– Senator John Tester (D-MT),  
February 3, 2016

For fiscal years 2014-2016, Congress has found a way out of sequestration for discretionary programs. However, the Budget Control Act (BCA) (P.L. 112-25), has mandated sequestration each year through FY 2021. Indian health simply cannot take any more sequestration cuts. Section



256 of the BCA explicitly holds IHS to 2% for any year other than FY 2013. However, with an already underfunded rate of 50% for the IHS, even a 2% cut is too much. Tribes should not be held responsible for the inability of the federal government to balance its books.

Should sequestration occur in FY 2017 or FY 2018, the Workgroup encourages the Administration to work with Congress to ensure that Tribes do not find themselves in this situation again, and the FY 2018 budget should reflect that commitment by permanently exempting the IHS from sequestration.

### ***5TH RECOMMENDATION: SUPPORT ADVANCE APPROPRIATIONS FOR THE INDIAN HEALTH SERVICE***

With the ongoing polarization in Congress, passage of a timely budget has become increasingly difficult and Continuing Resolutions (CRs) have become the appropriators' solution of choice in an effort to avoid a government shutdown. Since FY 1998, there has been only one year (FY 2006) when the Interior, Environment, and Related Agencies budget, which contains the funding for IHS, has been enacted by the beginning of the fiscal year. The lateness in enacting a final budget during that time ranges from 5 days (FY 2002) to 197 days (FY 2011).

The negative consequences for the Indian Health Service and Tribes have been substantial. Under CRs, annual funding levels are uncertain and timing of payments are unknown. Health Services must be limited to the funding in hand, new grant awards are put on hold, and provider recruitment grinds to a halt. In short, funding delays for health services can be measured in lives lost. Tribal health programs cannot enter into contracts with outside vendors and suppliers. In some cases, Tribal health programs are forced to take out private loans to cover the costs of expenses between the start of the fiscal year and the time when Congress passes a full budget. All these inefficiencies take away funds an already starved health system. Advanced appropriations can help mitigate such catastrophic effects. For the same reasons, Congress now provides advance appropriations for the Veterans Administration medical accounts.

Advanced appropriation identifies the level of funding available for the IHS in the appropriations process one or more years before it is applicable. Thus, advanced appropriation provides more certainty to operate the Indian health care delivery system. This change in the appropriations schedule will allow Indian Health programs to effectively and efficiently manage budgets, coordinate care, enter into contracts, and improve health quality outcomes for AI/ANs. Advanced appropriations for IHS would support the ongoing treatment of patients without the worry if—or when—the necessary funds would be available. Health care services require consistent funding to be effective. Advanced appropriations will help the federal government meet its trust obligations to Indian Country and bring parity to this federal health care system at no additional cost.

As in past years, the TBFWG continues to request that the Administration support Advance Appropriations for IHS in its FY 2018 Budget Request.

## Conclusion

The FY 2018 IHS budget request by Tribal Budget Formulation Workgroup focuses on making a bold impact to advance Indian health. We believe that this will empower sovereign Tribes to continue its path to work collaboratively with the federal government to build upon past improvements in a focused and sustainable way. This revitalized partnership effort will help to ensure that the federal obligations to Indian Country are funded equitably and to a high standard of quality.

The last several years have represented a historic new era between the Tribes and the United States. Bipartisan support in Congress and the Administration has allowed the IHS budget some growth from its severely under-resourced starting base. Engagement in meaningful Tribal consultation during this Administration has resulted in officials becoming more attuned to the needs of Tribal communities, and this has been reflected in budget requests to Congress. It is critical that we build on this renewed government-to-government relationship during the years to come.

However, the quest for better healthcare is not over. Together as Tribes, and as our federal trustee, we must rally to ensure that treaties our ancestors signed are honored. The rights we have as indigenous peoples cannot be forgotten amidst the complicated budget environment of Washington. Though the IHS falls in the discretionary budget, our treaties are *not* discretionary, and we urge this administration to build upon the necessary gains we have built together, and go further. IHS is not just another federal program, it is not welfare. It is our treaty right. The FY 2018 Budget is not just another policy proposal, but is a moral document, laying the foundation for the next Administration to take the bold step to outline a pattern for generations of American Indians and Alaska Natives to come.

It is time to meaningfully address severe funding and administrative challenges which remain across the IHS system. Huge facility infrastructure deficiencies affect care in every region with some IHS facilities over 100 years old and many in need of major upgrades. Tribal communities continue to suffer from third world water and sanitation issues, with many still lacking basic access to safe drinking water. Similarly, we must rebuild the trust in the IHS system. Recently several Indian health facilities were cited for evidence of inadequate patient care, unsafe environments, and lack of medical staff. FY 2016 reports released by the Centers for Medicare and Medicaid Services (CMS) indicate that some IHS direct-operated facilities are so unsafe that CMS has pulled some hospitals' accreditation, and others have closed down emergency services entirely. Chronic funding shortages affecting agency management capacity are significant contributors to this crisis. Tribes strongly believe that this situation must be remedied with an influx of resources so that these crisis situations are not replicated elsewhere. As the new Principle Deputy Director has stated, this is not acceptable. What we're doing now isn't working. Together we must do better.

In the next fiscal year, we request that the President take bold steps to renew this nation's promises with Indian Country and move us on a pathway to ensure that health funding for Tribal communities is equitable and of the highest quality by providing funding of **\$7.1 billion** for the IHS. We must have access to the latest technologies by making investments in telemedicine and electronic health records. Together, we must think creatively how to reform and renew the IHS system to be a 21<sup>st</sup> Century model of care – not one designed for the 1950s. We also must make critical investments in the new authorities granted to us by the IHCA. This historic law contains many solutions that will put Native people on a path to better health outcomes, and we must start to prioritize funding so that we are not left behind as the U.S. health system moves forward.

The failure to fund IHS means that our people live sicker and die younger. It is nothing short of unconscionable that our people continue, year after year, to represent the bottom of almost every health statistic in the United States. To ensure the sustainability for our next generation, we urge to you make a bold investment in the IHS, and issue dramatic reforms that will revolutionize the way that our people access healthcare. Federal funding for Indian health is not a luxury. These are trust agreements that our people have made generations in exchange for land and peace. We have prepaid for this care, and we implore you to fully honor Federal Indian Trust Responsibility as we continue the Quest for Equitable and Quality Indian Healthcare.

## Appendix

### Appendix A: Indian Health Service's Performance Improvement Between FY 2008 – FY 2015<sup>1</sup>

GPRA Measure	FY 2008 Results	FY 2015 Results <sup>2</sup>	Relative Increase between FY 2008 and FY 2015
<b>Diabetes Measures</b>			
<b>LDL (Cholesterol) Assessed</b>	63%	73.3%	16.4%
<b>Retinopathy Exam</b>	50%	61.3%	22.6%
<b>Dental</b>			
<b>Access to Services</b>	25%	29.2%	16.8%
<b>Immunizations</b>			
<b>Influenza 65+</b>	62%	65.4%	5.5%
<b>Prevention</b>			
<b>Mammography Rates</b>	45%	54.5%	21.1%
<b>Alcohol Screening (FAS Prevention)</b>	47%	66.6%	41.7%
<b>IPV/DV Screening</b>	42%	63.6%	51.4%
<b>Depression Screening<sup>3</sup></b>	35%	67.4%	92.6%
<b>Prenatal HIV Screening</b>	75%	86.6%	15.5%

<sup>1</sup> Of the 22 clinical measures on the IHS-All Dashboard (aggregate of federal and tribal reporting sites), the logic for these 9 measures has remained unchanged since 2008. Thirteen of the 22 measures are not included on this table. Eleven (11) measures cannot be compared to 2008 results because new standards of care changed the measure logic. Two (2) new measures were added since 2008.

<sup>2</sup>The IHS began calculating measure targets and results to one decimal point in FY 2011.

<sup>3</sup>GPRA measure since FY 2013.

# Appendix B: The Need to Expand Access to Hepatitis C Drugs in the Indian Health Service

## VIEWPOINT

**Jessica Leston, MPH**  
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MHA**  
Northwest Portland  
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## The Need to Expand Access to Hepatitis C Virus Drugs in the Indian Health Service

The American Indian/Native Alaska population is disproportionately affected by hepatitis C virus (HCV). The most recent national data show American Indian/Alaska Native people with both the highest rate of acute HCV infection and the highest HCV-related mortality rate of any US racial/ethnic group.<sup>1</sup> In 2013, the latest national data available, rates of acute HCV infection were 1.7 per 100 000 American Indian/Alaska Native persons.<sup>1</sup> From 2009 through 2013, their HCV-related mortality rate increased by 23.2%, accounting for 324 deaths in 2013.<sup>1</sup> The American Indian/Alaska Native mortality rate of 12.2 deaths per 100 000 population is more than double the national rate of 5.0 per 100 000.<sup>1</sup> Although prevalence data are limited, one national study estimates 120 000 persons living on Indian reservations are positive for the HCV antibody.<sup>2</sup> Another study has shown American Indian/Alaska Native veterans born from 1945 to 1965 have an antibody-positive seroprevalence of 10%.<sup>3</sup>

The Indian Health Service (IHS) is a government agency entrusted to be the primary source for the provision of health care for the American Indian/Alaska Native population. The provision of health services to

Indians/Alaska Natives. Direct-acting antiviral regimens have high rates of achieving sustained virologic response with few contraindications or adverse effects. These advances represent a major shift in treatment options for HCV and may likely reduce HCV-related deaths. Among persons with compensated HCV-related cirrhosis, measured by sustained virologic response, successful treatment can lead to a survival curve similar to that of the general population.<sup>5</sup>

Yet these new HCV drug therapies must be accessible to have meaningful health benefits for patients. Many state Medicaid programs and insurance companies have imposed restrictions to contain costs. Some of these policies mandate significant liver damage as a requirement for eligibility, such as having stage 3 (precirrhosis) or stage 4 (cirrhosis) of the liver on the METAVIR scoring system. These criteria present a quandary: earlier treatment can prevent advanced liver disease, but late-stage liver disease is needed to qualify for treatment. For a clinician, explaining this circular logic to a patient can be frustrating for both parties.

Although direct-acting antiviral drugs have been cited as being cost-effective, cost-effectiveness does not necessarily mean affordable. The public sector in general and IHS specifically have budget constraints that shape treatment decisions; per capita user health expenditures range from \$3099 per year in the IHS compared with \$8097 per year for the US general population.<sup>4</sup> Only a limited number of American Indian/Alaska

Native patients belong to tribes that have

notable incomes stemming from natural resource or gaming royalties. With 1 in 4 American Indian/Alaska Native people living below the poverty line and with an average household income of just higher than \$30 000, paying even a small proportion of the out-of-pocket cost for this potentially life-saving medical treatment is not an option for most patients.

Another federal agency that provides direct patient care, the Department of Veterans Affairs (VA), has added HCV drugs to its formulary and issued guidance that all patients with HCV should be treated, regardless of stage of liver disease. However, the policy change came in the wake of well over a billion dollars from Congress earmarked for HCV, coupled with reduced drug pricing.<sup>6</sup>

The IHS, an agency several times smaller than VA in size and budget (IHS has an annual budget of \$4.6 billion to serve 2.2 million,<sup>4</sup> whereas the VA has \$59 billion to serve 9 million veterans<sup>7</sup>), has not received supplemental funding for HCV treatment and does not have HCV drugs on its National Core

### Access to treatment for IHS patients should be a federal priority to fulfill its obligations to tribal nations and American Indian/Alaska Native people.

members of federally recognized tribes developed from government-to-government relationships between the federal government and Indian tribes. This relationship, established in 1787, is based on Article I, Section 8, of the Constitution and has been given form and substance by numerous treaties, laws, Supreme Court decisions, and executive orders. The IHS is under the US Department of Health and Human Services and comprises a network of health care facilities that collectively serves nearly 2.2 million people across 35 states.<sup>4</sup> Most facilities are primary health clinics in rural and remote settings, which are often the only source of medical care within a hundred miles. The IHS provides on-site medical care within its clinical and annual budgetary ability free of charge to all federally enrolled tribal members in accordance with the Indian Health Care Improvement Act. However, IHS is not insurance and relies on third-party insurers and other assistance programs to provide health care to its entire population.

Improvements in new treatment options for HCV could have a major effect on the health of American

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Formulary.<sup>8</sup> Consequently, IHS facilities are highly dependent on Patient Assistance Programs and state Medicaid programs for access to HCV drug therapies. This approach has 2 main drawbacks that can reduce the willingness and ability of IHS facilities to meet clinical need. First, navigating external HCV drug access programs places a heavy time burden on the clinician, which can be daunting when even small IHS clinics can have a backlog of more than 100 patients with HCV. Second, drug access is generally conditional on the patient having advanced disease. These access criteria are not evidence based, nor are they aligned with HCV treatment guidelines from the American Association for the Study of Liver Diseases/Infectious Diseases Society of America, which recommend providing access to HCV drug therapies for all

patients with HCV except for those with other, immediately life-threatening illnesses.

Access to treatment for IHS patients should be a federal priority to fulfill its obligations to tribal nations and American Indian/Alaska Native people. Following the precedent set by the VA, this may require special allocation of funding from Congress to allow access to treatment to meet clinical needs. The consequences of inadequate access to HCV treatment are visible in the continued disparity in morbidity and mortality in American Indian/Alaska Native people. Human rights and health equity are not simply vague ideals—they are guiding operational principles for health care institutions, health care business, and governments—embodied to create a system of equity, especially for marginalized populations.

#### ARTICLE INFORMATION

**Correction:** This article was corrected online June 9, 2016, before the print issue for missing a subject in one sentence, a preposition in another, and data in a third.

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## Appendix C: Facilities Appropriations Information Package

### Facilities Appropriations Information Package

The purpose of this document is to provide background information on Indian Health Service (IHS), Office of Environmental Health and Engineering (OEHE) programs funded through Facilities Appropriations, including purposes, needs, and activities.

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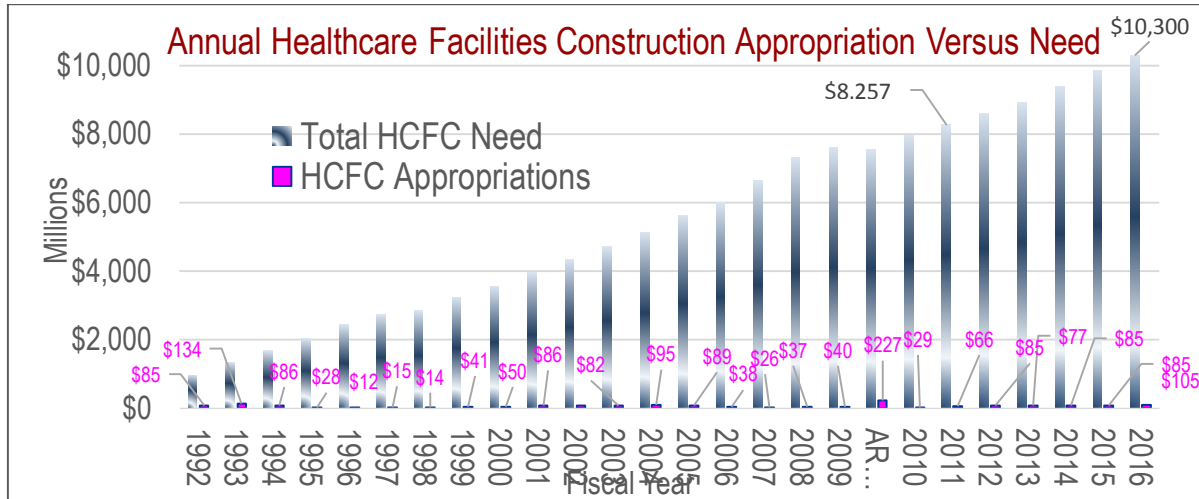
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## Health Care Facilities Construction (HCFC) Appropriations Quick Facts

The number, location, layout, design, capacity and other physical features of healthcare facilities are **essential** for:

- Eliminating health disparities
- Increasing Access
- Improving patient outcomes
- Reducing O&M costs
- Improving staff satisfaction, morale, recruitment and retention
- Reducing medical errors and facility-acquired infection rates
- Improving staff and operational efficiency
- Increasing patient and staff safety



- At the current rate of HCFC appropriations (~\$85 million/annually), a new facility in 2016 would not be replaced for over 400 years.<sup>10</sup>
- To replace IHS facilities every 60 years (twice a 30 year design life<sup>11</sup>), would need HCFC appropriations of ~\$500 million/annually.
- The IHS would need HCFC appropriations of ~\$1 Billion/annually to reduce the need by 95% by 2040.
- IHS would need HCFC appropriations of ~\$750 million/annually to match the U.S. expenditures in healthcare facility construction.<sup>12</sup>
- Without a sufficient, consistent, and re-occurring HCFC appropriation the entire IHS system is unsustainable.

The table at the left shows facility need in ft<sup>2</sup> and estimated cost by IHS Area in 2015. The data is based on IHS Health Facilities Data System (HFDS) existing program space, the 2014b Health System Planning (HSP) recommended space, approved Planning Documents and the Facilities Budget Estimating System (FBES).

For more information see "Detailed Health Care Facilities Construction (HCFC) Appropriations Information section.

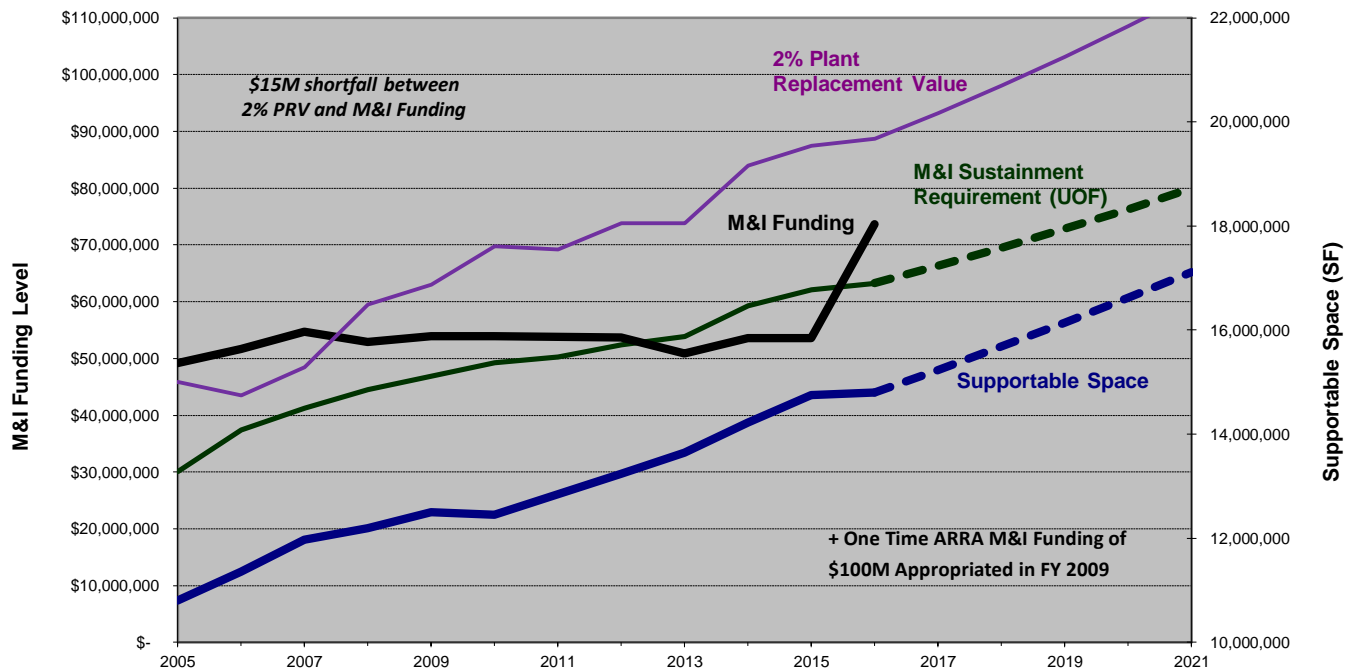
Area	Space Need ft <sup>2</sup>	Estimated Facility Need \$
AK	2,270,000	\$ 2,165,000,000
AB	1,040,000	\$ 527,500,000
BE	890,000	\$ 430,500,000
BI	890,000	\$ 387,500,000
CA	1,010,000	\$ 483,500,000
GP	910,000	\$ 472,800,000
NS	910,000	\$ 385,700,000
NV	2,590,000	\$ 1,494,800,000
OK	4,070,000	\$ 1,793,800,000
PH	1,980,000	\$ 1,319,300,000
PO	1,490,000	\$ 640,500,000
TU	260,000	\$ 180,800,000
<b>Total</b>	<b>18,310,000</b>	<b>\$10,281,700,000</b>

<sup>10</sup> Estimate need based on HFDS existing program space, HSP recommended space, FBES, 1.8% population growth. 2014.

<sup>11</sup> DHHS, IHS, OEHE, DES. Architect/Engineer Guide. 2013. Page 36, #8.

<sup>12</sup> Getzen, Thomas E. Health Economics and Financing. 4<sup>th</sup> Edition, John Wiley and Sons Inc.2010.

## Maintenance and Improvement Appropriations Quick Facts



- The FY-2016 Maintenance and Improvement (M&I) funding is \$73.6 million which for the first time since 2010 fully funds sustainment and provides some funding for major repair projects.
- From 2007 to 2015, M&I appropriations remained flat at about \$53 million annually. Consequently the annual M&I funding was below sustainment from 2011-2015.
  - By 2015, M&I funding was approximately 80% of the amount required to properly maintain the existing facilities.

The estimated total annual maintenance costs including all repair, preventive maintenance, materials, benchstock, direct labor and contract costs, should be:

- Approximately \$63 million using the IHS' traditional "University Oklahoma Formula", which calculates the funding level necessary for minimal maintenance and repair activities;
- Approximately \$90 to \$180 million using a 2% to 4% range of aggregate replacement value suggested by the National Research Council<sup>13</sup> to fully address sustainment;
- The backlog of deferred maintenance is about \$500 million, which if unaddressed could cost significantly more if systems fail;<sup>14</sup>
- An additional 2% to 4% of the aggregate replacement value is needed to reinvest in our existing plant to recapitalize/modernize the existing facilities.

For more information see "Detailed M&I Appropriations" Information section.

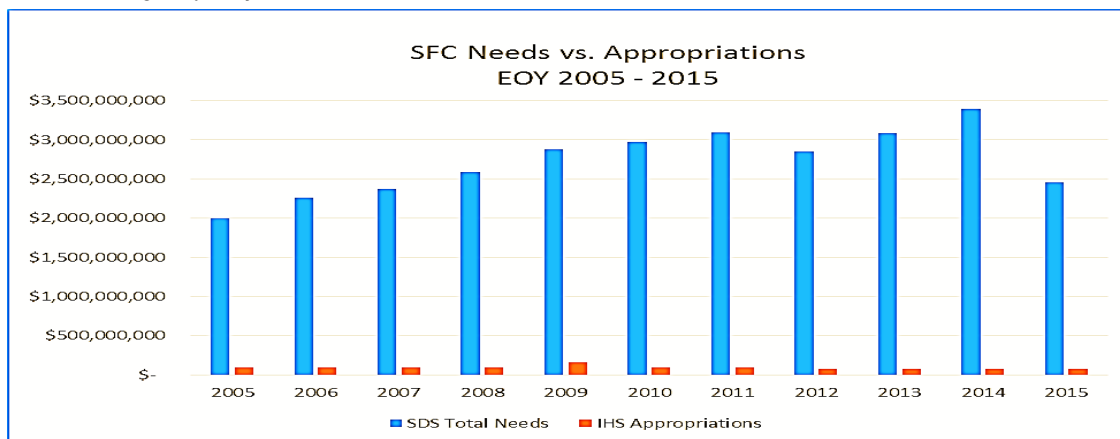
## Sanitation Facilities Construction Appropriations Quick Facts

<sup>13</sup> Committing to the Cost of Ownership: Maintenance and Repair of Public Buildings. National Academy of Sciences - NRC, Washington, DC. Building Research Board. 1990

<sup>14</sup> Madsen, Jana. Paying for Deferred Maintenance. Buildings Magazine. 2006. Accessed 10/15/15 at [www.buildings.com/article-details/articleid/3161/title/paying-for-deferred-maintenance.aspx](http://www.buildings.com/article-details/articleid/3161/title/paying-for-deferred-maintenance.aspx)

Funds appropriated for water supply and waste disposal facilities are under the Sanitation Facilities Construction (SFC) line item. Projects are cooperatively developed and transferred to Tribes who assume responsibility for the operation of safe water, wastewater, and solid waste systems, and related support facilities. The SFC program receives funds for three types of projects:

- Water, Wastewater, and Solid Waste facilities for Existing Homes and/or Communities,
- Water, Wastewater, and Solid Waste facilities for New Homes and/or New Communities, and
- Special or Emergency projects.



For more information see “Detailed SFC Appropriations Information section.

## Equipment Appropriations Quick Facts

- FY-2016 Equipment Appropriation is \$23.3 million which includes:
  - \$17.3 million medical equipment funds to support existing IHS and tribal programs;
  - \$5 million to support the initial purchase of equipment for tribally-constructed healthcare facilities;
  - \$500,000 to acquire excess medical equipment from DoD or other sources through the TRANSAM program; and
  - \$500,000 to procure ambulances for IHS and Tribal emergency medical services programs.
- IHS' medical equipment inventory is approximately 90,000 devices valued at approximately \$500 million
- Average Equipment life is approximately 6 years<sup>15</sup>.
  - To replace the Equipment on a 6 year cycle would require approximately \$80 million annually.

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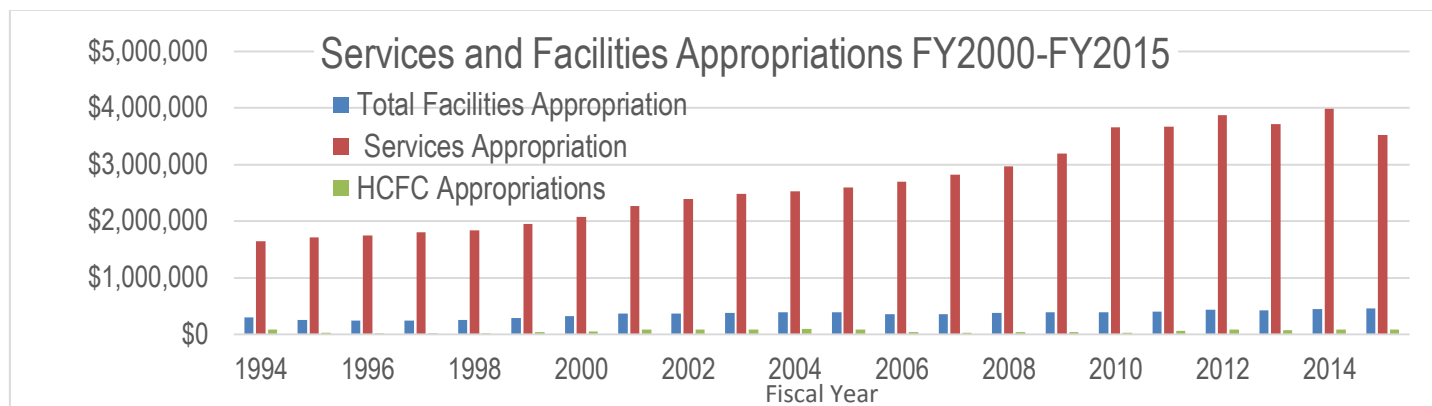
<sup>15</sup> Estimated Useful Lives of Depreciable Hospital Assets. American Hospital Association. 1998

Facilities Appropriation Budget Activity Line Items Budget Funds These Undertakings				
Health Care Facilities Construction (HCFC)	Maintenance and Improvement (M&I)	Equipment	Sanitation Facilities Construction (SFC)	Facilities and Environmental Health Support
<p>"Grandfathered" HCFC Priority List:</p> <ul style="list-style-type: none"> <li>• Gila River PIMC SE ACC, AZ</li> <li>• Salt River PIMC NE ACC</li> <li>• PIMC Central Hospital &amp; ACC</li> <li>• Whiteriver, AZ</li> <li>• Gallup, NM</li> <li>• Ft. Yuma, AZ</li> <li>• Rapid City, SD</li> <li>• Winslow-Dilkon, AZ</li> <li>• Alamo Navajo, NM</li> <li>• Pueblo Pintado, NM</li> <li>• Bodaway Gap, AZ</li> <li>• Albuquerque West</li> <li>• Albuquerque Central</li> <li>• Sells, AZ</li> </ul> <p>Estimated cost of \$2.1 billion.</p> <p>Health Care Facility Projects beyond "grandfathered" Priority List. Numerous Project Types and Phases in every Area. &gt;\$8 Billion.</p> <p>Small Ambulatory Program Funding for AI/AN tribes or tribal organizations to construct, expand, or modernize tribally owned small ambulatory health care facilities.</p>	<ul style="list-style-type: none"> <li>• Routine Maintenance</li> <li>• Projects to resolve the Backlog of Essential Maintenance, Alteration, and Repair (BEMAR). The current backlog is ~\$500 million.</li> <li>• Environmental audits and remediation.</li> <li>• Demolition of vacant, excess, or obsolete federally-owned buildings.</li> </ul>	<ul style="list-style-type: none"> <li>• Replaces medical equipment</li> <li>• Transfer of excess Department of Defense medical equipment (TRANSAM) to IHS/tribal programs</li> <li>• Replaces ambulances,</li> <li>• Provides equipment funding for tribal facilities constructed with non-IHS funding.</li> </ul> <p>The IHS/Tribal medical equipment inventory is ~\$500 million.</p> <p>The annual replacement need is ~\$80 million.</p>	<p>Projects for Water, Sewer, and Solid Waste needs for:</p> <ul style="list-style-type: none"> <li>• Existing Homes and Communities</li> <li>• New Homes</li> </ul>	<p>Facilities Support;</p> <ul style="list-style-type: none"> <li>• O&amp;M of health care facilities and staff quarters (real property)</li> <li>• Medical equipment technical support and repair</li> <li>• Construction management support</li> <li>• National maintenance management system for facilities and medical devices including tracking FDA alerts on medical equipment;</li> <li>• Facility operating costs, utilities, and building supplies.</li> </ul> <p>Environmental Health Support,</p> <ul style="list-style-type: none"> <li>• Environmental health service/staff</li> <li>• Injury prevention service/staff</li> <li>• SFC staff</li> </ul> <p>Office of Environmental Health and Engineering Support</p> <ul style="list-style-type: none"> <li>• Staff at IHS Headquarters OEHE and in the two regional Engineering Services (DES), for direct support/management of all the Facilities Appropriation activities.</li> </ul>

## Facilities Appropriations Summary

There are five line item for the Facilities Appropriation Budget Activity as shown in the table below. Each line item is described in more detail under its own section with specific potential benefits realized from increased funding and consequences from inadequate funding.

The table below entitled "Services and Facilities Appropriations FY2000-FY2015" compares the Facilities Appropriations with the IHS the Services Appropriations (without the ARRA supplement). The Services Appropriation has increased about 7% per year while the Facilities Appropriation has remained fairly flat. Maximizing Access to appropriate care requires three elements: an Appropriate Facility (capacity, location, layout, accredited, etc.); Qualified Providers (Services) and Appropriate Time (seeking/receiving care prior to condition worsening). Prevention coupled with Appropriate Timing facilitates care in an outpatient facility and reduces the need for inpatient care. If a facility is too far away or undersized or understaffed, appropriate timing is hindered. Services and facilities need to match up; facility capacity is wasted without providers and additional providers are wasted without an appropriate facility capacity.



Data relevant to IHS (Tribal and IHS) healthcare facilities Include:

- The IHS Service-Population is ~2.2 million AI/ANs.
- The User-Population is ~1.6 million (active users).<sup>16</sup>
- The Service-Population increases ~1.8% per year.<sup>17</sup>
- There are ~70,000 hospital admissions annually
- There are ~14 million outpatient visits annually.
- Tribes operate 107 of the 168 Service Units (SU).
- The average age IHS healthcare facility is ~40-years.
- The average age US healthcare facilities is ~10-years.<sup>18</sup>
- IHS/Tribes operate ~500 healthcare facilities in 36 States including<sup>19</sup>:
  - 45 Hospitals
  - 326 Health Centers (w/ school health centers)
  - 115 Health Stations
  - Almost 14 million ft<sup>2</sup> of existing healthcare space inventory
  - Over 160 Village Built Clinics in Alaska
  - Area Youth Regional Treatment Centers
  - Almost 2,300 staff quarter units
  - Almost \$500 million in medical equipment inventory

### Maintenance and Improvement Appropriations Details

Maintenance and improvement (M&I) funds are the primary source for maintenance, repair, and improvements for facilities which house IHS funded programs, whether provided directly or through P.L. 93-638 contracts/compacts. The FY-2016 Maintenance and Improvement (M&I) funding is \$73.6 million which for the first time since 2010 fully funds sustainment and provides some funding for major repair projects. The M&I program funding is distributed through a formula allocation methodology and is intended to cover a variety of needs, including:

- Maintaining, repairing, and improving existing IHS and Tribal healthcare facilities;
- Major projects to reduce the BEMAR and make improvements necessary to support healthcare delivery;
- Achieving and maintaining compliance with accreditation standards of the Joint Commission or other accreditation bodies;
- Ensuring that health care facilities meet building codes and standards;
- Modernizing facilities to meet changing healthcare delivery needs;
- Environmental compliance including audits, remediation, and improving energy and water efficiency;
- Demolition of vacant, excess, or obsolete federally-owned buildings; and
- Executive Orders and public laws, e.g., energy conservation, seismic, environmental, handicapped accessibility, and security.

Adequate funding is essential to ensure functional health care facilities that meet building/life safety codes, conform to laws and regulations and satisfy accreditation standards. From 2007 to 2015, M&I appropriations remained flat at about \$53 million annually. Funding for facilities maintenance began to dip below sustainment levels in 2011 and by 2015 was only about 80% of the amount required to properly maintain the existing facilities. The estimated total annual maintenance costs including all repair, preventive maintenance, materials, direct labor and contract costs, should be about:

<sup>16</sup> DHHS, Indian Health Service. Division of Program Statistics (DPS), Office of Public Health Support (OPHS). *Trends in Indian Health*. 2014 Edition

<sup>17</sup> DHHS, IHS, Division of Program Statistics (DPS), Office of Public Health Support (OPHS). *Trends in Indian Health 2014* edition.

<sup>18</sup> Optum. (2014). *Almanac of hospital financial & operating indicators: a comprehensive benchmark of the nation's hospitals* (2015 ed., pp. 176-179).

<sup>19</sup> DHHS, Indian Health Service. *Trends in Indian Health*. 2014 Edition

- Approximately \$63 million using the IHS' traditional "University Oklahoma Formula," which calculates the funding level necessary for minimal maintenance and repair activities.
- Approximately \$90 to \$180 million using a 2% to 4% range of aggregate replacement value suggested by the National Research Council<sup>20</sup> to fully address sustainment.
- The backlog of deferred maintenance is about \$500 million, which if unaddressed could cost significantly more if systems fail.<sup>21</sup>
- About 2% to 4% of the total replacement value is needed to reinvest in existing plant to recapitalize/modernize the existing facilities.

The average age of IHS healthcare facilities is 36 years with only limited recapitalization in the plant. The average age, including recapitalization and reinvestment, of U.S. private sector hospitals is approximately 10 years.<sup>22</sup> Sustainment costs increase as facilities and systems age and we cannot predict whether future budgets will fully fund the University of Oklahoma formula amounts. Available funding levels are impacted by:

- Age and condition of equipment may necessitate more repairs and/or replacement;
- Lessened availability of service/repair parts for aging equipment;
- Increases in supportable space funded. Over the 5-year period from 2011 through 2015, M&I supportable healthcare space increased at an annualized rate of 3.5 percent per year due in large part to:
  - 2 hospitals and 3 health centers constructed through the Healthcare Facilities Construction Program;
  - 1 hospital and 8 health centers constructed under the Joint Venture Construction Program; and
  - 4 health centers constructed under the Small Ambulatory Grants Program.
- Increased costs due to remote locations;
- Limited vendor pool in remote locations;
- Costs associated with correcting accreditation-related deficiencies;
- Increasing regulatory and/or executive order requirements; and
- Environmental conditions impacting equipment efficiency and life.

### Equipment Appropriations Details

Accurate clinical diagnosis and effective medical treatment depend in large part on health care providers using modern and effective medical equipment/systems to assure the best possible health outcomes.

- FY-2016 Equipment Appropriation is \$23.3 million which includes:
  - \$17.3 million medical equipment funds to support existing IHS and tribal programs;
  - \$5 million to support the initial purchase of equipment for tribally-constructed healthcare facilities;
  - \$500,000 to acquire excess medical equipment from DoD or other sources through the TRANSAM program; and
  - \$500,000 to procure ambulances for IHS and Tribal emergency medical services programs.
- IHS and Tribes manage approximately 90,000 biomedical devices consisting of laboratory, medical imaging, patient monitoring, pharmacy, and other biomedical, diagnostic, and patient equipment valued at approximately \$500 million.
- Equipment funding has remained relatively flat. Based upon current funding, equipment would be replaced approximately every 30 years if not for the use of collections and other resources.
- Medical Equipment funds provide for:
  - Maintenance and repair of existing medical devices;
  - Limited replacement of outdated equipment;
  - Initial purchase of equipment for Tribally-constructed health care facilities; and
  - Leasing of ambulances for the emergency medical services programs.

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<sup>20</sup> Committing to the Cost of Ownership: Maintenance and Repair of Public Buildings. National Academy of Sciences - NRC, Washington, DC. Building Research Board. 1990

<sup>21</sup> Madsen, Jana. Paying for Deferred Maintenance. Buildings Magazine. 2006. Accessed 10/15/15 at [www.buildings.com/article-details/articleid/3161/title/paying-for-deferred-maintenance.aspx](http://www.buildings.com/article-details/articleid/3161/title/paying-for-deferred-maintenance.aspx)

<sup>22</sup> Optum. (2014) *Almanac of hospital financial & operating indicators: a comprehensive benchmark of the nation's hospitals* (2015 ed., pp. 176-179).

- Average Equipment life is approximately 6 years<sup>23</sup>
- Renewal is necessary to replace outdated, inefficient and unsupported equipment with newer electronic health record-compatible equipment to enhance speed and accuracy of diagnosis and treatment.
- To replace the Equipment on a 6 year cycle would require approximately \$80 million annually
- IHS replaces four to six over-aged/over-mileage ambulances per year.

#### Clinical Engineering-Medical Equipment Considerations

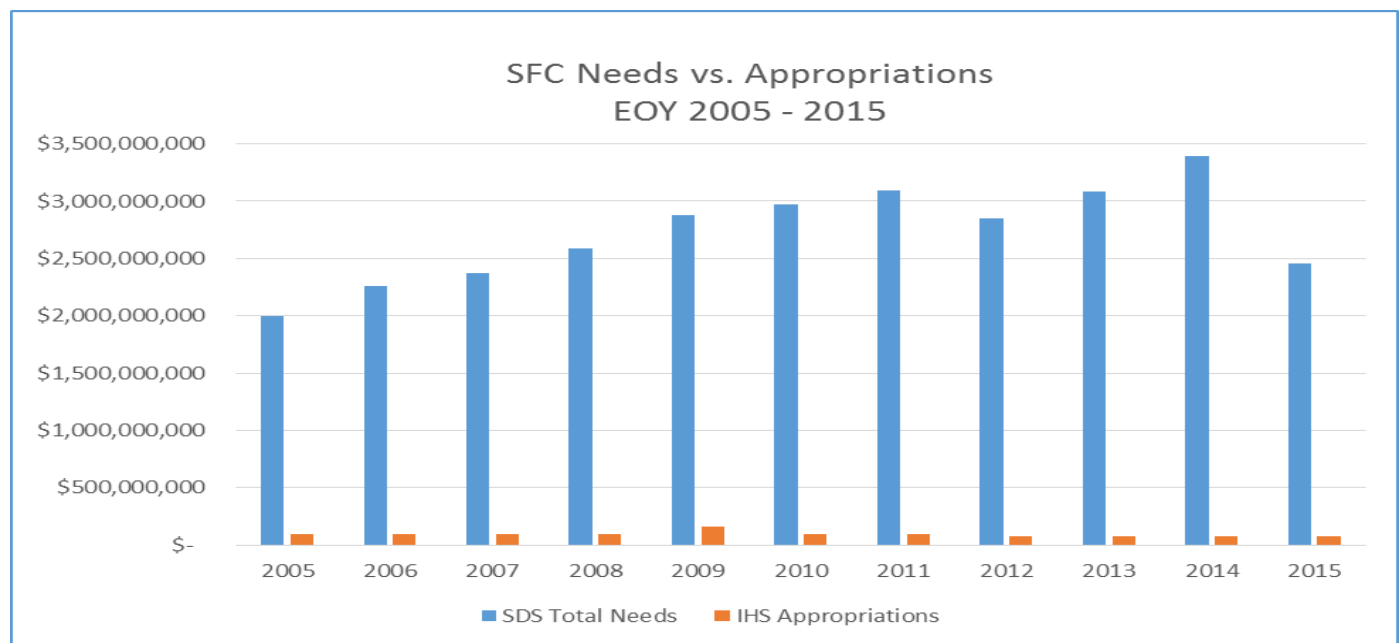
- Accurate clinical diagnosis and effective therapeutic procedures depend in large part on healthcare providers using modern and effective medical equipment/systems to assure the best possible health outcomes.
- Many health care services require special medical equipment to meet their mission.
- IHS and its tribal partners utilize and rely on telemedicine systems in many locations.
- Appropriate types, standardization, needs, use and interoperability of devices must be determined and recommended.
- Equipment must be acquired, installed, tested and calibrated, and maintained.

### Sanitation Facilities Construction Appropriations Details

Funds appropriated for water supply and waste disposal facilities are under the Sanitation Facilities Construction (SFC) line item. Projects are cooperatively developed and transferred to Tribes who assume responsibility for the operation of safe water, wastewater, and solid waste systems, and related support facilities. The SFC program receives funds for three types of projects:

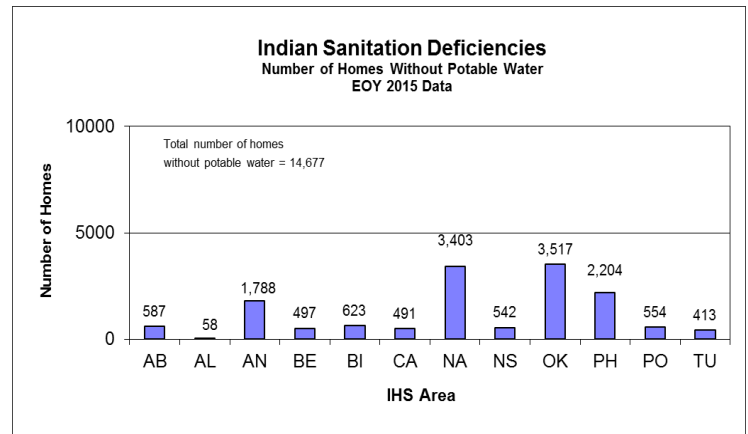
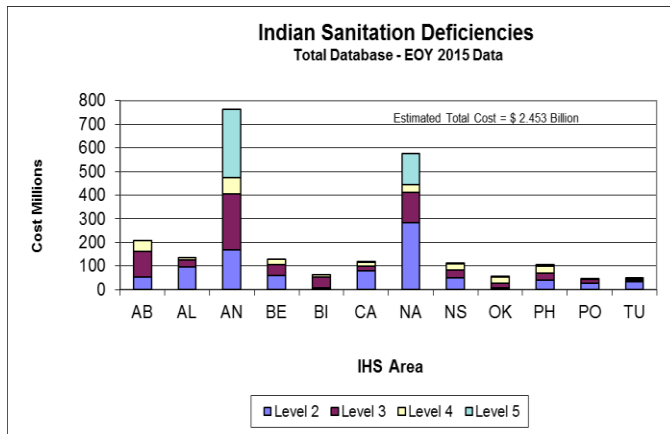
- Water, Wastewater, and Solid Waste facilities for Existing Homes and/or Communities,
- Water, Wastewater, and Solid Waste facilities for New Homes and/or New Communities, and
- Special or Emergency projects.

The sanitation project need is almost \$2.5 billion, including almost 14,000 AI/AN homes without potable water.



<sup>23</sup> Estimated Useful Lives of Depreciable Hospital Assets. American Hospital Association. 1998





SFC Engineers (funded under Environmental Health Support; for more details see the Environmental Health Support section) provide project related services such as:

- Coordination with all funding and regulatory agencies
- Project site review, surveying, pre-design
- Obtaining construction and environmental permits
- Preparation of contract documents
- Transfer documents and final reports
- Project Data System inputting and reports
- Preparation of as-builts and O&M manuals
- Construction project management and inspection services
- Attending tribal meetings; meeting individual homeowners
- Archeological and other environmental review activities at the site
- Engineering designs, data collection, and preparing specifications and drawings
- Clerical support, project employee training, and project related travel time
- Administrative and supervision/support for project related employees
- Project start-up and training (operators and homeowners)

## Detailed Health Care Facilities Construction (HCFC) Appropriations

Health Care Facilities Construction (HCFC) Appropriations are the primary source for new or replacement healthcare facilities. The number, location, layout, design, capacity and other physical features of healthcare facilities are **essential** in eliminating health disparities, improving patient outcomes and increasing Access.

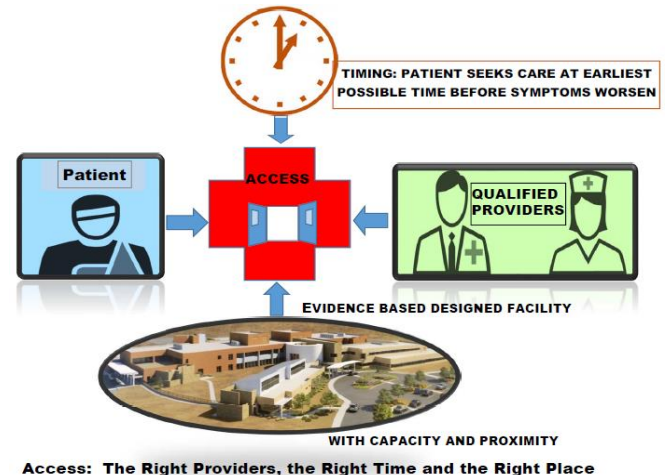
The absence of an adequate facility frequently results in either treatment not being sought, sought later prompted by worsening symptoms and/or referral of patients to outside communities which significantly increases the cost of patient care and causes travel hardships for many patients and their families.

### The Importance of the Facility Environment to Patient Outcomes

The healthcare physical environment has long been recognized as having a substantial impact on patient care experiences and outcomes. There is overwhelming rigorous research, more than 600 credible studies, that link the physical environment of care to health outcomes<sup>24</sup>.

The impact of the healthcare facility physical environment on the occupants is significant. Research reveals that specific design features in the healthcare environments can:<sup>25</sup>

- Improve patient outcomes
- Reduce medical errors
- Improve staff satisfaction, morale, recruitment and retention
- Allow achievement of key safety goals
- Increase staff effectiveness
- Reduce costs



<sup>24</sup> Ulrich, Roger, Xiaobo Quan, Craig Zimring, Anjali Joseph, and Ruchi Choudhary. The Role of the Physical Environment in the Hospital of the 21st Century: Once-in-a-Lifetime Opportunity. Center for Health Design. Sept 2004.

<sup>25</sup> U of M, Center for Spirituality and Healing. What is a healing environment? Kreitzer, Mary Jo, Terri Zborowsky, and Jean Larson, accessed at <http://www.takingcharge.csh.umn.edu/explore-healing-practices/healing-environment> on 7/14/15

- Improves the quality of care
- Enhance efficient workflow patterns and processes
- Reduce stress and anxiety
- Increase a facility's market share
- Improves staff and operational efficiency
- Decrease patient lengths of stay, and
- Reduce the rate of hospital-acquired infection
- Increase patient and staff safety

The Center for Health Design defines Evidence-Based Design as the “process of basing decisions about the built environment on credible research to achieve the best possible outcomes.” Evidence-Based Design creates safe, healing, efficient and therapeutic environments for patient care. Evidence-Based Design yields improvements in clinical, economic, productivity, satisfaction, and cultural measures.<sup>26</sup> Design characteristics that have a pronounced effect on care include<sup>27</sup>:

- Room configuration and layout
- Furniture, Fixtures & Equipment (FF&E)
- Standardization
- Unit configuration and layout
- Size/capacity of the facility with respect to the user-population
- Automation
- Acoustic Environment
- Flooring material to minimize fatigue
- Interior Material
- Adjacencies/departments
- Providing immediate, accessible information near point of service
- Building location/site optimization
- Scalability, adaptability, flexibility
- Space and resources for patient/family involvement with care
- Visibility of patients to staff
- Lighting (artificial and natural)
- Minimizing patient transfers/handoffs

### **The Importance of the Healthcare Facility Physical Environment for the Model of Care**

The physical environment must also accommodate the model of care. The Patient-Family-Centered Care (PFCC) model practiced by IHS and its partners has been the international and national standard since 2001.<sup>28</sup> Crucial features of the physical environment are:

- PFCC design principles correlate highly with improved measures of patient experience and clinical outcomes.
- Studies show that certain physical environment attributes are needed for PFCC to be realized.<sup>29</sup>
- PFCC must provide a supportive/nurturing physical space for patients, families, and providers.
- The exam rooms need to be sized to hold the patient's family members along with the provider.
- PFCC has been shown to reduce both underuse and overuse of medical services.<sup>30</sup>
- Incorporates supportive technology to access information and caregivers for patients and families.<sup>31</sup>
- The care team shares an office space for improved interaction and information flow among the provider team.<sup>32</sup>

Older health care facilities predate Evidence Based Design and the Patient-Family-Centered Care model of care. Older facilities were designed for perceived ‘clinical efficiency,’ and physician authority with some features that interfere with Patient/Family-Centered Care,<sup>33</sup> contribute to stress and adverse outcomes for patient and staff.

### **The Importance of the Healthcare Facility Physical Environment for HIPAA**

The HIPAA (Health Insurance Portability and Accessibility Act of 1996) regulations address security and privacy of "protected health information" (PHI). These regulations put emphasis on acoustic and visual privacy. While HIPAA does not regulate facilities design, its implications for healthcare facilities affect location and layout of workstations that handle medical records and other patient information, as well as patient accommodations.

### **The Healthcare Facility Low Capital Cost Versus Cost of Other Healthcare System Components**

In terms of overall healthcare costs, renovating or constructing an appropriate physical environment of care is considerably less expensive than staffing, operation and maintenance. Points to consider are:

- Health care is labor-intensive with highly skilled and highly paid staff.

<sup>26</sup> American Institute of Architects, Academy of Architecture for Health, Facility Guidelines Institute). *Guidelines for Design and Construction of Hospital and Health Care Facilities*. Washington, DC: AIA Press, 2001.

<sup>27</sup> Ulrich R, Zimring C. *The role of the physical environment in the hospital of the 21st century: a once-in-a-lifetime opportunity*. Report to The Center for Health Design, for the Designing for the 21st Century Hospital Project 2004:3.

<sup>28</sup> Hughes, R., (May 31, 2011) "Overview and Summary: Patient-Centered Care: Challenges and Rewards" OJIN: The Online Journal of Issues in Nursing Vol. 16, No. 2, Overview and Summary. DOI: 10.3912/OJIN.Vol16No02Man05

<sup>29</sup> Arneill, B., & Frasca-Beaulieu, F. (2003). *Healing environments: Architecture and design conducive to health*. S.B. Frampton, L. Gilpin, & P.A. Charnel, Putting Patients First: Designing and Practicing Patient-Centred Care. San Francisco, CA.

<sup>30</sup> Agency for Healthcare Research and Quality, National Healthcare Quality Report, Publication No. 06-0018 (Rockville, Md.: AHRQ, Dec. 2005).

<sup>31</sup> Altringer B. The emotional experience of patient care: a case for innovation in health care design. *J Health Serv Res Policy* 2010;15(3):174-177.

<sup>32</sup> McCormack, B., Dewing, J., McCance, T., (May 31, 2011) "Developing Person-Centred Care: Addressing Contextual Challenges Through Practice Development" OJIN: The Online Journal of Issues in Nursing Vol. 16, No. 2, Manuscript 3. DOI: 10.3912/OJIN.Vol16No02Man03

<sup>33</sup> McCormack, B., Dewing, J., McCance, T., (May 31, 2011) "Developing Person-Centred Care: Addressing Contextual Challenges Through Practice Development" OJIN: The Online Journal of Issues in Nursing Vol. 16, No. 2, Manuscript 3. DOI: 10.3912/OJIN.Vol16No02Man03

- About 60 to 75% of annual expenses in healthcare are labor costs.
- A design that increases productivity or efficiency and reduces staffing needs can have a major impact on costs.<sup>34</sup>
- Operations and maintenance costs over a 30-year life cycle contribute up to 80% to the life cycle cost.<sup>35</sup>
- Physical improvements to facilitate maintenance or reduce life-cycle costs have vast returns on a relatively small up-front investment<sup>36</sup>.
- The operational costs are drastically impacted by the physical environment of care.
- Capital investment that improve patient outcomes, increase access, and reduce operating costs are cost effective.

### **The Healthcare Facility Physical Environment's Impact on Staff**

The physical work environment influences (positively or negatively) the mindset of the service providers and their efficiency and ability to innovate in delivering expanded services. Architecture is often recognized as an important tool in recruiting and retaining the best doctors and nurses and the most patients. The facility greatly impacts incidence of medical error, safety, staff attitudes and behaviors.

There is a high incidence of medical error in healthcare:

- Studies from the 1990s had concluded medical errors were killing ~100,000 Americans annually<sup>37</sup> as the 8<sup>th</sup> leading cause of death.<sup>38</sup>
- Recent studies estimate medical errors kill ~210,000 to 400,000 Americans annually<sup>39</sup> making medical errors the 3<sup>rd</sup> leading cause of death.<sup>40</sup>
- Medical errors are estimated to cost between \$17- \$29 billion annually.<sup>41</sup>
- Medical errors are preventable.
- Specific design features in the healthcare environments influence the rate of medical errors.<sup>42</sup>
- Physical features can cause interruptions to human neurological systems, and lead to human error.<sup>43</sup>
- Minimizing/eliminating these features yields fewer adverse events and improved patient outcomes.<sup>44</sup>
- The design of space not only communicates with those who enter it but also "controls their behavior."<sup>45</sup>
- Individuals are much more likely to be clumsy when things they use are badly conceived and designed.<sup>46</sup>
- Skilled providers may be "compelled to commit errors by the way in which the design of their environment beckons their behavior."<sup>47</sup>

Healthcare workers face a number of serious safety and health hazards.<sup>48</sup> They include:

- Bloodborne pathogens and biological hazards
- Potential chemical and drug exposures
- Waste anesthetic gas exposures
- Ergonomic hazards from lifting and repetitive tasks
- Hazards associated with labs, radioactive material and x-ray.
- Laser hazards
- Workplace violence
- Respiratory hazards
- More workers are injured in the healthcare and social assistance industry sector than any other.<sup>49</sup>
- Nursing aides, orderlies, and attendants had the highest rates of musculoskeletal disorders of all occupations in 2010.
- Contemporary evidence based designed facilities reduce hazards to health workers, patients and visitors.

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<sup>34</sup> Carr, Robert F. Health Care Facilities. Whole Building Design Guide, National Institute of Building Science. October 2014.

<sup>35</sup> Federal Facilities Council (FFC). Investments in Federal Facilities: Asset Management Strategies for the 21st Century. NRC, National Academy of Sciences 2004.

<sup>36</sup> Federal Facilities Council (FFC). Investments in Federal Facilities: Asset Management Strategies for the 21st Century. NRC, National Academy of Sciences 2004.

<sup>37</sup> American Hospital Association. Hospital statistics. Chicago: the Association; 1999.

<sup>38</sup> Center for Disease Control and Prevention (National Center for Health Statistics). Deaths: final data for 1997. National Vital Statistics Reports. 1999;47(19):27. [PubMed]

<sup>39</sup> James, John T. PhD. A New, Evidence-based Estimate of Patient Harms Associated with Hospital Care Journal of Patient Safety, September 2013, Volume 9, Issue 3, p 122–128

<sup>40</sup> Shots, Health News from National Public Radio. *How Many Die From Medical Mistakes In U.S. Hospitals?* Marshall Allen, ProPublica. September 20, 2013.

<sup>41</sup> Thomas EJ, Studdert DM, Newhouse JP, Zbar BI, Howard KM, Williams EJ, et al. Costs of medical injuries in Utah and Colorado. Inquiry 1999;36:255-64. [PubMed]

<sup>42</sup> U of M, Center for Spirituality and Healing. What is a healing environment? Kreitzer, Mary Jo, Terri Zborowsky, and Jean Larson, accessed at <http://www.takingcharge.csh.umn.edu/explore-healing-practices/healing-environment> on 7/14/15

<sup>43</sup> Reason J. Managing the risks of organizational accidents. Aldershot, UK: Ashgate Publishing, 1997:1–126. Leape L. Error in medicine. JAMA1994;272:1851–7.

<sup>44</sup> Reason JT. Understanding adverse events: the human factor. In: Clinical risk management: enhancing patient safety. London: BMJ Publishing Group; 2001. p. 9-30.

<sup>45</sup> Kleeman WB Jr. The challenge of interior design. New York: Van Nostrand Reinhold, 1983:128.

<sup>46</sup> Norman D. The psychology of everyday things. New York: Basic Books, 1988:42.

<sup>47</sup> Moray N. Error reduction as a systems problem. In: Bogner MS, ed. *Human error in medicine*. Hillsdale, NJ: Lawrence Erlbaum Associates, 1994:67–91.

<sup>48</sup> Occupational Safety & Health Administration Safety and Health Topics, Healthcare. Accessed on August 18, 2015 at <https://www.osha.gov/SLTC/healthcarefacilities/index.html>

<sup>49</sup> Occupational Safety & Health Administration Safety and Health Topics, Healthcare. Accessed on August 18, 2015 at <https://www.osha.gov/SLTC/healthcarefacilities/index.html>

Patient decisions are usually based on cost, accessibility, quality of service, and quality of medical care. An aesthetically pleasing facility is a key aspect of the perceived quality of care.<sup>50</sup> Evidence confirms a correlation between the physical healthcare environment and the safety, quality, and patient's perception of that care.<sup>51</sup>

A facility bears a message to patients, providers, community, visitors, and volunteers staff about the organization and the medical care being provided.<sup>52</sup> The physical environment of care (the setting, facility), is as important and as much a part of treatment, as are medicine and providers.

### Planning, Designing and Constructing IHS Facilities

Contemporary healthcare facilities are designed around the needs and preferences of patients, families, and staff. The modern-day IHS constructed facilities, designs and plans successfully integrate these and numerous other important factors, including:

- Tribal and federal consultation;
- Proposed care model;
- Services to be provided;
- Culture;
- Life Cycle Cost;
- Efficiency;
- Healing environments;
- Number of program staff;
- Safety and injury prevention;
- Codes, standards and guidelines;
- Tribal, federal, state, and local government requirements and/or input;
- Incorporate evidence-based, proven and effective design principles;
- Remoteness, climate, access to site (road, waterway, seasonal, etc.);
- Individual patient/family needs/preferences;
- User-Population specific healthcare needs;
- Future projections of User-population and changing needs;
- Sustainability, renewable energy, and conservation;
- Staff needs, health, efficiency, comfort, work space, and preferences;
- Minimum user-populations required to sustain services; and
- Environmental regulations, security and safeguards.

The IHS adheres to strict qualification standards for personnel and contractors that participate in the planning, design, construction and operation of its facilities including the requirement for licensed Architects and Engineers, FAC-P/PM<sup>53</sup> Project Managers, AICP<sup>54</sup> Planners and FBPTA<sup>55</sup> competent Facility Managers. These requirements help to ensure that the IHS and tribal healthcare facilities are planned, designed, constructed and operated as culturally appropriate health care facilities that meet programmatic requirements, incorporate proven and effective design principles, are sustainable, and that contribute to the health and healing process of the AI/ANs they are intended to serve.

The health care facilities constructed by the IHS safeguard access to quality, and culturally competent care for one of the poorest and most vulnerable populations in the United States.

### How IHS Uses and Distributes HCFC Appropriation Funds

The HCFC appropriations continue to fund projects off the “grandfathered” HCFC Priority list until it is fully funded.

- In the late 1980s Congress directed IHS to develop the HCFC priority system
- The system was implemented in the early 1990s with 27 projects on the initial list.
- Most projects are major capital investments exceeding annual HCFC funding resulting in projects being funded over several fiscal years.
- Projects are funded in phases according to acquisition, engineering, and project management requirements.
- Portions or phases of several projects are funded during a given fiscal year. This allows several projects to move forward simultaneously and helps distribute the funds geographically benefiting more than one Area.
- There are separate lists for facility types, for instance, Inpatient, Outpatient, Youth Regional Treatment Facilities or Staff Housing.
- Budget documents identify the specific projects off the grandfathered HCFC List, the phases and the estimated costs for that fiscal year.
- There are 13 remaining facility projects on the “grandfathered Priority List” with a current estimated completion cost of \$2.1 billion.
- Once those 13 projects are funded, the remaining \$8 billion can be funded with a revised priority system that will periodically generate updated lists.

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<sup>50</sup> Carr, Robert F. Health Care Facilities. Whole Building Design Guide, National Institute of Building Science. October 2014.

<sup>51</sup> Sadler BL, Joseph A, Keller A, Rostenberg B. *Using Evidence-Based Environmental Design to Enhance Safety and Quality*. IHI Innovation Series white paper. Cambridge, Mass: Institute for Healthcare Improvement; 2009.

<sup>52</sup> Carr, Robert F. Health Care Facilities. Whole Building Design Guide, National Institute of Building Science. October 2014.

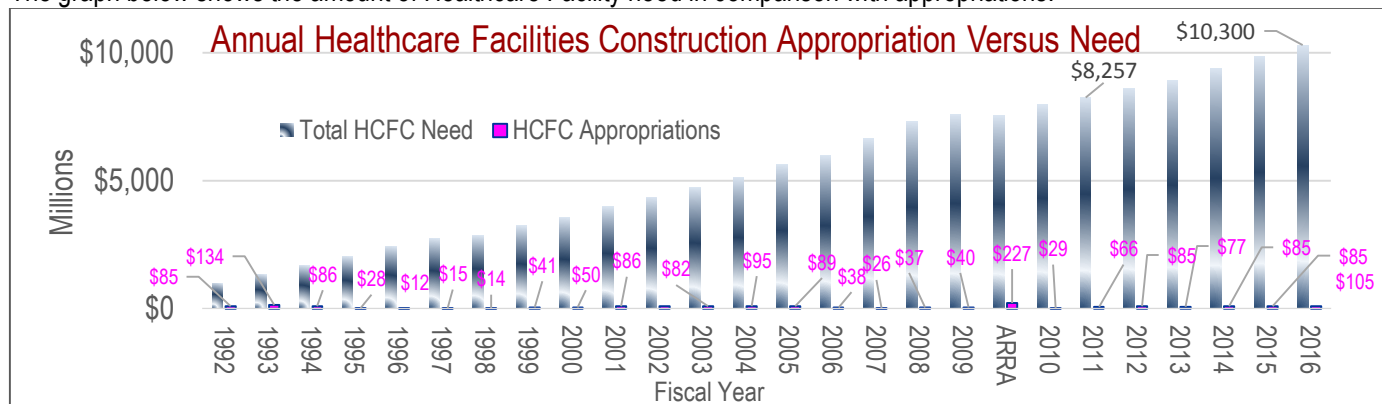
<sup>53</sup> Federal Acquisition Certification for Program and Project Managers (FAC-P/PM)

<sup>54</sup> American Institute of Certified Planners (AICP)

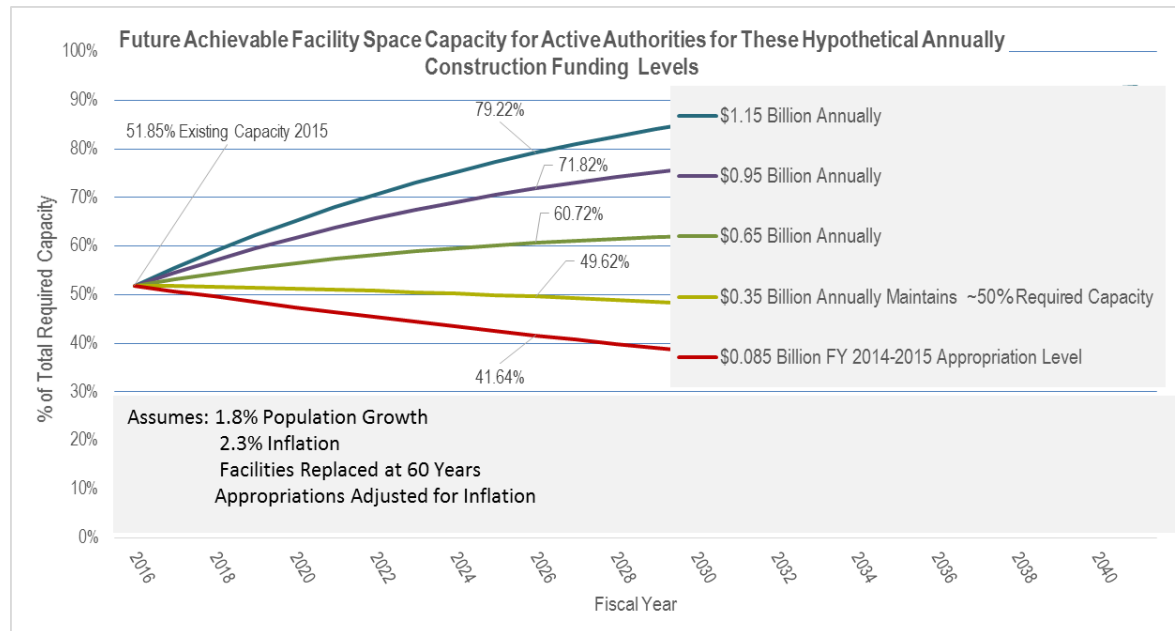
<sup>55</sup> Federal Building Personnel Training Act (FBPTA)

## The Amount of Health Care Facility Construction Needs

The graph below shows the amount of Healthcare Facility need in comparison with appropriations.



Approximately 5% of the U.S. annual health expenditures are investments in health care facility construction.<sup>56</sup> In 2013, that \$118 billion investment in health care facility construction equaled ~\$374 per capita compared with IHS health care facility construction appropriation of \$77 million or ~\$35 per AI/AN.<sup>57</sup> That means the nation invests annually in health care facility construction for the general population over 10 times the amount per capita that it appropriates for IHS healthcare facility construction. This disparity in facility construction is reflected in patient outcomes and the immense need for facilities in IHS.



In general, IHS facilities are old, undersized, with traditional layouts, and expensive to operate and maintain. The 2011 Facilities Needs Assessment Report to Congress estimated the need at ~\$8 billion. The need for new and replacement facilities in 2015 exceeds 18 million ft<sup>2</sup> at an estimated cost of about \$10 billion.<sup>58</sup>

<sup>56</sup> Getzen, Thomas E. Health Economics and Financing. 4<sup>th</sup> Edition, John Wiley and Sons Inc.2010.

<sup>57</sup> Centers for Medicare and Medicaid Services. National Health Expenditure data. Accessed on September 21, 2015 at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet.html>

<sup>58</sup> Estimate based on HFDS existing program space, HSP recommended space, approved planning documents and FBES.

## Facilities and Environmental Health Support Appropriations

The Facilities and Environmental Health Support (FEHS) budget line item provides resources to staff and support its headquarters, regional, area, district, and service unit activities. The three major cost categories are:

Facilities Support	Environmental Health Support	OEHE Support
<ul style="list-style-type: none"> <li>• O&amp;M Staff for facilities and quarters</li> <li>• Some utilities, and building supplies</li> <li>• National IT maintenance management</li> <li>• Construction management support</li> </ul>	<ul style="list-style-type: none"> <li>• Staff and Operating costs at the IHS Area, District, and Service Unit levels for:                             <ul style="list-style-type: none"> <li>○ Environmental Health Services,</li> <li>○ Injury Prevention,</li> <li>○ Institutional Environmental Health, and</li> <li>○ Sanitation Facilities Construction Staff</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• IHS Headquarters OEHE staff</li> <li>• Engineering Services staff</li> <li>• Direct support/management of overall Facilities appropriation services and activities.</li> </ul>

### Environmental Health Services

The IHS delivers a comprehensive, national, community-based and evidenced-based Environmental Health (EH) program.

- Five foci
  - Children's environment
  - Safe drinking water
  - Vector-borne and communicable diseases
- Food safety
- Healthy homes
- Key services
  - Identify EH hazards and risk factors in communities and propose control measures
  - Conduct investigations of disease and injury incidents
  - Provide training to federal, tribal, and community members
- Consultation and technical assistance to tribes in an effort to provide safe, healthy environments
- Program support and guidance to Area and Tribal EH programs
- National environmental health database that includes an inventory of public, commercial, and governmental facilities and services provided by IHS and Tribal EHS staff and programs
- Coordinates inter- and intra-agency agreements among various federal and non-federal agencies
- Allocates funds appropriated for environmental health services activities
- Advocates for tribes during the development of policies, regulations, and programs
- Assists tribes in responding to emergency situations
- WebCident System Management and Support – WebCident is the IHS incident reporting system used by any IHS affiliated facility for collecting occupational injuries and illnesses, visitor injuries, patient safety errors and adverse events, security events, property damage, and hazardous conditions

### Injury Prevention

The IHS Injury Prevention (IP) Program is funded within the Facilities and Environmental Support line item under the Environmental Health Services Account and applies a comprehensive public health approach to injury prevention.

- Unintentional Injuries are the leading cause of death for AI/ANs 1-44 years, and the 3<sup>rd</sup> leading cause of death overall<sup>59</sup>
  - Unintentional injury mortality rates for AI/ANs are ~2.4 times the combined all-U.S. rates rate
  - Injuries are not "accidents" but predictable and preventable events
  - Funds provide administrative support to the program
  - Occasionally funds are (have been) appropriated for specific initiatives
  - Facilitates community and evidence-based IP initiatives using multiple strategies to reduce and prevent injuries and fatalities
  - Foster tribal capacity by raising awareness, training, technical assistance, knowledge sharing and program implementation support
- Some successful IP initiatives include
- Tribal Injury Prevention Cooperative Agreement Program (TIPCAP)
  - Ride Safe (targets motor vehicle related injuries to children ages 3-5 years)
  - Sleep Safe (targets fire and burn injuries to children ages 3-5 years)
  - Participation in Projects to reduce motor vehicle injuries and fatalities by:
    - Increasing occupant restraint use through Tribal motor vehicle occupant restraint policy development;
    - Supporting tribal law enforcement in deterring drunk drivers (DUI policy development); and
    - Highway environmental modifications (street lights, guard rails, highway striping, etc.).
  - Training Programs include
    - Introduction to Injury Prevention
    - Intermediate Injury Prevention
    - Advanced Injury Prevention
    - Safe Native American Passengers (SNAP)
    - Injury Prevention Specialist Fellowship

<sup>59</sup> DHHS, IHS, OPH, Division of Program Statistics. Indian Health Service, Trends In Indian Health, 2014 Edition.

As a result of these efforts, unintentional injury deaths to AI/ANs, while still high, decreased by ~40% between 1980 and 2009.<sup>60</sup>

### Institutional Environmental Health

The Institutional Environmental Health Program's primary focus is on assisting community institutions like healthcare and child care facilities maintain safe and healthy environments. The Institutional Environmental Health staff

- Ensure facilities have in place effective occupational health and safety programs
- Have knowledge and skills in the following
  - Industrial Hygiene
  - Patient Safety
  - Ergonomics
  - Fire Safety
  - Built Environment Hazard Recognition and Control
  - Emergency Management
  - Occupational injury and Incident reporting and recordkeeping
  - Radiation Protection
  - Environmental Compliance
  - Health Care Accreditation
  - Occupational Health and Safety

### Sanitation Facilities Construction Personnel and Operations

Personnel and Operations for the Sanitation Facilities Construction program are funded under the Environmental Health Support account. The SFC staff provide engineering and project management for sanitation facility projects and technical assistance to AI/AN communities. Project funding for water, wastewater and solid waste facilities are under the Sanitation Facilities Construction line item. In addition to Sanitation projects, the program:

- Develops and maintains an inventory of sanitation deficiencies in AI/AN communities for use by the IHS and the Congress;
- Provides environmental engineering assistance with utility master plans and sanitary surveys;
- Plans and coordinates multi-agency funded sanitation projects and assists with grant applications to leverage IHS funds;
- Provides professional engineering design and/or construction services for water supply and waste disposal facilities;
- Provides technical consultation and training on the operation and maintenance of tribal water supply and waste disposal systems;
- Advocates for tribes during the development of policies, regulations, and programs; and
- Assists tribes during sanitation facilities emergencies.

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<sup>60</sup> DHHS, IHS, OPH, Division of Program Statistics. Indian Health Service, Trends In Indian Health, 2014 Edition.



## Appendix D: Shield IHS from Sequestration



**NORTON SOUND  
HEALTH CORPORATION**

*Providing quality health services and promoting  
wellness within our people and environment.*

**To:** Verne Boerner, ANHB President/CEO

**FR:** Angie Gorn, NSHC President/CEO

**Date:** Wednesday, January 6, 2016

**Re:** Shield I.H.S from Sequestration

As you are well aware, the IHS was subject to a sequestration of roughly 5 percent of the IHS's overall budget, even though other health programs – notably the Veterans Administration, State Medicaid grants and most of Medicare - were exempted. For Norton Sound Health Corporation (NSHC), the only regional health system serving 10,000 residents living in Northwestern Alaska, a total of \$1,327,370 was cut from our FY13 annual Operating Budget. The system includes a regional hospital, which we own and operate under an Indian Self-Determination and Education Assistance Act (ISDEAA) agreement, a nursing home with 18 residents, and 15 village-based clinics.

The sequestration of IHS funds should not have taken place and a number of Members – including our delegation – are committed to protecting the IHS from future sequestration. We are grateful that Congress took action to avert a sequestration in FYs 2014 and 2015, but, of course, we are faced with the prospects of it in FY 2016 and beyond.

NSHC and the residents of the Bering Strait Region, were significantly impacted by the sequestration. In March of 2013, NSHC opened its new replacement hospital and ambulatory care center facility in Nome, the construction of which was funded by the Recovery Act. The IHS and NSHC worked together as government-to-government partners to construct and furnish the new facility. At the same time, NSHC opened a replacement nursing home, funded by the State of Alaska.

The replacement facility is nearly three times the size of the former Norton Sound Regional Hospital and has facilitated increased patient visits in the primary and acute care areas, including chronic disease prevention and management. It has provided enhanced trauma and emergency services. To staff the new replacement facility, NSHC was required to hire people for a significant number of new jobs.

NSHC was disheartened when we first learned that sequestration was a possibility. At the same time, NSHC was waiting to hear if our Staffing Package to fund the new facility would be fully approved. At the start of FY13, NSHC was only guaranteed half of the funding for the necessary 159 positions required to operate safely and optimally. As a result of this funding uncertainty, the approval of NSHC's FY13 Operating Budget was put on hold. Several new, required positions were also put on hold.

Both the Tribal and IHS programs suffered under this situation. We always strive to do the best job possible in planning, decision-making, and administering programs. During this difficult time, we were limited by not knowing how much funding would be available or when it would be available. It also required constant re-working of our budget, resources better devoted to providing health care services.

On April 12, 2013, NSHC received a memo informing our facility of the over \$1.3 Million Dollar sequestered funds. Even though NSHC had been able to open the facility, new positions were put on hold and existing programs and services were carried out in a limited capacity.

NSHC was greatly limited in its ability to recruit and hire medical professionals, instead having to focus primarily on hiring the core, essential operational staff. During FY13, NSHC was not able to expand the health care services provided, as intended and for which the new and larger facility was constructed.

We thus strongly urge the Congress to fully exempt the IHS from any future sequestration, just as the VA and other health programs are exempt.

## Appendix E: Hot Issues by IHS Service Area

### ALASKA

#### 1. Hospitals and Health clinics: \$ 428.221M

##### a. Village Built Clinic Leases: Fully Fund Leases (*See stand-alone document on VBCs*)

The VBCs are essential for maintaining the Indian Health Service (IHS) Community Health Aide Program (CHAP) in Alaska, which provides the only local source of health care for Alaska Native people in rural areas. The CHAP program is mandated by Congress as the instrument for providing basic health services in remote Alaska Native villages. The CHAP program cannot operate without the use of safe, well-equipped clinic facilities. The IHS has for many years consistently severely under-funded the leases of VBCs by as much as 90% in some cases. In addition, lease rental amounts for the VBCs have failed to keep pace with costs –the majority of the leases for VBCs have not increased since 1989. The IHS has instead shifted its statutory responsibilities onto economically-poor villages and already underfunded Tribal Health Organizations (THOs). In several regions, THOs have agreed to take responsibility for utilities, staffing, and all maintenance of the VBC's in order to avoid closure. The leases in total are not enough to support facilities utilities, janitorial, supplies under this program, and most have no provision for repairs or maintenance.

Alaska based Tribal Health Organizations are excited to see that a \$2M increase, a first of its kind in decades, has been included in the FY2016 Consolidated Appropriations Act and an additional \$9 million in the President's FY2017 Budget. We support full funding for the Village Built Clinic leases. A personal testimony shared the following:

*My Grandmother and my namesake (a spiritual connection for my People) was one of the first generation Community Health Aides, an IHS model that has been replicated globally. I remember as a child patients coming to our home (which then did not have hot running water or a flush toilet) for care. I have watched as my friends and relatives received stitches, penicillin injections, care for parasite infections, and other care. The clinics have done so much to improve health care (and confidentiality) in our communities, but underfunding of these has put the advances at-risk. We cannot provide care or operate as we did when I was a child.*

*(Verné Boerner, Enrolled tribal member Native Village of Kiana)*

##### b. Health IT: \$20M

Across the Alaska Tribal Health System (ATHS), the use of Information Technology in maintenance of patient and provider records, as well as the actual delivery of health-care services, is essential. Because of unique geographic challenges and the ATHS referral system, adequately functioning Health IT services are even more important than in many urban areas in the Lower 48 states as it impacts emergency and routine medical consultation and care coordination with providers hundreds of miles away. . Providing adequate financial resources to carry out these functions is critical to the ATHS. It is critical as Health IT rapidly evolves that IHS maintain a strong Office of Information Technology. Resources will continue to be needed to ensure that IHS include and work collaboratively with Tribes to further develop its Information Data Collection System Data Mart and ensure that Tribes can access their co-owned data. Doing so will improve overall clinical data reporting and provide the President the most accurate data for developing the President's Budget, while allowing Tribal leaders and administrators the most accurate data in determining resource allocation and program development. Working certified EHRs, with immediately accessible personal health records, are a necessary function of patient care as providers move

into the highly effective Patient Centered Medical Home (PCMH) model. PCMH works when the team has access to realtime clinic data which is shared with the patient to engage him or her with care teams to develop personal health improvement plans and monitoring. IHS will also need the resources and time to collaborate with other federal agencies and departments, such as the Centers for Medicaid and Medicare Services (CMS), the Health Resources Services Administration (HRSA), and the Department of Veterans Affairs on guidelines and reporting requirements. This collaboration will reduce the need for largely redundant/duplicative systems and reducing the administrative burdens and cost, allowing for more resources to be dedicated to patient care. It is imperative that the IHS' development of systems keep pace with the evolving requirements for The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and Patient Centered Medical Home models. MACRA permanently replaced the sustainable growth rate (SGR) formula under former Meaningful Use of EHRs. The PCMH models are proven to be effective in organizing primary care that emphasizes care coordination and communication to transform primary care into "what patients want it to be." Those that are able to implement PCMHs experience higher quality and lower costs, and measurable improvement in the overall experience of care for the patient and provider.

#### *RPMS Laboratory Package Issues*

An urgent area of concern which has repeatedly been raised with the IHS without resolve, and which has direct effect on patient safety is the need to fix several RPMS Laboratory Package Issues. Specifically, there are five high-priority action items related to the RPMS laboratory package that greatly impact patient care, and which have been identified by the National Laboratory Professional Service Group ("Lab PSG") since at least 2012. These action items remain unresolved despite repeated past assurances from the Indian Health Service.

1. Auto-verification of In House Testing;
2. Auto-verification of Reference Laboratory Testing;
3. Microbiology interface for Vitek and Microscan;
4. Critical Value flagging of Qualitative Test Results;
5. Ask-at-Order Questions not Passing from EHR to Lab Package.

Continued neglect of these 5 issues creates the highest risk of causing harm to our people who seek care in an RPMS facility. These 5 issues are creating the greatest burden to smaller tribal / IHS clinics (which, typically, do not have laboratory professionals on staff) that must somehow manage the many "work-around" that these 5 issues create in order to protect patients. IHS must be provided resources to address not only national-driven initiatives such as ICD-10 and MU, but also to address the backlog of RPMS patches, especially those which affect patient care. Not doing so creates an incentive for Tribes to purchase alternative commercial systems. As one leader commented, "It's about patient safety. That has to be first when making our decision." Funding for OIT should be increased to ensure adequate resources not just for IHS OIT but for Tribal systems as well.

#### **c. CHAP training \$3M**

The shortage of available Community Health Aides (CHA) and Practitioners (CHAP) available to Village and other rural areas presents a significant risk to the health of Alaska Native people and the strength of the ATHS. The Alaska CHAP program trains, certifies and supports our CHAP who are considered as the "backbone" of the Tribal health system. CHAs and Practitioners are the only providers of primary and emergency care in most rural Alaskan communities. When this care is not available, beneficiaries needing even the most routine of care are forced to travel, at great personal and provider expense, to regional hubs. Often times, the shortage of primary care results in symptoms going

unaddressed and even minor maladies escalating into far costlier procedures. For trauma and other medical emergencies, it quickly becomes a matter of life and death. Adequately funding for the CHAP training program is an essential step in ensuring the rest of AHS functions correctly. The CHAP training program is a successful model which can be replicated in other rural Tribal communities where providers are difficult to recruit and retain. The \$3 million requested will provide additional training staff and training center capacity in Alaska to allow current CHA's the timely training they need to achieve certification. Currently there is a backlog of training slots of 1-2 years within the State. This compromises care and puts a burden on supervising physicians when CHA's are not able to complete training within a reasonable timeframe.

We applaud that the CHAP program is a model being considered by the IHS as a way to provide physician extenders into remote clinics where it has been difficult to recruit and retain providers. If this were to occur, however, the amount needed to expand and/or establish new CHAP training centers will have to be considered. Again, the \$3 million increase requested is for the existing CHAP program in Alaska which currently has the only training centers within the IHS health system.

#### **d. Housing**

The lack of adequate staff housing in rural areas is crippling efforts to recruit and retain trained and qualified personnel. The current system is not addressing the need and funding for staff housing must be identified separate from the facilities priority system. The ability to provide safe housing for providers willing to work in isolated rural communities has become a critical issue as funding to maintain and replace the few existing houses has not been made available for the past 20 years. In addition, not all clinics offer permanent housing for providers or even temporary housing for visiting specialists or locum staff. Locum staff working in rural clinics often are required to sleep on cots, or on the floor, in sleeping bags or are placed in costly lodging options, if even available. This disrupts their ability to be well-rested and alert when providing routine and 24/7 on-call emergency patient care.

## **2. Purchased and Referred Care (P/RC): \$218.003M**

Purchased and Referred Care (P/RC) funding levels only meet approximately half of the identified need for P/RC services and that denial of care under of P/RC is the critical issue facing the Tribes concerning the P/RC program. The pressure has lifted a bit in states that have expanded Medicaid, and Tribes anticipate this will significantly impact the overall health status of American Indians and Alaska Natives. However, it is important to note that in many Tribal health programs P/RC claims are not 100% paid, even under the current policies which were written in a way to limit access to care due to limited funds available for this program.. Many Tribal health programs still must rely on P/RC funds because their programs do not have the resources to directly offer the needed medical care. The majority of new facilities are for outpatient care; this has resulted in an increased need for referral to in-patient facilities with emergency rooms and higher acuity care services. While Medicaid Expansion has moved many facilities from being able to provide Priority One level of care to now providing Priority Three or Four levels, again access is still highly restricted based on old P/RC policies. Tribes believe that the ability to address Priority Four level of care promises the greatest return with regards to health status and quality of life improvement. Indeed, it is what our forefathers negotiated for when entering into treaties and agreements with the United States government. Tribes advocate for flexibility on the use of P/RC funds to be based on actual patient need. In order to ensure safe, quality continuum of care for all American Indians and Alaska Native, the P/RC manual must be updated to remove some of the existing barriers to eligibility for P/RC funded services. Additionally, efforts must be made to ensure the new authorities under the Indian Health Care Improvement Act for long term care, preventative and other services are incorporated into the updated P/RC manual. We fought long and hard for the IHCIA reauthorization and

these new authorities must be incorporated into all of the long-outdated IHS policy and program manuals and health delivery system reform.

### **3. Behavioral Health**

It is noteworthy that two of the three Alaska Tribes' priorities for the unfunded authorities in the Indian Health Care Improvement Reauthorization Act are centered on behavioral health initiatives (see Deliverable #3). Alaska continues to suffer from the highest suicide and unintentional deaths rates in the country. Most of these tragic events are associated with substance use and/or abuse.

#### *Increase funding for Tele-Behavioral Health*

Tele-behavioral health capabilities (Video Tele-conferencing—VTC) are essential to Alaska to expand services to rural communities. Many of our Alaskan villages are in remote areas off the road system, which severely compromises access to care. VTC offers promise, but some areas still require infrastructure development. In many villages digital connectivity is non-existent or rely on a satellite-based Internet system that is slow and unreliable. According to the Federal Communications Commission nearly 81% of rural Alaska residents lack access to modem broadband services with sufficient speed needed for high quality voice, data and video transmission.

In Alaska, recruiting and retaining clinicians, psychiatrists and other behavioral health providers statewide is challenging. Due to the remoteness of villages across the state and difficulty with transportation to these villages, maintaining licensed providers in every rural community is impossible. Therefore, Tele-behavioral health is a significant and crucial component to the spectrum of resources which must be provided remotely to support Alaska's Behavioral Health programs. Alaska Tribes support the need for the IHS to increase funding for tribal behavioral health programs to appropriately supply clinics throughout the state with Video Tele-Conferencing equipment and the necessary Internet connectivity in order to sustain and expand service delivery access to village based services.

#### *Increase funding for Behavioral Health Workforce Development (Staff Recruitment & Retention)*

Alaska has been progressive in replicating its highly successful CHAP training model by creating an innovative Behavioral Health Aide Model which focuses on prevention, intervention, treatment, case management and aftercare services in our rural communities. The trained and certified BHAs are a critical component of our care teams providing a local outreach and remote services for those who are affected by trauma, substance use and mental illness. However, traumatized individuals or those with substance use and/or mental health disorders often experience difficulty trusting others, including behavioral health providers, to begin their healing processes. This is exasperated by staff turnover, partially caused by the highly stressful nature of the job. Alaska's behavioral health programs statewide struggle with hiring Masters level qualified and licensed providers necessary to improve the quality, quantity and consistency of the behavioral health workforce in Alaska. We strongly advocate for increased funding to assist with the recruiting, retaining and training of culturally-responsive Alaska Native behavioral health providers. This includes funding programs which support Alaska Native students studying within the field of psychology through initiatives such as Alaska Native Community Advancement in Psychology. We are supportive of their program's mission to increase the number of Alaska Native college students majoring in psychology, graduating with a psychology degree and to promote working in the behavioral health field throughout Alaska Native communities.

### **4. Maintenance & Improvement combined with Sanitation Facilities Construction**

#### **a. M&I**

Many facilities and clinics are in dire need of maintenance and improvement, resulting from decades of neglect due to lack of funding. With the average age of many Tribal facilities well beyond industry standards, the need to address immediate repairs and to put in place a system to adequately fund their upkeep is essential. When patients and providers lack access to well-functioning facilities and equipment, the delivery of care and patient health is quickly compromised. In order to provide the level of care necessary to ensure a minimum standard of patient care, more resources need to be provided at the facility and clinic level. Furthermore, with proper maintenance and improvements to facilities, investments are protected by extending the usability of the facilities.

#### **b. Sanitation Facilities**

The Arctic Research Consortium of the United States reports that over 5,000 rural homes in Alaska are considered unserved (homes without running water and wastewater service within the home) and more than 2,000 of these homes are considered non-serviceable (homes that do not have running water and wastewater service AND cannot be provided service even if available within the community for various reasons such as: the home is not structurally sound, does not have a thermostatically controlled heat source, is too far from the community center to feasibly serve, is too small or is not a year-round occupied home) via traditional approaches (e.g., pipe or haul systems) because of concerns related to capital costs. Water and wastewater systems all over the state of Alaska are failing or out of regulatory compliance. These third world conditions are unacceptable in this day and age, especially as new technologies are making it more feasible to have water and waste systems put in which are more affordable and sustainable.

The IHS Sanitation Facilities Construction Program, an integral component of the IHS disease prevention activity, has carried out those activities since 1960 using funds appropriated for Sanitation Facilities Construction to provide potable water and waste disposal facilities for AI/AN people. As a result, the rates for infant mortality, the mortality rate for gastroenteritis and other environmentally related diseases have been dramatically reduced, by about 80 percent since 1973. The IHS physicians and health professionals credit many of these health status improvements to IHS' provision of water supplies, sewage disposal facilities, development of solid waste sites, and provision of technical assistance to Indian water and sewer utility organizations. The provision of Indian sanitation facilities is a very important component of the overall effort required to achieve a reduction in waterborne disease outbreaks, a goal highlighted in Healthy People 2020 "Topics & Objectives" for Environmental Health. Safe drinking water supplies and adequate waste disposal facilities are essential preconditions for most health promotion and disease prevention efforts, as well as being a major factor in the quality of life of Indian people.

### **5. Indian Health Professions**

Indian Health Professions, including funding to support a training center of Dental Health Aide Therapists (DHAT), are critical in order to meet the recruitment and retention needs faced by Tribal health programs. The shortage of providers, including DHATs, is one of the greatest barriers to access to care. One solution that invests in Tribal individuals and health programs is to "Grow Your Own." This also has the added benefit of building capacity, reduces turnover and helps support culturally appropriate approaches. The DHAT program has proven to be successful, providing both safe and cost effective care closer to home (in many cases in one's own home community). It has increased access to routine dental care and the benefits of early intervention are evident.



In addition, Alaska Tribes advocate the expansion of the Indian Health Professions scholarship program to extend opportunities for individuals interested in pursuing these highly successful community-based alternative careers paths such as DHATs, Community Health Aide Practitioners, Behavioral Health Aides and other alternative provider-extender certified programs. As this country faces shortages in all health professions, these alternative provider-extender models provide an effective way to ensure access to care in remote communities with chronic provider shortages. Scholarships are a way to finance the training and certification so that rural communities can afford to recruit and retain these new providers. The alternative is that many communities will go without access to basic health care, resulting in costly care needs down the road or even unnecessary early death.

## **6. IHS Advance Appropriations**

Late funding under Continuing Resolutions has significantly hampered budgeting, recruitment, retention, provision of services, facility maintenance and construction efforts of tribal and IHS health care providers. Providing sufficient, timely and predictable funding is needed to ensure the federal government meets its obligation to provide uninterrupted, safe health care for American Indian and Alaska Native people.

Since FY 1998, appropriated funds for medical services and facilities through IHS have not been provided before the commencement of the new fiscal year and only one year (FY 2006) when the Interior, Environment, and Related Agencies budget, which contains the funding for IHS, has been enacted by the beginning of the fiscal year.

In FY 2010, the Veterans Administration (VA) medical care programs achieved advance appropriations due to the impact on patient care when funds are not made available in a timely manner. The fact that Congress has implemented advance appropriations for the VA medical programs provides a compelling argument for tribes and tribal organizations to be given equivalent status with regard to IHS funding. Both systems provide direct medical care and both are the result of federal policies. Just as the veterans groups were alarmed at the impact of delayed funding upon the provision of health care to veterans and the ability of the VA to properly plan and manage its resources, so do tribes and tribal organizations who share similar concerns about the IHS health system.

We urge the Secretary to work with Congress to take the necessary steps for IHS funding to begin an advanced appropriations cycle so that tribal health care providers, as well as the IHS, would know the funding a year earlier and would not be subject to continuing resolutions.

## **7. Special Diabetes Program for Indians**

Few programs have proven to be as effective as the Special Diabetes Program for Indians (SDPI) has proven to be. Tribes are implementing evidence-based approaches that are attesting to the improvement of quality of life, lowering treatment costs, and yielding better health outcomes for tribal members. However, the disparities still exist. The progress made as a result of the SDPI is at risk due to shorter authorization periods, flat funding and more tribes needing access to SDPI funds, as reported in the Indian Health Service Special Diabetes Program for Indians 2011 Report to Congress:

SDPI not only provides targeted resources that enable the 404 grant programs to employ hundreds of health care professionals but also supplies the tools that help hundreds more receive training in delivering quality diabetes services. This strong network of professionals has dramatically increased access to diabetes medical care and prevention services for tens of thousands of American Indian and Alaska Native people.

SDPI resources put a spotlight on the need to reverse the growth of diabetes and diabetes-related chronic care issues. These resources enable local communities to concentrate on providing essential services to prevent and treat diabetes—services that are not often reimbursable by third party payers. Without these targeted funds, the spotlight on diabetes would fade quickly as Tribes do not have the funds within their limited available resources to deal with the diabetes epidemic.

However, the flat funding of the SDPI program has meant that the existing programs have already lost purchasing power. Diluting the funds further by expanding program to more tribes without additional funding would adversely affect the viability of current programs.

Alaska Tribes request for a minimum increase of \$50 million for a new total of \$200 million. Current programs should be held harmless from inflation erosion, and the additional funds will allow for tribes not currently funded to develop programs which to has been highly effective in reducing the devastating impact that diabetes has in Tribal communities..

## **8. Long-term Care/Eldercare**

“Elders need to be near the river where they were raise,” Rose Jerue, 1989. These and similar words from countless Alaska Native elders and their families guide the work to establish long term care services within the Alaska Tribal Health System (ATHS). Like elders anywhere, Alaska Native elders say they would prefer to be in their own home throughout their lives. In the past elders did stay at home with their families. But in these changing times, that is not always possible and more elders are finding themselves in nursing and assisted living homes in urban areas, far from the river where they were raised. Although elders would prefer to stay in their homes, sometimes this is not possible and their care needs exceed what their family and other supports can provide and they require nursing or assisted living care.

Long term care is care of an elder or individual with a disability who requires on-going assistance with daily activities such as bathing, dressing, eating, shopping and cooking. Long term care is a system that integrates medical and social needs to provide services over time. The system includes nursing and assisted living homes, as well as services brought to the home such as personal care, meal delivery and chore assistance.

People over the age of 65 are one of the most rapidly growing segments of the population in Alaska. From a population growth projection, this population is expect to grow from 7,135 in 2004 to 15,135 in 2020. Increases in life expectancy can also lead to a higher prevalence of chronic disease and with it increased incidence of disability and functional limitations. American Indians and Alaska Natives reportedly have more disabilities than other ethnic groups (Jackson 2000, John and Baldrige 1996). Higher rates of disability and functional limitations along with the increasing numbers of elders exacerbate the need for long term care planning within the Alaska Tribal Health System

Due to lack of housing, access to locally-available specialized care in rural clinics, and poor reimbursement options to cover costs, Alaska tribal health organizations are opting for nursing rather than assisted living home care. This is made more fiscally feasible in part because the Nursing home rates are cost-based in Alaska,. More tribal health organizations might be interested in assisted living if the IHS provided some operating funding for individuals needing a lower level of care than nursing-level care. These services include residential care, such as nursing homes and assisted living facilities, home and community-based services, caregiver services, case management and respite care.

The authority under the Indian Health Care Improvement Act (IHCIA) which allows IHS to offer and fund long-term care services presents great promise for meeting the needs of our Elders and those with disabilities. Alaska Native elders and the disabled must have access to the long-term care services and support necessary to remain healthy and safe while retaining as much independence as possible in their communities. Alaska tribes urge the IHS to target funds to implement LTC services as authorized under the IHCIA. There is also a need to support and coordinate the efforts of IHS and the Centers for Medicare & Medicaid Services to address reimbursement and certification/regulatory issues.

## ALBUQUERQUE

### 1. Hospitals & Clinics

The Hospital and Clinics Line Item Program has been underfunded for many years. In prior years, the program has been incurring deficits and/or services have not been provided due to inadequate funding. The increase will maintain or supplement services that have been achieved to date. Due to personnel, medical supplies and more specific pharmaceutical inflation cost increases, current H&C budget does not adequately cover the minute mandatory funding increases received in prior years. The population growth and patient demand resulting in increasing patient load contribute to insufficient funding. The increases will maintain current services that have been achieved to date. Funding supports the operations of IHS and is needed to support current services, and for the expansion of services, purchase of necessary supplies and equipment and hire additional staff.

IHS and tribally operated (638) facilities located on the reservations are often the only place that Native American patients can obtain healthcare. In the urban setting, such as the Albuquerque Metropolitan Area, the Urban Indian population heavily relies on facilities such as the Albuquerque Indian Health Center and First Nations Community Health Source to obtain direct healthcare services. By the year 2050, it is anticipated that the Native American population will reach approximately 8 million, thereby requiring us to increase access to care by hiring additional and expanding services to help meet the need. Additionally, with the changes in healthcare delivery, and the Affordable Care Act, we must not only increase access to care, but also, meet various requirements with IT infrastructure, reporting measures as part of Meaningful Use and measureable outcomes.

Increased H&C funding is also greatly needed in order for IHS to become more competitive with the salaries for physicians in regard to recruitment and retention. Recruiting, and more importantly, retaining a core of primary care providers is essential to successfully achieving Patient Centered Medical Home status and stability.

Due to changes in healthcare delivery and payment systems, as we move away from a fee-for-service and more towards a pay for performance and wellness system, prevention is key. Additional H&C dollars will be needed to focus on wellness and prevention, which has proven to be more cost effective than reactive spending to treat the illness, chronic disease or injury.

Of all the health disparities between New Mexico's Native American population and the general public, injuries remain near the top. For instance, in October 2013 the New Mexico Department of Health reported that the motor vehicle death rate among Native Americans was 37.2 per 100,000 in the years 2010-2012, compared to 16.0 per 100,000 among all residents of New Mexico and 11.3 per 100,000 nationwide. Addressing injuries can be helped with an increase in Hospitals and Health Clinics funding, to increase the capacity to engage in health promotion and healthy lifestyle education within our communities.

At the Mescalero Service Unit, due to the remoteness of the facility an increase in urgent care hours is needed as the nearest Emergency Room is 25 miles away. During the winter months the travel for community members becomes hardship. An extension of Urgent Care hours can be sustained with recurring funds.

The Ramah/Pine Hill Tribal Health Clinic does not have enough IHS funds to provide healthcare full time and as a result they had to reduce their clinic operating hours. This led to their providers leaving and putting their patients at risk. The clinic has requested Commission Officers to fill the need, but they are too costly to obtain. We only have locum-tenen providers who come out to Pine Hill on a limited base to provide medical care. Additionally, at the Zuni I.H.S federal facility, there are critical positions that are vacant. This includes nurses and medical providers. Zuni provides service to the various outlying areas into Arizona. The outpatient clinic (OPD) visits is increasing annually at an alarming rate. In late 1990s annual visits totaled 55,000 for Zuni-Ramah Service Unit and now it is reaching over 115,000.

H & C and be utilized for Health Promotion to address community increases in Obesity and Allergies. The Jicarilla Apache community programs and the Jicarilla Service Unit are very interested in implementing strong outreach programs to target the Headstart children and the obese population in the community. Establishing an outreach program to develop programs that implement healthy eating habits, stronger exercise and fitness programs, training on child rearing and positive parenting and incorporating cultural programs is the focus. Funding may also be used to develop walkways or bike trails within the community. [IHCIA Sec. 123. Diabetes Prevention, Treatment and Control.]

Additionally, at the Jicarilla Service Unit, many patients are denied payment of medical bills through the Purchased Referred Care program because of different reasons. When patients who are tribal members are denied, they take their medical bills to the Jicarilla Apache Nation Treasurers office who pay for these bills for the patients. The funding is depleted due to the high cost of health care. Additional funding would assist this program with meeting the health care needs of those who are ineligible for Purchased Referred Care and do not have an alternate resource.

Finally, H & C could be utilized by the Jicarilla Apache Nation EMS program. The program is actively hiring additional qualified EMTs and paramedics to their staffing levels. The six ambulances are in need of upgraded equipment to support the services the staff provide in this remote location. Transports of patients can exceed 100 miles one way to the nearest medical center and adequate equipment is required.

H & C for the Ute Mountain Health Center is underfunded and requires supplementation with third party funds each year. The Ute Mountain Ute Tribe is particularly concerned about the availability of medical specialists, cancer screening/diagnosis/care and diabetes care. The Tribe would like to see more medical specialist coming to the Health Center rather than Tribal Members being sent elsewhere. The Tribe would also like to see more available services in Towaoc both for cancer, diabetes care and preventive/educational health care.

The medical health care needs of the To'hajiilee community are high due to insufficient facilities, health providers, and equipment. The diabetes disease is very high and we have 207 community members that are affected by this disease and this requires major health care services and education. Also the health study conducted by the NM Department of Health in 2013 indicated that the Death Rates for Diabetes is the highest for Native Americans in the State of New Mexico and is 3 times higher than the US rate for Diabetes deaths. Major health care services are needed in To'Hajiilee for the following areas: Diabetes, Obesity, Mental Health, Cancer, Heart Disease, Optometry, Elder Health, Maternal & Child Health, Infectious Diseases, and Diabetes education.

The participants in the Santa Fe Service Unit's (SFSU) budget consultation session all agreed that an increased emphasis on health promotion and disease prevention (HP/DP) is a key component to any healthcare system. In fact, HP/DP concepts and principles should be incorporated into every level of our agency's operations. The

increased funding for HP/DP should be in Hospitals and Health Clinics in order to increase capacity within the agency.

The IHS has a history of attracting high quality primary care providers who can provide maternal and child health services, such as pediatricians, family physicians, certified midwives and nurse practitioners. The best way to ensure adequate access to maternal and child health services is to increase Hospitals and Health Clinic funds, so that we can increase and maintain the number of primary care providers within the agency.

## **2. Purchased Referred Care (PRC)**

The Purchased & Referred Care Line Item has been underfunded for many years. Many facilities are restricted to Priority I and Catastrophic Healthcare Emergency Cases (CHEF). Patient access to services beyond what can be provided as direct care at an IHS facility is critical to ensuring that medical conditions are treated. Ongoing specialty care for chronic medical conditions can become very costly. Additionally, only 1 or 2 CHEF cases or patients with a diagnosis such as cancer requiring very expensive medications, treatments, prolonged hospitalizations...can quickly utilize much of the budget.

Although the current denied and deferred data is not as complete as we would like, the need for purchasing specialty care from private providers is still greater than the annual appropriated funding to date. While we work on improving reliable data collection, we strongly recommend continuing to increase the base funding. As historical data indicate most of the current base funding is used for Priority I (life and limb) in most locations with a few locations extend to Priority II, III, IV and rarely at V due to implementation of ACA.

Indian Health Service (IHS) has established Medical Priorities because PRC funding is inadequate to fund all needed medical services. Currently, many facilities are restricted to pay for life & limb threatening emergencies (Medical Priority 1).

Because of IHS priorities and lack of funds, the following services must be paid for by the patients:

- Arthroscopic knee surgery
- Cataract surgery
- Dentures
- Allergies
- Podiatry services
- Dermatology services
- Physical Therapy services

The Purchase & Referred Care has been underfunded for many years. For most facilities, only Priority I (life & limb) and Catastrophic Healthcare Emergency Cases (CHEF) are being funded. Many service units requested CHEF dollars but this fund was depleted where many CHEF cases were unfunded thereby utilizing PRC or other resources.

The Zuni Service Unit is aggressively enrolling native people into the managed care organization providing them with Medicaid and Medicare reimbursements to meet these shortfalls. The use of Medicaid Medicare reimbursements for PRC deficits leave less for much needed renovations and other capital improvements. Even though PRC regulations require our Tribal members to enroll in alternative health care, there is a percentage that do not qualify and PRC is still needed to meet those individual needs

For example, Ramah still has their Tribal shares with the federally run PRC Program and supports the increase in funds for its Zuni-Ramah Service Unit. Ramah understands that Zuni I.H.S. may run out of PRC funds and will use Medicaid and Medicare reimbursements to meet the shortfall if ACA is rescinded or drastic changes come about due to legislative actions. Nationally not all States expanded their Medicaid programs to allow for more people to enroll in this health insurance program and fortunately in New Mexico it elected to expand its Medicaid program. Even though the service unit is working aggressively to enroll our people into this program, some still hesitate assuming that I.H.S. provides their healthcare. If we had a Native American managed care organization, patients might be more willing to apply for health insurance.

The Zuni-Ramah Service Unit has seen a tremendous increase in the daily flights of our community members being referred for tertiary care to metropolitan areas. It is very common to hear a plane leave Zuni one to two times per day for medical transports.

Again even though the Health Care System regarding third party billing is in place, our community members still prefer IHS as their primary provider.

The Ute Mountain Ute Health Center has been able to move into Priority 3-4 due to Medicaid Expansion in the State of Colorado. Due to Colorado Medicaid Expansion, the patients in Utah have also benefited, receiving equal PRC coverage. The Ute Mountain Ute Tribe recognizes the need for increased access to care to specialty services within the Indian Health Service.

At the Taos Picuris Health Center, the facility has been able to move into Priority 4 at this time primarily due to Medicaid Expansion in the State of New Mexico. However, this has increased the number of referrals that need to be processed. There we are recommending this increase to be used to add PRC staff to assist patients with referrals and getting appointments arranged.

At the ACL Service Unit, Purchase Referred Care is ranked as the number 2 priority ( IHCIA Sections 121) because PRC provides a lot of specialized medical care services to community members. PRC provides specialized medical services, health education and prevention services conducted by medical specialist to treat and cures illnesses and prevents many of the illnesses and diseases in the To'Hajiilee community. Specialized Medical Practitioners provide specialized health care services and prevention education to To'hajiilee community members in the following areas: Diabetes, Obesity, Substance Abuse, Cancer, Health Disease, Maternal & Child Health, Elder Health, Respiratory/Pulmonary, Dental, Domestic Violence/Abuse and Infectious Diseases.

ACA and Medicaid expansion has significantly impacted the I.H.S. and Tribal health systems positively by increasing revenue generated from direct services, as the majority of Native Americans, eligible users are qualified for third party resources. This eligibility allows the facility to generate significant funds that can then be used to support the specific facility services expansion and PRC. Increased funding directly to PRC should continue to be a priority for I.H.S. to ensure that Native American men, women, and children can access high quality specialists, and other alternative treatments for medical problems can be supported. More consideration should be given for expanding the scope of allowable services under PRC. Sec 129. Patient Travel Costs could be considered as a category to be reimbursed by PRC. Sec. 129 authorizes use of funds for travel costs of patients receiving health care services provided either directly by I.H.S or by a contracted provider.

The Santa Fe Service Unit (SFSU) recommends PRC funds be increased to assist with Chronic Disease Management. Effective cancer care begins with early diagnosis, and this is particularly true for the more common cancers of the cervix, breast, and colon, all of which have effective screening tests (PAP smears for cervical cancer, mammography for breast

cancer, and stool blood assays or colonoscopy for colon cancer). Cancer screening is relatively inexpensive compared to actual cancer treatment, and this is a service that is already well-integrated into the agency's primary care services. Once diagnosed, however, cancer treatment can be very expensive, so to adequately address this high priority condition, funding increases to address cancer should be in Purchased and Referred Care.

Heart disease is a multifactorial health problem, and coronary artery disease remains near the top of the list for causes of death among our communities. The most significant risk factors for coronary artery disease among the patients in the SFSU include type 2 diabetes mellitus, hypertension, and high blood cholesterol. Those who are obese are at a much higher risk for developing these health problems, as well as conditions such as obstructive sleep apnea, which can lead to right heart failure. Our budget consultation participants agreed that a significant amount of funds should be dedicated towards increasing the capacity within our agency to address issues such as obesity screening, both with children and adults, and community-based healthy lifestyle education; such services are provided well within the agency's primary care clinics. The budget consultation participants also recognized, however, that patients with heart disease generally need higher levels of care that are not available within the IHS, such as cardiology consultations, admissions to coronary care units, high tech diagnostic testing (exercise stress testing, echocardiography, cardiac catheterization, etc.), and highly specialized surgical procedures such as coronary artery bypass. For this reason, the SFSU recommended that budget increases to address heart disease and obesity should be in PRC to ensure access to private sector specialty care.

SFSU Diabetes mellitus continues to be the most significant single health problem among our tribal communities, and our budget consultation participants expressed the belief that the best way to address it is to engage in prevention activities at a very young age and to regularly screen for the condition to ensure proper treatment and, hopefully, to minimize its many complications. As with heart disease and obesity, these services are already addressed well within the agency's primary care clinics. A sad reality of diabetes mellitus is that in a population such as ours with a rate which is much higher than the rest of the country, there will also be a disproportionately high number of referrals to private sector specialists such as cardiologists, retinal specialists, nephrologists, podiatrists, and wound care specialists. For this reason, any increases in funds to address diabetes mellitus should be in P/RC.

### **3. Dental Care:**

While sufficient tools and technology exist to prevent and control oral disease, American Indians/Alaska Native (AI/AN) children continue to experience tooth decay at higher rates than the general population. According to the National Institute of Dental Research, dental caries is the most common disease in childhood and, at the same time, the most preventable. The first oral health survey of a national, community based sample of AI/AN preschool children confirms that in the United States, AI/AN children served by IHS/Tribal programs are one of the racial/ethnic groups at highest risk of ECC.

Funds are also needed for Competitive market pay salaries. After researching the 2014 salary tables of other ranked IHS facilities dentist and comparing the Occupational Employment and Wage Estimates for 2014 for the state of New Mexico it is clear this I.H.S. facilities falls way short on being competitive for dental salaries and has caused on particular job applicant to seek a higher salary at another facility after a job offer was made.

There is a need in funding supplies and continue to purchase and/or upgrade equipment requirement in order to continually provide standard of care to our patients. We will continue to need funds in order to provide the best care possible and purchase equipment to complete procedures that at the very least provide standard of care.

As with mental health and substance abuse services, the Santa Fe Service Unit (SFSU) constituent tribes regularly state that the IHS chronically underfunds dental care in proportion to the marked unmet need in our communities. Most of the dental providers within the IHS, and this is certainly true for all of the SFSU's dental officers, are trained to do higher levels of care such as crowns, bridges, root canals, and other restorative dental care, but inadequate staffing levels compel



most of our dental programs to focus almost exclusively on preventive care and acute dental issues. Our budget consultation participants stated that the best way to address our communities' unmet dental needs is to increase capacity within the agency, hence the recommendation that increased funds go to Dental Services.

The Mescalero Service Unit is staffed with one Dentist and one Dental Assistant and cannot meet the demand for dental care of the patients. The increase in funding would improve access to care and services with a focus on prevention

The Zuni Service Unit provides Services to a wide spectrum of communities and in this respect this adversely affects the services. Children within our community are referred out for dental services outside of Zuni. A pediatric provider is needed. One avenue that this will benefit the tribe would be to have a pediatric specialty clinic to decrease the referrals. With the Health Care System that was developed this will provide the third party reimbursement to decrease the over expenditures. Presently the Zuni Service Unit has a waiting list of community members for dental services. This can be alleviated if other factors such as space, staffing and housing issues which directly affect this is also considered in the overall Budget formulation. As requested, there are several items that need to be addressed when requesting funds for the Dental Department. As we stated before Staffing needs is a primary concern. We are understaffed to accommodate this service units existing Patient population.

According to statistical data, in order to support the services unit's patient pool would need 15 assistants, 7 dentists, 3 hygienists and 1 front desk person. This computes to 3 support staff 1 Dentist very well short of current staffing pattern. To comply with IHS recommended facility Doctor to chair ratio's we would also need 14 dental operator chairs for dentists and 3 chairs for hygienist. This falls short to current conditions.

The Ute Mountain Ute Tribe would like to see more dental services aimed at dental health and hygiene in attempts to save teeth versus extractions. The tribe would like to increase access to care to services within the clinic such as dental hygienists, endodontics and orthodontics for patients.

There is a critical need for adult dental services across the Albuquerque Service Unit, particularly for the Urban Indian, uninsured population. Dental exams are a standard of care for all adult, but particularly for pregnant women, diabetics and those with HIV. Many Urban Indian patients have to make a long drive to find a dental clinic located on the surrounding reservations, but very often cannot make the long drive to the outlying dental clinics and cannot get dental services, other than being seen for a dental emergency

The ACL Service Unit ranked Dental as a high priority (IHCIA Section 121) because there are limited dental services in the To'Hajiilee community. The Canoncito Clinic has a dental program that is open 5 day a week in FY 2015 however, the clinic has problems retaining Dentist, Dental Assistants and Receptionist; and the clinic has a part Dental Hygienist. Dental services are also provided at the ACL Service Unit and in Albuquerque, NM and both dental facilities are 40 miles away. There is a long waiting list for a dental appointments and it may several months to be seen by a Dentist or Dental Hygienist. The Canoncito Clinic and the ACL Service Unit needs specialized dental staff for dental services and prevention, and dental equipment to service the growing population.

#### **4. Alcohol and Substance Abuse:**

The Alcohol and Substance Abuse Line Item has also been underfunded for many years. Funding is needed to support the operation of IHS and is needed to support current services and the expansion of additional prevention, outreach and education services. There is currently an IHS initiative to reduce the abuse and misuse of controlled substances in Indian Country. This "legal" form of substance abuse is becoming widely recognized as a form of substance abuse that negatively impacts our patient population.

A health study conducted by the NM Department of Health in 2013 indicated that Alcohol-related Death Rates is the highest for Native Americans in the State of New Mexico and is 4 times higher than the US rate for alcohol-related deaths.

As with the first priority listed above, Santa Fe Service Unit's (SFSU) tribes consistently report that the IHS in general and the SFSU in particular does not have adequate funding to address alcohol and substance abuse treatment and prevention. Inadequate funding for alcohol and substance abuse services has a ripple effect on other funding sources, such as overloading the agency's outpatient clinics, urgent care departments, and emergency departments with unnecessary visits (typically funded by Hospitals and Health Clinic funds and third party collections). The increased number of patient visits to private sector emergency departments also puts an increased burden on Contract Health Services. In our budget consultation session, most participants agreed that the best way to deal with this top priority was to increase our capacity within the agency with increased line item funds in Alcohol and Substance Abuse.

At the Jicarilla Service Unit, many clients are sent away from the reservation for long term treatment programs but when they return to the community, there is not a place they can go to for transitional services back to the environment of the reservation. Some return to the habits of alcohol and substance abuse. The Jicarilla Apache Nation Behavioral Health program is recommending the establishment of a safe house and a juvenile treatment center. This program will support the clients in transitioning back into the community with systems such as employment, counseling, healthy behaviors, culture, language and other programs. [IHCIA Section 708 Indian Youth Program involvement. Section 709. Inpatient and Community-Based Mental Health Facilities Design, Construction and Staffing. Section 726. Indian Youth Life Skills Development Demonstration Program.]

The ACL Service Unit ranked Alcohol and Substance Abuse as a priority (IHCIA Section 702) because of the increasing problems with alcohol and drug abuse in the To'Hajiilee community which includes the youth population. Canoncito has very limited in-patient treatment money for clients and through its' 638 A&SA program allocates about \$5,000 for in-patient treatment per year which is enough for 1 patient for 30 days. Prevention education is provided to clients and provided at public events.

## **5. Mental Health/Behavioral Health**

Mental Health issues continue to plague many Native American communities. There are several mental health related disparities that still exist. Recruiting and retaining professional and culturally sensitive healthcare professionals remains challenging. There is a great need for counseling/therapy services. It has been estimated that depression is quite prevalent in the outpatient primary care setting, with estimates of 9% to 16% of general medical outpatients. If healthcare now requires us to focus on prevention and wellness, more must be done to address mental health, which impacts co-morbid conditions and outcomes related to chronic illness. Increased funding in the area of mental health would allow for expansion of and integration of behavioral health into the primary care clinics so that there is focus on the physical and mental health. There is also IHS Initiatives to promote programs that will prevent and reduce teen suicide.

A health study conducted by the NM Department of Health in 2013 indicated that Suicide Death Rates and Homicide Death Rates are the highest for Native Americans in the State of New Mexico and both are 4 times higher than the US death rates. There are very limited funds available for mental health treatment and the treatment is very expensive.

With the emphasis on addressing mental health in preventing and with underlying chronic disease Zuni Hospital is limited to providing those services. Mental Health professionals are able to obtain market pay in urban areas and are not attracted to the remote isolated areas unless good retention benefits are offered.

The Santa Fe Service Unit's (SFSU) constituent tribes have long expressed that the IHS in general and the SFSU in particular have very inadequate funds to address behavioral health and mental health issues such as depression, anxiety disorders, and suicide (particularly among adolescents and young adults). Contract Health Services funds are not available to cover routine outpatient behavioral health and mental health services. When these problems go untreated, they often lead to expensive emergency department visits and inpatient psychiatric admissions, placing an increased burden on Contract Health Services. In our budget consultation session, most participants agreed that the best way to deal with this top priority was to increase our capacity within the agency with increased line item funds in Mental Health. It is also the Health Board's contention that, with the high prevalence of diabetes in Native American communities, additional funding in the Mental Health line item is needed to assist with increased mental health support that diabetics need.

The Jicarilla Apache Nation Behavioral Health program has a large turnover in staff and when new staff come on board, they are not from this community. The JAN BH programs wants to develop a stronger in-service/orientation program that incorporates tribal culture, child rearing skills, tribal language for stronger communication, traditional values and dealing with behaviors specific to students as bullying and stalking. [IHCIA, Section 127. Behavioral Health Training and Community Education Programs; Section 702 Behavioral Health Prevention and Treatment Services; Section 704. Comprehensive Behavioral Health Prevention and Treatment Program]

The Ute Mountain Ute Tribe recognizes the huge need for additional staffing in the mental health program. In particular, the current mental health program does not have enough staff to meet the needs for BIA Detention (particularly with the new Parole Re-Entry Program being planned), needs of Tribal Children in local schools who need counseling/intervention and the increasing needs of the general Tribal Membership particularly as the benefits of the mental health program have received greater awareness in the community.

The ACL Service Unit ranked Mental Health as a priority (IHCIA Section 702) because health services and prevention services are needed in the community of To'Hajiilee for youth and adults that have mental problems including dual disorders. Canoncito does not offer mental health treatment in To'Hajiilee and relies on the ACL Service Unit for treatment and ACL Service Unit also has limited services.

## **6. Health Care Facilities Construction**

Many IHS facilities are decades only and in need of major renovation and/or reconstruction. There is a great need to improve efficiency not only with patient flow, but also with energy efficiency and this is quite challenging in the older pre-existing buildings still in use. New IT and equipment upgrade requirements are also challenging in some of the old structures. Major renovations, reconstruction and/or new construction is often required.

The Mescalero Service Unit is over 40 years old with major repairs needed. Inpatient exterior windows need to be replaced. The plumbing in the inpatient rooms all have to be replaced. Exterior entrance way with handicap ramp has crumbling cement on the walkway. In the outpatient flooring contains asbestos. Need for space is a big issue for our growing patient load. Security issues with lack of street lights in parking lot areas and surrounding campus building.

The Jicarilla SU is located in the remote town of Dulce, NM. Housing for potential health care employees is at an all-time low with many current employees commuting as far away as 90 miles one way and 45 miles one way on a daily basis. The lack of housing also has a negative impact on future recruits. Many potential employees for both I H S and the JAN Behavioral Health program have declined positions due to the lack of housing. Having needed housing available in support of recruitment, will increase quality of and access to health care and support a huge investment in the community as far as recruitment.

The Ute Mountain Ute Tribe recognizes the underfunding of Facilities Maintenance & Improvement, Sanitation Facilities Construction, Health Care Facility Construction, and Equipment. The Tribe realizes current facilities are outdated (most over 30 years versus the private sector which is well under 10 years). Not only are facilities outdated and old, but also are inefficient in design hindering efficient patient care and access to care. With additional space and more efficient design, additional services can be provided and access to care increased.

## **7. Facilities & Environmental Health Support**

The Mescalero Apache Tribal community lacks adequate water & sewer services to serve about 35% of the tribal members that require the service for new homes. There is a waiting list for members to obtain services.

## **8. Community Health Representative Program (CHR)**

Community Health Representatives (CHRs) play a valuable role in healthcare delivery and community education particularly on the reservations. Their services are highly utilized, particularly for community members who rely on them for transportation to and from necessary medical appointments. They also play a critical role in helping to disseminate information and gaining the trust of the community, as they are often members of the community in which they serve.

For the 2018 IHS Budget formulation the Zuni/Ramah Service Unit identified the Community Health Representative program as a priority for funding. Research has shown that home visits by a service provider improves health outcomes and is primary strategy in doing an effective prevention program.

Zuni Service Unit provides Services to a wide spectrum of communities and in this respect this adversely affects the services. Community Health Providers (CHR) is the primary contact person between IHS and the community. They provide services such as non-emergency transportation for community members wanting to access doctor appointments; conduct bedside care for home bound patients; are reliable resource persons between the provider and the patient in coordinating the health care; and outreach to promote prevention with many of the illnesses that affect our community. Limited budget affects how these services are provided. In order to provide not just patient care but transportation regarding purchasing of vehicles and maintenance along with staffing needs to be considered.

The CHR program covers the spectrum of the stages of life from prenatal to our Elders and they are the primary contact between the Services Units and patient homes. They have the ability to comprehensively assess their patient needs and develop a plan of care that can greatly improve their quality of life. For instance the CHR program can develop patient centered medical homes (PCMH) to advocate and assist patients navigate their healthcare system. This can reduce no-shows and follow ups of patient care. In addition coordinated care can be developed so that patients can be assisted with other resources that can assist them in improving their quality of life. Increasing home visits can also address people who never access services and reinforce their connective to their community. Elders have stated that “no one visits them anymore” “Where have all my relatives gone?” In addition, Native communities have health disparities that are higher than the national averages and the root causes may be adverse childhood experiences.

*“The ACE Study findings suggest that certain experiences are major risk factors for the leading causes of illness and death as well as poor quality of life in the United States. It is critical to understand how some of the worst health and social problems in our nation can arise as a consequence of adverse childhood experiences. Realizing these connections is likely to improve efforts towards prevention and recovery.”(CDC Adverse Childhood Experience).*

By increasing our CHR program and increasing their home visits to monitor the health of their communities through a coordinated health system will resolve a lot of our physical and mental health disparities that affect Native communities.

At the Jicarilla Service Unit, the need for transportation for patients to medical appointments has grown significantly plus other healthy initiatives regarding diabetic education, increased participation in the Group Lifestyle program and other outreach efforts. The current CHR program has lost positions due to the effects of sequestration to the budgetary process in the past years.

The Ute Mountain Ute Tribe has identified a barrier to access to outside care. It recognizes the need to increase the Community Health Representative program. The program can assist patients and the community in promoting healthy lifestyles, disease preventions, accessing outside services, assisting patients in keeping appointments and coordinating care.

The establishment of CHR programs in Urban areas will benefit Native American individuals that reside in near-by reservation cities and frequently move between reservation and cities, to support the care coordination and navigation needs they have. A direct linkages between existing and new Urban programs should be required for care coordination, support, case staffing and training. The Urban CHR program will create a new dynamic to care and these programs can interface with public Hospitals and clinics that serves large Native American populations. Funding for this program to establishment of a Community Health Representative program for urban Indian organizations to train and employ Indians to provide health care services is supported.

## **9. Contract Support Cost**

The Congressional mandated to Indian Health Service to fund Tribal Grantees at 100% for Contract Support Cost but not allocating additional funds to the I.H.S. budget to cover the cost. We are recommending that additional funds be allocated for CSC. Funds are available to cover current services and binding obligations, but not for CSC. We understand that this will continue to affect IHS's delivery of services as more Tribes contract these services with IHS and long term solutions need to be identified to address this issue. The delivery of services will affect tribes if CSC continues to be an issue. Tribal Leaders along with support from the IHS director needs to advocate Congressional support to increase the IHS budget. Primarily, Tribal Leaders need to advocate for increasing the budget for IHS. Secondary, Tribal Leaders need to develop a Native American Health Plan use the I/T/U as their managed care providers. By developing a Native American Health Plan as a managed care organization it can contract the State Medicaid programs and Native American enterprises and Tribal organizations' health plans.

## **10. Urban**

The Albuquerque Service Unit and First Nations Healthsource provide medical care to a large Urban Indian population. Patients that utilize these facilities represent the 500+ federally recognized tribes and this is their only means of access to healthcare, particularly for the uninsured and/or those who are do not live within their own CHSDA.

# **CALIFORNIA**

**1. Increase Funding for the Tejon Tribe based upon membership increases since 2012.** The Tejon Indian Tribe was reaffirmed as a federally-recognized tribe on January 3, 2012. New Tribes Funding for 296 unduplicated users was submitted by the CAO for the FY 2015 Budget. Subsequently in May 2015 the Bureau of Indian Affairs reviewed and approved the Tribe's rolls of 796 duly enrolled members. The Tribe, as of November 2015, has 815 enrolled members. The Tribe requests that a correction to the rolls be made to reflect

the true number of Tribal members. The legitimate roll for the Tribe is a critical Hot Topic to ensure some measure of parity, and development of a budget recognizing the accurate and approved numbers.

**2. The Hoopa Valley Tribe (Hoopa) and the K'ima:w Medical Center ambulance service are seeking IHS funding to offset their rising operating costs.** The K'ima:w ambulance service provides critical advanced life support emergency medical services to the Hoopa Valley Tribe, portions of the Karuk Tribe and Yurok Tribe, and surrounding communities, responding to approximately 980 calls in the past year. The ambulance service started without any IHS, state, county, or community funding. In 1983, Hoopa used funds from IHS (Community Health Representative and IHS Headquarters) to obtain an ambulance from General Services Administration (GSA). The tribe is seeking IHS funding in the amount of \$850,000 to compensate for increases in operating costs for the K'ima:w Medical Center ambulance service. Medicare and Medi-Cal reimbursements, in addition to the Hoopa Valley Tribe subsidizing operational costs, are not sufficient to sustain the K'ima:w ambulance program.

**3. The Southern California Tribal Chairman's Association (SCTCA) advocates for an Adult Drug and Alcohol Treatment Center.** There are currently no culturally-based treatment centers available for Native Americans over the age of 18 in southern California. The SCTCA proposes a 20 bed in-patient facility that serves 26 Tribes and Urban area located in southern California. The Southern California Adult Health Center will provide culturally relevant substance abuse and mental health wellness to American Indian patients and families in southern California. Treatment will utilize a Trauma Informed Care platform with the objective to substantially improve outcomes of lifetime recovery for patients.

**4. Mr. Jess Montoya, Executive Director, Riverside/San Bernardino County Indian Health, is advocating for Medicare-Like Rates.** It is projected that Medicare-Like Rates could save tribes over 100 million dollars annually. This will greatly expand the buying power of the Purchased and Referred Care funding. PRC is critical in California because there are no IHS or tribal hospitals. Guidelines for Medicare-Like Rates were developed and posted in the Federal Register and California Area programs submitted comments. Medicare-Like Rates are very important and provide cost savings throughout the United States.

**5. Mr. Preston Pete, Tribal Representative, Pinoleville Pomo Nation, is concerned about the long-term viability of the Resource & Patient Management System/ Electronic Health Record (RPMS/EHR).** Commercial off-the-shelf electronic health record systems are often advertised as having more advanced features and options than RPMS. The gaps in technology between off-the-shelf EHR software products and RPMS seem to be getting larger. IHS appears to be focused on the immediate needs, such as Meaningful Use, and does not appear to be devoting resources to allow RPMS to compete with the other commercial products. Unless RPMS can compete with other commercial EHR systems, more tribal health programs will switch from RPMS to other commercial EHR products. This will exacerbate the funding issues as more programs will take their RPMS shares.

**6. Dr. Mark LeBeau, Executive Director, California Rural Indian Health Board, Inc., advocates for funding for Section 124 of the Indian Health Care Improvement Act.** Section 124 provides authority for the IHS to carry out hospice care in addition to long-term care, assisted living, and home- and community-based services in tribal communities. A large amount of funding for infrastructure is needed to support long-term care services. This funding should be directed to develop staffing programs and carry out home- and community-based services that are reimbursable under Medicaid. This would allow these programs to become self-sustaining and to help address the aging population within Indian Country in California.

## **BEMIDJI**

### **1. H&C +\$201M**

The Bemidji Area recommends 26%, or \$201M, of the increased funding available be applied to the Hospitals & Clinics (H&C) budget line item. The funding is requested in the H&C line as this allows Areas and Tribal programs to apply the funding in a targeted, appropriate, and independent and program specific manner.

The funding is also requested in the H&C line to align with current programs and services and Indian Health Care Improvement Act (IHCIA) authorities currently unfunded. The funding recommendation of the H&C increase would be distributed using the IHCIF formula authorized by the IHCIA. The goal of the IHCIF is to raise the lowest funded programs to at least the Indian Health Services' (IHS) average level of need funded. In FY2010, the IHS Director initiated consultation with Tribes to inquire about the need to revise the current IHCIF given the new program authorities allowed in the IHCIA reauthorization. Tribes responded the current formula should not be changed until all programs meet the existing goal. This goal is not yet met and this recommendation aligns with the Tribe's response.

Tribes require specific funding to aid their efforts in advancing and meeting the anticipated demand on Tribal Information Technology (IT) infrastructure as the provision of healthcare services changes. The method currently used by the IHS to fund IT initiatives is to carve it out of the H&C budget line. While the IHS is able to retain their portion of IT funds in this manner for RPMS activities, Tribal programs have similar hardware and software deficiencies that must be accommodated by what is available as Tribal shares. Therefore, Tribal programs are required to manage IT needs from funding that has already been reduced and balance the infrastructure need with direct care. As the IHS uses H&C to fund IT, so do the Tribes recommend an increase in this budget line appropriated specifically for their Tribal IT programming needs.

Tribes and Urban sites agreed with the Tribal Budget Workgroup that IT is very vital for quality healthcare and to add a specific "budget line" item for IT, thus, breaking it away from the H&C line item. The FY 2018 National Budget Workbooks were submitted with IT having a separate line, however, there was no amounts put in the line. Going forward it was requested to have the amount for IT be inputted which would add visibility to what is actually being assigned for this service activity and providing detail for a more informed recommendation on earmarking any increases directly for IT.

Also, there is a funding recommendation for the H&C increase to be targeted to Health Care Provider recruitment. The Tribes realize the health care practitioners embody the strength of their health care delivery system. By investing a portion of the H&C funding increase they will invest in hiring quality health care providers to provide the highest standards of care to an appreciative and deserving patient population. This H&C funding recommendation supports funding Section 103, 104 and 105 of IHCIA.

### **2. Mental Health + 146.6M**

The Bemidji Area recommends 19%, or 146.6M, of funding available is applied to the Mental Health (MH) budget line item to address the root causes of community members' mental health issues. As the Bemidji Area has found, the inability to address the root cause has manifested into an increasing problem of prescription and synthetic drug abuse/misuse as well as experimentation and addiction to illicit drugs. This funding recommendation supports Section 127 of the IHCIA for increasing the number of mental health providers and funding training/education as well as Sections 704 and 705 which advance the behavioral health programs and programming to address community issues.



Bemidji Area Tribes expressed Mental Health program increased funding needs specifically to be for After Treatment Care, After-Hour Care and 72 Hour Inpatient Care. Strengthening funding for Section 702 of the IHCIA would include support in meeting these needs.

Lastly, there is a compelling case in the Bemidji Area for increased funding of IHCIA, Section 708, authorizing increased adolescent care and family involvement services, primarily targeting Psychiatry Adolescent Care. Funding Sections 708 would be beneficial in advancing support to meet this need.

### **3. Purchased/Referred Care (PRC) (formerly Contract Health Services) +\$138.9M**

The Bemidji Area recommends 18%, or \$138.9M, of increased funding available be applied to the Purchased/Referred Care (PRC) budget line item. The Bemidji Area Tribal programs are heavily dependent on PRC. Historically, the Bemidji Area Tribal programs were primarily PRC programs as part of the Great Plains Area when Bemidji was a Program Office. Approximately 2/3 of the Area Tribes are considered very small Tribes and therefore do not typically have the capacity to provide comprehensive health services through conventional methods of a clinic and must rely upon PRC to provide services to their communities. Coupling this reality with rural locations increases the demand on PRC. Overtime, all Area Tribal programs have invested their own resources to build primary and direct care opportunities for their respective communities to meet the need. While primary and direct care programs exist, access to more advanced care is still needed. The demand for PRC has not decreased in Bemidji Area and data revealed that approximately 72% of users are also eligible for PRC.

### **4. Alcohol & Substance Abuse (ASA) +\$131M**

The Bemidji Area recommends 17%, or \$131M, of the funding available be applied to the Alcohol & Substance Abuse budget line item to address the drug abuse issues of the Area. The impact of alcohol and substance abuse within the Area is having a dramatic negative effect on lives, families and communities of the native people. Increased funding is needed to combat this adverse societal condition.

Prescription drug abuse and diversion has been declared a public health emergency on the three reservations with direct service programs and listed as a major problem by contracting and compacting Tribes at HHS Tribal consultation meetings. This is a multifaceted problem that requires involvement of Tribal Leaders, law enforcement, education, health care professionals, States, Federal Agencies and the community to solve. There is also a need for alternative resources such as physical therapy, behavioral health and buy-in to pain treatment utilizing alternatives to abused medications.

### **5. Urban +\$84M**

The Bemidji Area recommends that 11%, or \$84M, of the funding available be applied to the Urban budget line item to support the Indian Health Service (IHS) priority to “Improve Quality of and Access to Care” and the National Council on Urban Indian Health (NCUIH) priorities to 1) Increase access to healthcare, 2) Serve unmet needs, and 3) Implement Affordable Care Act. Funding recommended for Urban programs would be used for human resources, information technology, expanding program services, and improving the Urban programs’ competitiveness. Human Resource funding would be used to increase staffing that would not only improve the Urban programs’ ability to meet current services but also the increased demand due to the implementation of the Affordable Care Act (ACA). In FY2013, Bemidji Area programs embraced the ACA implementation serving as Navigators and Assistors as well as participating as an Accountable Care Organization in a State demonstration project. Focusing on Human Resource funding would also enable Urban programs to have dedicated staff to improve the program’s care coordination for patients and continuity of care which supports efforts to advance the concept of the medical home. Information technology (IT) advancements

would support a variety of projects including the continuing evolution of the electronic health record and modernizing business operations. Funding is required in these areas to ensure that Urban programs continue to advance National priorities such as the meaningful use of the electronic health record and the continued implementation of ICD-10. Urban programs require funding to meet the demand for mental health, dental, and optometry services as indicated by patient and community feedback. The implementation of the ACA increases the demand for mental health services and Urban programs continue efforts to integrate behavioral health into the medical program. Very few Urban programs have dental and/or optometry services but to remain competitive in a metropolitan setting, expanding services and service options is required. In addition, Urban programs' are seeking funds to improve competitiveness by achieving accreditation status. Currently any funds provided to Urban programs are focused on current service provision. However, funding is required to meet accreditation standards whether they be related to the designation as a Medical Home or an ambulatory care clinic. Urban programs must be marketable and attractive to consumers and the hallmark of quality service remains accreditation.

## **6. Dental +\$76.6M**

The Bemidji Area recommends 10%, or \$76.6M, of the funding available be applied to the Dental budget line item to address the Area and Tribal program needs. Dental services are a growing need in the Area and a recent analysis of the funding received showed that the current level of funding equates to only \$20 per individual in the Bemidji Area. In the Bemidji Area specifically, Tribal programs are establishing and expanding dental program operations but the limited funding leaves the programs with the difficulty of balancing and supplementing these changes with other funding eroding the program's purchase power. The changes to the programs are needed as Area Tribes recognize that the oral health is a component of holistic care. Oftentimes, oral health suffers/diminishes as collateral damage when the need for medical care is greater from a fiscal perspective but studies have shown that dental problems are exacerbated when coupled with chronic disease. Funding is needed to improve access to dental/oral health care services and treatment to ensure that a holistic approach to health is achieved.

## **BILLINGS**

The FY2018 Budget Justification Narrative is based on a prioritization process directly correlating the budget increases to the health concerns burdening the Billings Area Indian Health Service (IHS). These priorities were determined through consultation and approved by the Billings Area Tribal and Urban Leaders at the 2018 Budget Formulation meeting held in Billings, Montana on October 21 and 22nd, 2015.

The Billings Area's 2015 User Population is estimated at 72,664. IHS services are provided by six (6) Federal Service Units: Blackfeet (Heart Butte), Crow (Pryor, Lodge Grass), Ft. Belknap (Hays), Ft. Peck (Wolf Point), Northern Cheyenne, Wind River (Ft. Washakie, Arapaho), five (5) Urban health programs and two (2) Tribally operated health programs.

### **1. PURCHASED/REFERRED CARE (PRC) + \$253M**

Current base funding for Billings Area supports only Priority I (loss of life and limb). With additional funding we'd be able to better meet the health care needs of our patients.

PRC will remain the top health care priority because of the constant and underfunded need for specialized care and emergency procedures that our local hospitals and clinics in the field cannot provide. Deferred cases and unmet need remain a major challenge for every location in the Billings Area every fiscal year.

Service Units have been forced to use any available 3<sup>rd</sup> Party resources (Medicare, Medicaid, and Private Insurance) to pay for care when PRC funds have been exhausted. In prior years this dollar amount has been greater than \$5 million.

Although there have been increases throughout the years, the impact of the rescission and sequester in FY2013 (\$2.9 million) was devastating to an already underfunded program.

## **2. MENTAL HEALTH + \$214M**

Behavioral Health and Mental Health related disorders continue to have devastating impacts in our American Indian communities both on and off reservations throughout Montana and Wyoming. In recent National Vital Statistics Reports, Montana has consistently ranked in the top five for the highest rates of suicide in the nation for the past thirty years with the highest rates of suicide occurring among American Indians. According to the Montana Department of Public Health and Human Services Suicide Prevention Program Report from October 2012, the rate of suicide among American Indians is 27.2 per 100,000 compared to 22.2 per 100,000 for non-American Indians. Furthermore, the recent 2011 Youth Risk Behavior Survey found that 16.2% of American Indian students on reservations had attempted suicide one or more times compared to 6.5% of all Montana students in grades 9 through 12.

In 2015, there were approximately 115 suicide attempts with 9 completed suicides reported in the RPMS for IHS facilities in Montana and Wyoming among all patients served. These numbers are subject to reporting that may not always be completed due to confidentiality reasons, staffing issues or other unknown reasons.

It is a concern of the Tribes from Montana and Wyoming that many of the health issues that the tribes are faced with begin with the mental health of the patients. The Billings Area faces a shortage of clinical psychologists. It's difficult for the Billings Area to hire and retain clinical psychologists because of the greater amount of salary they can make in the private sector. This data strongly supports Mental Health as the #2 budget priority for the Billings Area. With the alarming suicide data, vacancy rates and consistent ranking as a top reason patients are seen at the Billings Area IHS facilities, Mental Health should be a budget priority for the Billings Area and the Indian Health Service on the larger scope.

## **3. ALCOHOL AND SUBSTANCE ABUSE + \$206M**

According to the P.L. 93-638 Contracted Tribal Substance Abuse Programs AccuCare's Aggregate Report Generation System (ARGS) report, all substance abuse patients assessed by the Billings Area Tribal Substance Abuse Programs indicate that the Primary Alcohol/Drug of Choice is:

- Alcohol 60.09%,
- Heroin 0.02%,
- Methadone 0.026%,
- Opiates/Analgesics 0.73%,
- Barbiturates 0.06%,
- Other Sed/hyp/tranq. 0.06%, Cocaine 0.03%,
- Amphetamine/Meth. 3.49%,
- Cannabis 5.12%,
- Inhalants 0.15%,
- Alcohol and multiple drugs addictions 11.65%.

Methamphetamine use has continued to increase in the State of Montana and Wyoming and this increase has also been seen in pregnant women. Alcohol and methamphetamine abuse in utero is a significant issue in the

Billings Area. Mother's ability to participate in treatment programs are limited because treatment centers who will take prenatal patients and her children are limited. At one of the Service Units in 2012, 44% of the babies born had Inutero Drug Exposure (IUDE) (15% to methamphetamine, 6% to alcohol).

Additional funding for the Alcohol and Substance Abuse Program would provide the tribes a mechanism to help their community members and schools, hire additional professional staff, treatment opportunities, etc.

#### **4. HOSPITALS AND CLINICS + \$190M**

Indian Health Service (IHS) is currently funded at only 56.2% of total need. The Billings Area Federal Disparity Index (FDI) is 55.9%. In 2013, the IHS per capita expenditures for patient health services were just \$2,849, compared to \$7,717 per person for health care spending nationally.

The Hospital and Clinics (H&C) budget line item supports essential health services including inpatient care, routine and emergency ambulatory care, and medical support services including laboratory, pharmacy, nutrition, diagnostic imaging, medical records, physical therapy, etc. In addition, specialized programs for maternal and child health, youth services, communicable diseases, women's and elder's health, and disease surveillance. The Billings Area is not able to support many of these services with Hospitals and Clinics funding alone.

Health Information Technology (IT) needs critical IT support for the IHS, Tribal, and Urban health care facilities that care for more than 2 million American Indian and Alaska Natives across IHS. IT is expanding constantly. With all of the mandates for Electronic Health Record (EHR), Centers for Medicare & Medicaid Services (CMS), Meaningful Use, Health Exchange, systems, IT security, networks for data flow, etc., more expert IT staff and continuous upgrades to our systems are needed to ensure stability and to ensure efficient access to the medical records for our patients. Each year the IT assessment costs continue to climb at a rapid pace and the hospitals and clinics budget is not keeping pace.

Subtitle B – Health Services, Sec. 121. Indian Health Care Improvement Fund, is funded to address deficiencies in health status and resources of Indian tribes, and authorizes additional uses and services paid by the “fund”. Additional funding is needed to carry out this Act within the Billings Area.

The majority of the Billings Area hospitals and clinics are direct service health care facilities which makes this an important budget activity to fund and provide increases to. Increased funding in hospitals and clinics will help improve recruitment and retention of medical professionals.

#### **5. DENTAL + \$89M**

This increase in funding would support the provision of critical dental care through clinic-based treatment and prevention services and community oral health promotion and disease prevention activities in the Billings Area. The Billings Area is funded at approximately 30% level of need in Dental and 50% of care is emergent care. The Final 2015 Government Performance and Results Act (GPRA) clinical measure for General Dental Access was only 30.9% which is down 6% from the 2014 results.

Dental Health remains a high priority for the tribes of Montana and Wyoming because of the medical and social effects of poor dental care for our patients. The lack of adequate funding for dental health in the Billings Area means many of the patients of the Billings Area go without proper dental care that in turn can have a long-term negative impact on their overall health care and wellness.

## **GREAT PLAINS**

### **1. Medicare Like Rates**

Enacting Medicare Like Rates for referred non-hospital services could save the IHS millions per year for the purchased/referred care program. Given the Great Plains Region strong dependence on contracted care not only for hospitalizations but for also for specialty care office visits, Medicare Like rates could significantly alleviate the tremendous burden on the PRC budget.

### **2. Impact of Sequestration, Continuing Resolution, Shutdown, Rescission**

The Continuing Resolutions result in budgetary uncertainty and waste many hours of manpower in doling out percentages of the recurring base. Advance appropriations would provide for more efficient operations. These delays make it very difficult for Tribal health providers and IHS to adequately address the health needs of AI/ANs. Even once appropriations is enacted, there is an administrative process of apportionment involving the Office of Management and Budget that causes delay in actually getting funding down to the local level. The cascading effect continued reduction continues to result in the service units utilizing funds earmarked for other services like personnel, supplies, equipment, building construction and building maintenance where Federal budget constraints have long plagued improvement to quality care and services.

### **3. Community Health Workers**

As states are considering third party reimbursement for community health workers. Very possibly, community health workers will need to have completed certain coursework or training, and there will be costs associated with that. It is difficult to recruit and retain prevention specialists, in part because the labor pool does not have people with the type of preparation needed. There is online training for CHRs but no practicums. CNA training is often available through Tribal colleges, but that is clinical. More education is needed about the public health model to prepare community health workers to be effective in their communities.

### **4. Third Party Revenue**

The Winnebago Hospital has been de-certified and therefore is losing third part revenues every day. Other Service units in the Great Plain region are also at risk. The Great Plains tribes request that the IHS supplement the Hospitals & Clinics budget for Winnebago Hospital and other facilities that may lose certification..

### **5. Medicaid Expansion**

With the proposed changes to broaden the eligibility of 100% FMAP reimbursements for IHS beneficiaries, additional resources are needed to assist tribes with coordination of care policies protocols and administrative costs for implementation.

### **6. Purchase and Referred Care**

As mentioned in above priorities, underfunding for PRC in addition to antiquated information technology systems result in consequences that affect quality of care. An emerging issue in the Great Plains is the growing burden of uncompensated care on the major contracted providers.

The administrative process used by the IHS is uniform throughout the entire nation when administering PRC. Following all of these requirements is a significant administrative burden on private sector providers and the IHS, as the process is manual, paper-driven susceptible to errors and slow. As currently administered the process is slow and susceptible to errors. Finally, the payment process is delivered through a national fiscal intermediary who is required to issue payment via paper checks and remittance advices, adding substantial reconciliation efforts for providers.

Along with the administrative costs, there are undesirable consequences through the existing IHS PRC process. Payments for private sector care are often denied due to appropriation or budget limits and medical priority determinations. When payments are denied, it is possible an individual tribal member will be responsible for the payment of provided services, which generates a financial burden for the individual and the provider. One of the primary reasons provided in South Dakota for the lack of support for the Medicare Like Rates legislation is attributed to unsettled PRC claims.

## **7. Substance Abuse and Mental Health Funding**

Urgent and immediate funds are needed to support Substance Abuse and Mental Health programs in the Great Plains region. The ability to recruit and retain licensed competent staff is hampered by inadequate resources. The impact of meth use and addiction and suicide is obvious in urban centers. The availability of treatment is limited. The disproportionate rates of suicides are symptomatic of the need.

## **8. Contract Support Costs (CSC)-Long Term Solution**

The full funding of Contract Support Costs (CSC) for the last two years, has been a major victory for Tribes and for self-governance. However, the current way that CSC is still funded through the discretionary appropriations process—which means CSC takes directly takes funds away from other IHS direct services if the precise amount needed is not appropriated at the start of the fiscal year. For example, direct services saw a \$25.1 million cut in FY 2014 in order to address CSC need that was not known early in FY 2014. Tribes that rely on direct services should not be made to compete for resources against tribes that are predominately self-governed. In order to this funding, Great Plains Tribes believe that the mandatory costs for CSC should be stabilized by the following means:

- Develop CSC payout plan that is regionalized and does not require reducing the budget for Great Plains area and other areas that are predominately-direct service care recipients to cover CSC cost in areas where tribes are predominately self-governed. support legislation to separates mandatory funding of Contract Support Costs from the direct services line item.
- Develop Standard AFA language to deal with IHS Anti-Deficiency Act concerns
- Develop two-year appropriation authority
- Develop strategies to deal with new/expanded programs and changing IDC rates following payout
- Analyze data to better estimate CSC need for appropriations
- Develop process to better estimate CSC need; pass-through and exclusions

## **9. Indian Health Service utilizing carryover funds and third party collections to settle potential Fair Labor Standards Act claims**

Great Plains tribes opposes any attempt by Indian Health Services to utilize funding from previous years and/or third party collections that could and can be used to provide better health care for Tribal members at our Service Units Great Plains tribes see the proposed expenditures as a violation of 25 U.S. Code § 1621 - Indian Health Care Improvement Fund.

# **NASHVILLE**

## **1. Purchased/Referred Care (PRC) +\$152.2 M/\$15.0 M**

PRC funding is the top-ranked budget priority for the Nashville Area. IHS and the Tribes serve primarily small, rural populations and provide mainly primary care and community health services. Much of the secondary care, and nearly all of the tertiary care needed, must be purchased from non-IHS facilities. PRC funds are used to purchase essential health care services, including inpatient and outpatient care, routine emergency ambulatory

care, transportation and medical support services, such as diagnostic imaging, physical therapy, laboratory, nutrition and pharmacy services. These funds are critical to securing the care needed to treat injuries, heart disease, digestive diseases, and cancer, which are among the leading causes of death for AI/ANs. New PRC funds are distributed using a formula based on active user population, the cost of purchasing health care services within a geographic area, and access to care, such as lack of availability of inpatient care. Tribes currently manage 54% of the PRC budget. At current funding levels, most IHS and tribal PRC programs are approving limited services beyond medical emergent referrals (to preserve life and limb), and less urgent, routine or preventive care must be deferred or denied pending additional appropriations.

As with H&C funding, these investments in PRC would be used to improve both access to care and the quality of care. Increasing access to outside health care services and working with off-site providers to improve the quality of care provided under PRC will help to reduce health disparities and the number of deaths due to heart disease, cancer, diabetes, unintentional injuries, chronic liver disease, chronic lower respiratory disease, stroke, suicide, influenza/pneumonia and nephritis.

## **2. Hospitals & Clinics \$126.9 M/\$13.3 M**

Funding for Hospitals & Clinics (H&C) remains a top tribal budget priority, as more than half of the IHS H&C budget is transferred under P.L. 93-638 contracts or compacts to the Tribes, who are responsible for approximately 58% of the IHS outpatient workload and 50% of the inpatient workload. H&C funding supports essential personal health services including inpatient care, routine and emergency ambulatory care, and medical support services including laboratory, pharmacy, nutrition, diagnostic imaging, medical records, physical therapy and other services. H&C funds also supports community health initiatives targeting health conditions disproportionately affecting AI/ANs, such as specialized programs for diabetes, maternal and child health, women's health, elder health and disease surveillance.

## **3. Alcohol/Substance Abuse (A/SA) +\$101.7 M/11.6 M**

A/SA remains a great priority for the Nashville Area. The abuse and misuse of substances is at epidemic levels within the Area and the limited dollars available doesn't provide our citizens the adequate care they need. The integration of culturally appropriate alcohol/substance abuse programs into comprehensive behavioral health prevention and treatment programs, and the further integration of behavioral health services with primary care provide great promise in changing not only lifestyle choices and risk behaviors, but the many social determinants that also impact the health of our tribal communities. New approaches are needed to reduce significant health disparities in motor vehicle death rates, suicide rates, rates of new HIV diagnoses, binge drinking and tobacco use.

## **4. Dental Health \$101.7 M**

American Indians/Alaska Natives (AI/AN) suffer disproportionately from dental diseases: 3-5 year-old AI/AN children have approximately four times as much tooth decay as the general U.S. population (43% vs. 11%), causing significant consequences such as delayed speech development, poor self-esteem, and high costs to repair; 6-9 year-old AI/AN children suffer almost twice as much decay as the general U.S. population (83% vs. 45%), resulting in increased missed school days, poorer school performance, and pain; and 13-15 year-old AI/AN children have five times the tooth decay prevalence as the general U.S. population (53% vs. 11%). Even in adults, the prevalence of disease is much higher: in adults over the age of 35, AI/ANs have more than five times the prevalence of periodontal disease as the general U.S. population (16.2% vs. 2.9%).

As a result of these disparities in oral disease, the IHS has created three national initiatives. The IHS Early Childhood Caries (ECC) Collaborative is focused on preventing tooth decay (ECC) in American Indian/Alaska



Native (AI/AN) children under the age of 71 months. The ECC Collaborative began in 2010 with the goal of reducing ECC in the AI/AN population through a coordinated, nationwide collaborative utilizing not only dental programs but also medical and community partners such as medical providers, public health nurses, community health representatives, pharmacists, Head Start teachers, and more. By the end of the first five years of this initiative, the IHS had increased access to dental care for AI/AN children under 71 months by 7.9% and significantly increased prevention and early intervention efforts (sealants increased by 65.0%, the number of children receiving fluoride varnish increased by 68.2%, and the number of therapeutic fillings increased by 161.0%), resulting in a net decrease of ECC prevalence from 54.9% in 2010 to 52.6% in 2014. To support this initiative, the IHS conducted a nationwide surveillance of 1-5 year-old AI/AN children through two coordinated efforts of 8,451 children in 2010 and 11,873 in 2014 - the largest oral health surveillance sample size ever of this age group in the AI/AN population. In FY 2015, the IHS ECC Collaborative continued through promoting early access to dental care for 1-5 year-olds as well as increased attention to prevention activities in IHS dental programs. At the same time, and continuing into FY 2016, the IHS ECC Collaborative has focused on identifying best practices in ECC prevention from programs that have had the most significant successes so that those practices can be shared throughout IHS, Tribal, and Urban dental programs.

A second national initiative that has been created is the IHS Periodontal Treatment Initiative. This initiative aims to raise awareness of, and reduce the prevalence of periodontal disease in AI/ANs by building capacity in periodontal expanded function dental assistants, creating more training of dental providers, and standardizing periodontal treatment throughout the IHS. This initiative began in late FY 2015 and is expected to continue for at least five years.

A third national initiative that has been created is the IHS Dental Workforce Efficiency Initiative. This initiative, which began in FY 2016 and is expected to continue for five years, is designed to elevate the issue of improving dental workforce efficiency within the Indian Health Service (IHS), especially at IHS, Tribal, and Urban (ITU) dental programs throughout the country. With significant oral disease disparities in the American Indian and Alaska Native (AIAN) population, along with increasing dental professional vacancies in ITU programs throughout the country, the emergence of alternative dental workforce models offers promise and hope in reducing the disease burden of this historically underserved population. The IHS Dental Workforce Initiative aims to educate ITU providers, tribal communities, and outside organizations about alternative workforce models and promote such models to help address oral disease disparities in the AIAN population.

Increased funding for dental health will enable the IHS to support – through the continuation of these three initiatives – increasing the workforce, improving efficiency of programs, and prioritizing oral health in an effort to reduce the aforementioned disparities in oral health in the AI/AN population.

## **5. Mental Health +\$88.9 M**

Behavioral Health, including Mental Health, is a top tribal health priority. The high incidence of mental health disorders, suicide, violence, and behavior-related chronic diseases is well documented. Each of these serious behavioral health issues has a profound impact on the health of individuals and community health, both on and off reservation. Mental Health program funding supports community-based clinical and preventive mental health services including outpatient counseling, crisis response and triage, case management services, community-based prevention programming, outreach and health education activities. After-hours and emergency services are generally provided through local hospital emergency rooms. Inpatient services are generally purchased from non-IHS facilities or provided by state or county mental health hospitals. Group homes, transitional living services and intensive case management are sometimes available, but generally not as IHS programs. The IHS Mental Health Program is currently focused on the integration of primary care and

behavioral health services, suicide prevention, child and family protection programs, tele-behavioral health, and development and use of the RPMS Behavioral Health Management Information System.

## 6. Urban Indian Health

It is important to bear in mind that urban Indian health programs are funded from a single IHS line item, and do not have access to funding appropriated to other areas of the IHS budget. Thus, the \$295 million dollar increase the Administration has proposed for the broader Indian Health Service budget will not benefit urban Indian health programs or the Native communities they serve. It is critical that Congress direct resources to the urban Indian health line item in order to provide health care services to urban Indian patients. Full funding of UIHPs at a rate of 231 million dollars annually was recommended by NCUIH in April 2014 through annual increases of 19 million dollars over ten years.

In addition to prioritizing these five areas, the Tribes in the Nashville Area continue to advocate for the development of an **Area Distribution Fund under the Health Care Facilities Construction** line item. While Nashville Area Tribes have supported increased funding for Health Care Facilities Construction in the past, the Nashville Area (along with the Bemidji, California and Portland Areas) has not historically benefitted from the program in its current form. An Area Distribution Fund would allow the Areas currently underserved by the IHS Health Care Facilities Construction program and the out-of-date Priority List to address major facilities needs. The Nashville Area would support a Fund as a more equitable dissemination of Health Care Facilities Construction dollars.

## NAVAJO

### 1. Specialty Care

Specialty Care needs to be addressed in many Native American communities. Since this Hot Issue is coming from Navajo, Navajo is very large. I.H.S. should assess where their largest expenses are coming from, how can they help create a sustainable model in Indian Country? Indian Country cannot continue to hire and waste money on very expensive Contractors, such as physicians, specialty nurses, etc. I.H.S. needs to provide grants to create internal I.H.S. Clinical Education program models.

What is PRC spending on Tuba City Regional Health Care Corporations highest specialty send outs? These would be, Cardiology, Gastroenterology, Oncology, Dialysis, and Neurosurgery.

I.H.S. needs to carve out Specialty service payment from the OMB rate. There ARE, facilities, that are Innovative and would develop these programs, but because of the OMB rate the rate of return on developing these programs is a complete loss. Our communities cannot even afford to leave their communities for work, and even afford gas and overnight accommodations when they or their families end up at health facilities that are more than 70 miles away. Having to leave because Specialty care cannot be developed at home is a MAJOR hardship for Indian Country communities.

**RECOMMEND:** Provide funding for those health care facilities that can meet established criteria to operate a Specialty program. Arrange meetings with Large >70 bed facilities to develop these programs, provide startup funding and work with them on Return on Investments, but these programs MUST come with additional housing plans.

### 2. Poverty

Here are some facts:

- Percentage below poverty line, range: 27.2% (Oak Springs) – 65.5% (Sawmill).
- Per capita income range: \$6,476 (Wide Ruins) – \$14,667 (Crystal)

- Percentage of children living in poverty range: 41.94% Apache County
- Educational Attainment range: 54% high school diploma (Kinlichee) – 85% (St. Michaels)
- Educational Attainment bachelor's degree range: 2% (Steamboat) – 14% (St. Michaels, Ganado)

I encourage you to read the following op/ed: <http://blog.oup.com/2013/11/poverty-public-health-united-states/>

### **3. Facilities Quarters (M&I) Replacement**

Due to the advanced age of a large number of quarters, the M&I funding should be appropriated for replacement of quarters. Most quarters were built in the 1960s, using BIA designs. The kitchen size is inadequate; the plumbing is in the attic space, making it susceptible to freezing. Without safe, comfortable housing, it is extremely problematic for Service Units to recruit and retain medical professionals (Physicians, Nurses, Pharmacists, Physical Therapist). Without an adequate number of medical professionals, success of the mission of the Service Units is greatly impacted and obstructed.

Service Units are instructed to use Rental income to maintain current housing, as the age of housing only increases, this is not sustainable for the mission of Indian Health Services and 638 Tribal Organizations.

### **4. Correctional Health**

Local I.H.S and Tribal 638 healthcare facilities are affected in providing healthcare to inmates of correctional facilities. Currently, there is no additional I.H.S/BIA budget for additional inmate health care needs. The estimated cost to provide care to inmates is \$5.5 million for TCRHCC annually. We now see >100 inmates a month for outpatient care. The cost of providing care is not reimbursed through current MEDICAID reimbursements.

There is a Public Health concern over need for infectious disease screening and treatment and over resource allocation to jail inmates. For example, screening of TB exposures alone = \$52,500 (150 people x \$350/visits for PPD test) from 1 single active TB exposure incident. This amount does not account for staffing and hours spent conducting contact investigations of individuals and locating people for testing by current Public Health Nursing staff.

The new Jail in Tuba City is the first modern corrections facility with more facilities being constructed throughout the Navajo Nation. Despite its modern building amenities, the new jail in Tuba City is devoid of a correctional health program by professional staff, including infectious disease screening and treatment.

TCRHCC respectfully request for Indian Health Services to support a request to CMS and Congress to allocate funding for these additional visits that have no reimbursement attached. The second request is for equipment specific to these programs. When planning new facilities there should be a secure protective room in Emergency Rooms, and an increased funding for Security personnel for the safety of Healthcare Professionals.

**RECOMMENDATION:** Provide Medicaid reimbursement funding for those inmates from Correctional Health Facilities, and provide Equipment and Telehealth communications to Indian Health Services, and 638 Facilities, at an estimated cost of \$500k to \$1M dollars per facility to include an ongoing fixed costs and personnel. The state of Arizona has >5 tribes that have inmates that are allowed to have terms up to and over a one year sentence. There are other states that have tribal correctional health facilities.

# OKLAHOMA CITY

## 1. Medicaid Expansion

Lack of expansion in Oklahoma has directly affected the opportunity to collect additional third party revenue. Patients that may have been covered under this expansion will continue to be covered by PRC. The tragic result is limited access of care for the patient population that would have been covered by a Medicaid expansion. In addition, there is inconsistency between the scope of services between States creating a disparity for AI/AN patients. The OCA recommends that IHS explore a direct relationship with CMS for the Medicaid program. In addition, the OCA recommends that IHS funding formulas be evaluated to adjust for Tribes in States that do not have Medicaid expansion.

By not expanding coverage, Oklahoma is leaving some 150,000 Oklahomans (approximately 1 in 5 of the state's uninsured) without any kind of health insurance coverage availability, because they are too poor to be eligible for health care subsidies on healthcare.gov but are not currently eligible for Medicaid. Medicaid expansion is a net benefit for state budgets as uncompensated care cost drop as more people gain health coverage, and the new economic activity driven by infusion of federal funds boosts state income and sales tax revenue. Some health care expenditures currently being paid for with state dollars would be covered by federal funds if the state expands coverage. The Leavitt Report totals the net savings for Oklahoma created by expansion at \$446 to \$485 million by 2023.

Medicaid Expansion creates a healthier workforce. As of 2011, more than 140,000 uninsured workers in Oklahoma fall into the income range that would be eligible for coverage under Medicaid expansion. These are restaurant and fast food workers, construction workers, child care workers, home health aides, and more. Medicaid Expansion has greatly affected the Tribal, IHS and Urban facilities where States have approved expansion of Medicaid. Catastrophic Health Emergency Funding cases have markedly decreased in states where Medicaid Expansion is present. Tribes and IHS facilities report anecdotally that many additional levels of medical priority are being reached with the Purchased and Referred Care program in states with Medicaid Expansion.

Medicaid expansion provides an opportunity for significant improvements in the health of Oklahomans. Currently, almost one out of every two working-age Oklahomans with income below the federal poverty level is without health insurance. Many in this population suffer from chronic physical and mental health conditions that impede their ability to take care of themselves and their families and be productive citizens. We know from the experience in other states that expanding Medicaid coverage will lead to better access to health care services, less financial hardship, and better health outcomes. Better access to health care will bring benefit to our economy by allowing more people to work and boosting worker productivity.

## 2. Mandatory Contract Support Costs

While the FY 2016 Omnibus Appropriation Bill includes an indefinite amount and payment of full Contract Support Costs (CSC), a significant improvement from past practices of underfunding, the OKC Area strongly supports permanent Mandatory Contract Support Costs appropriations as the long term solution for CSC funding challenges. A mandatory appropriation is the most effective answer to the dilemma posed by locating a legally binding obligation within an appropriation structured to address discretionary service requirements. Paying CSC out of the Agencies' discretionary appropriations leaves Tribes at risk for future funding reductions and possible competition between CSC and program funds. Avoiding the reprogramming of funds from health care services into administrative costs is of highest concern. A mandatory appropriation precludes such consequences for the future, while assuring that Tribal contractors and compactors will be paid in full for services duly rendered to the United States.

### 3. OEH SFC

#### A. *Regular Scattered Housing Projects*

- **Issue:** Flexibility to substitute a different home with the same deficiency for a home on the project that no longer needs service would be eliminated. The OCA has utilized this approach for at least the past 30 years to serve homes as quickly as possible. HQ has stated that all homes being served should be identified on the SDS submittal.
- **Impact:** Existing homes would only be served if specifically listed on an SDS project. This would impact service times for existing homes that have urgent sanitation deficiencies such as surfacing sewage or no water. Service times could range between 1-2 years. Homeowners may encounter local environmental enforcement consequences.
- **Comment:** This is the greatest issue of concern. The timeliness of the delivery of sanitation services is directly related to the health of Indian families.

#### B. *Housing vs. Regular Funds Allocation*

- **Issue:** Between FY 2011 and FY 2012 the National SFC budget was cut \$16M. Housing funds felt the brunt of that decrease going from \$46M to \$34M while regular funding went from \$46M to \$42M.
- **Impact:** Housing funds for the OCA decreased from \$5.3M to \$4M and fewer homes are being served with housing dollars. Housing projects allow individuals to be served in a timelier manner due to not having to go through the SDS funding process.
- **Comment:** This is directly related to the issue above. With additional housing dollars many of the homes on regular projects could be served with housing funds.

### 4. Reduce CHEF threshold to \$19,000

Section 122 of the Indian Health Care Improvement Act requires that the initial CHEF threshold be set at \$19,000, and increased each succeeding year by medical inflation. However, the increase in appropriations for CHEF for recent years, as well as the recent decrease in CHEF requests have resulted in funding nearly all of the eligible requests. To increase the threshold would place an undue burden on small PRC programs to provide the cash flow required to pay for these catastrophic medical cases up front, and wait for possible reimbursement later in the year. Very small programs have limited resources for PRC overall and would be required to deny critically needed medical care in order to float the cash for the additional CHEF threshold level. Accordingly, the OCA Tribes recommend that the budget request include a request to keep the CHEF threshold at \$19,000.

### 5. SDPI permanent part of budget

The Special Diabetes Program for Indians (SDPI) is a proven, successful program with measurable improvement in health outcomes. SDPI has been authorized annually until FY 2015 when it was authorized for only two years. Further, the funding level has remained stagnant at \$150 million nationally, which has not kept pace with the growing costs of medical care. This represents an effective decrease. Calculating for inflation, \$150 million in 2002 would be about \$115 million in 2014 – or *23 percent less*. Tribes nationally have consistently recommended that SDPI be authorized on a permanent basis, and that the funding level be increased from the existing \$150 million to \$200 million annually. The OCA Tribes support the national recommendations for permanent authority for SDPI with a \$200 million funding level for FY 2017. Finally, the OCA Tribes support the current national allocation of these funds.

### 6. Concern over constant Continuing Resolutions (CRs) and impact on patient care

With the ongoing polarization in Congress, passage of a timely budget has become increasingly difficult and Continuing Resolutions (CRs) have become the appropriators' solution of choice in an effort to avoid a government shutdown. Since FY 1998, there has been only one year (FY 2006) when the Interior, Environment, and Related Agencies budget, which contains the funding for IHS, has been enacted by the beginning of the fiscal year. The lateness in enacting a final budget during that time ranges from 5 days (FY 2002) to 197 days (FY 2011).

The negative consequences for the Indian Health Service and Tribes have been substantial. Under CRs, annual funding levels are uncertain and timing of payments are unknown. Health Services must be limited to the funding in hand, new grant awards are put on hold, and provider recruitment grinds to a halt. In short, funding delays for health services can be measured in lives lost. Advanced appropriations can help mitigate such catastrophic effects. For the same reasons, Congress now provides advance appropriations for the Veterans Administration medical accounts.

Advanced appropriation identifies the level of funding available for the IHS in the appropriations process one or more years before it is applicable. Thus, advanced appropriation provides more certainty to operate the Indian health care delivery system. This change in the appropriations schedule will allow Indian Health programs to effectively and efficiently manage budgets, coordinate care, enter into contracts, and improve health quality outcomes for AI/ANs. Advanced appropriations for IHS would support the ongoing treatment of patients without the worry if—or when—the necessary funds would be available. Health care services require consistent funding to be effective. Advanced appropriations will help the federal government meet its trust obligations to Indian Country and bring parity to this federal health care system at no additional cost.

## **7. Construction dollars beyond list**

Health Care Facilities Construction (HCFC) Appropriations are the primary source for new or replacement healthcare facilities. The number, location, layout, design, capacity and other physical features of healthcare facilities are essential in eliminating health disparities, improving patient outcomes and increasing Access. The absence of an adequate facility frequently results in either treatment not being sought, sought later prompted by worsening symptoms and/or referral of patients to outside communities which significantly increases the cost of patient care and causes travel hardships for many patients and their families. The healthcare physical environment has long been recognized as having a substantial bearing on patient care experiences and patient outcomes. There is overwhelming rigorous research, more than 600 credible studies, that links the physical environment of care to health outcomes.

The Indian Health Service (IHS) uses the HCFC appropriations to fund projects off the “grandfathered” HCFC Priority list until it is fully funded. In the late 1980s Congress directed IHS to develop the HCFC priority system. The system was implemented in the early 1990s with 27 projects on the initial list. Most projects are major capital investments exceeding annual HCFC funding resulting in projects being funded over several fiscal years. Projects are funded in phases according to acquisition, engineering, and project management requirements. Portions or phases of several projects are funded during a given fiscal year. This allows several projects to move forward simultaneously and helps distribute the funds geographically benefiting more than one Area. There are 13 remaining facility projects on the “grandfathered Priority List” with a current estimated completion cost of \$2.1 billion. Once those 13 projects are funded, the remaining \$8 billion need can be funded with a revised priority system that will periodically generate updated lists.

Approximately 5% of the U.S. annual health expenditures are investments in health care facility construction. In 2013, that \$118 billion investment in health care facility construction equaled ~\$374 per capita compared with IHS health care facility construction appropriation of \$77 million or ~\$35 per AI/AN. That means the nation invests annually in health care facility construction for the general population over 10 times the amount per capita that it appropriates for IHS healthcare facility construction. This disparity in facility construction is reflected in patient outcomes and the immense need for facilities in IHS. In general, IHS facilities are old, undersized, with traditional layouts, and expensive to operate and maintain. The 2011 Facilities Needs Assessment Report to Congress estimated the need at ~\$8 billion. The need for new and replacement facilities currently exceeds 18 million feet at an estimated cost of about \$10 billion.

At the current rate of HCFC appropriations (~\$85 million/annually), a facility completed in 2016 would not be replaced for over 400 years. To replace IHS facilities every 60 years (twice their 30 year design life), would need HCFC appropriations of ~\$500 million/annually. The IHS would need HCFC appropriations of ~\$1 Billion/annually to reduce the need by 95% by 2060. The IHS would need HCFC appropriations of ~\$750 million/annually to match the U.S. expenditures in health care facility construction. Without a sufficient, consistent, and re-occurring HCFC appropriation the entire IHS system becomes unsustainable.

## **PHOENIX**

The following hot issues on health care risks of importance to Tribes and urban Indian health programs that have not been adequately addressed or adequately funded through current IHS appropriations were identified and agreed to in the FY 2018 budget meeting for the Phoenix Area.

### **1. The need for Advance Appropriations**

Since FY 1998, there has been only one year (FY 2006) when the Interior, Environment, and Related Agencies budget was enacted by the beginning of the fiscal year. It is simply too difficult for the Indian Health Service and tribally operated health programs to plan, budget for, and sustain their health care services to Indian patients and to recruit and retain qualified medical staff when funding levels are unpredictable and are distributed piecemeal throughout the year. For the same reasons, Congress now provides advance appropriations for the Veterans Administration medical accounts. Two-year advance appropriations should likewise be enacted for the Indian Health Service to provide stable and predictable funding for the Indian Health Care system.

### **2. The need for a Sequestration Exemption**

In FY 2013, the Indian Health care system experienced major reductions due to the imposition of Sequestration across all federal agencies, although a number of programs were identified as exempt (i.e., Veterans' Administration) or subject to special rules. Sequestration was triggered because the Joint Select Committee on Deficit Reduction was not able to find agreement on a plan to reduce the federal deficit by \$1.2 trillion over a ten year period as required by the Budget Control Act. Tribes must continue to make the case for an exemption that IHS and the Special Diabetes Program for Indians (SDPI) will continue to be subjected to through 2023.

### **3. The need to implement the Medicare-Like-Rate for non-hospital services**

Efforts must be reignited to extend the Medicare-Like Rate Cap on payments for physician and other nonhospital services made through IHS and Tribal Purchased Referred Care (PRC) programs. Currently the cap only applies to the rate IHS and Tribal providers pay for hospital services through the PRC programs. PRC funds are diminished quickly because the programs routinely pay full billed charges for these services which significantly exceed what Medicare would pay. Other federal agencies such as the Department of Defense and the VA do not pay full billed charges for health care from outside providers.

### **4. The need to increase mental health services and facilities, crises response to suicidal and violent behavior and eliminate barriers to mental health evaluation services for adults & youth.**

### **5. The need to address co-occurring disorders associated with substance abuse, alcoholism and mental illness**

Mental Health and Alcohol Substance Abuse, including associated co-occurring disorders continue to be top program expansion priorities of Tribal leaders. This is such a high priority that Tribal leaders advocated to the U.S. Secretary of Health in 2015 to establish a National Tribal Behavioral Health Agenda to guide behavioral health policy and programs going forward. Many families across Indian Country experience devastating issues and have little recourse relying upon a behavioral service delivery system that is understaffed and underfunded.



Tribes were apprised that the FY 2016, IHS budget request included some increases for these line items which is a relief for Tribes and IHS programs that provide the services at their communities. Plus the Administration sought \$25 million for the Tribal Behavioral Health Initiative for Native Youth under Alcohol and Substance Abuse line item. These efforts are promising and must be continued.

#### **6. The need for longer term rehabilitation on or near reservations to address a variety of debilitating injury and illness**

Indian Health Service, Tribal and urban Indian health programs see the devastating impacts of unintentional injury, including motor vehicle crashes on the American Indian population. In fact it is the third leading cause of death in the Phoenix Area. IHS has a long established injury prevention program that works with Tribes on efforts to reduce risks, such as road hazards and address tribal codes and policies on inebriated driving, seat belt use and the availability of child safety seats. Unfortunately for those who require longer term rehabilitation as a result of injury, covering the cost of care can be afforded through PRC if it is within medical priorities, Medicaid and some health insurance plans. However, accessing rehabilitation services, such as physical therapy on or near many Indian reservations is limited.

#### **7. The need to implement Dental Health Aide Therapy (DHAT) in the lower 48 states**

Oral health disparities of American Indian people are profound when compared to the general U.S. population. Tribal leaders are very concerned that dental disease rates among American Indian people, especially children are much worse than the general U.S. population and rival some third world countries. IHS reports staggering rates of tooth decay and periodontal disease. American Indian people in this region experience great difficulty when trying to access dental health care. Tribal leaders recommend addressing oral health care demands by hiring more dentists and expanding the oral health workforce by instituting the Dental Health Aide Therapy program in the lower 48 states. Tribal Leaders in the Phoenix Area seek the necessary amendments to state or federal law to bring this to fruition.

#### **Local hot issues were identified by some Tribes. These are:**

- Determine Ak-Chin Indian Community Program Shares
- Establish a Dialysis Unit/Center for the Ute Tribe
- Address inconsistent IHS consultant visits by the Parker Service Unit and the Phoenix Indian Medical Center

## **PORTLAND**

### *1. Cancer*

American Indian and Alaska Native (AI/AN) have higher mortality rates than the general population from specific. One factor contributing to this is the limited access to cancer screening. At least four cancers (cervical, breast, prostate and colorectal, accounting for about 50% of all cancers) have widely accepted standards of care for screening and early diagnosis that are an integral part of primary care services. However, limitation in access to these preventive services (such as mammograms and pap smears) is a major impediment to cancer prevention in Indian Country. Another major contributor to this increased mortality among AI/ANs is the lack of adequate resources to coordinate care and provide the sophisticated and specialized cancer treatment that is available.

### *2. Behavioral Health (Mental Health, Alcohol/Substance Abuse, Suicide, Domestic Violence and Sexual Assault)*

*This category summarizes the need for additional funds to support many programs that share the common goals of: healthy lifestyles and quality of life. This request identifies the need to improve programs' ability to reduce health-related complications, prevent the onset of unhealthy lifestyles, and educate our communities to deal with behavioral*

*health issues. There is a need to enable the I/T/U programs to expand access to multiple programs for services and implement a comprehensive, coordinated network of care.* Tribes are active in this area, but with the small funding increases, measurable improvements are predicted to occur slowly.

Tribes are effective in sharing information from community to community, yet the development of effective models is more difficult due to the lack of significant funding increases. Tribes want to address all forms of addictive behavior including gambling.

The use of methamphetamine is causing tremendous cost to the Indian health care system. Studies show that to be effective, Tribes need to pay for 180-day inpatient treatment, as well as follow up care. The need for increased funding for follow up care is critical.

According to the US Department of Justice, AI/AN women are 2.5 times more likely to be raped or sexually assaulted than women in the USA in general; 34.1 percent of AI/AN women – or more than one in three – will be raped during their lifetime; it is widely accepted that these statistics do not accurately portray the extent of the sexual violence against AI/AN women. Tribes emphasized the need for tribal clinic facilities to have funding for personal specifically trained to provide treatment for this population.

Tribes reported that past trends for DV measures show stagnant rates through FY 2005 and then a significant increase in FY 2006 of 28 percent. In FY2007, the proportion of women who are screened for DV at healthcare facilities was 36 percent. The FY 2009 target was to maintain the FY 2008 result of 42%. Some reasons for the improved screening was increasing provider awareness, improved documentation, and improved efforts to better match targets with program performance.

Suicide is a sensitive issue, but one that is of great concern to many AI/AN communities. Data suggest that suicide is a significant problem throughout Indian Country, particularly among Native youth, males, veterans, and elders. The Portland Area has one of the higher suicide death rates for AI/AN among the IHS service areas. The Tribes strongly encourage IHS to provide additional funding to reduce suicide rates among AI/AN and to increase tribal capacity to prevent suicide throughout Indian Country.

### **3. Diabetes**

Depending on the region, AI/ANs are two to four times as likely, compared to all other races to have diabetes. There are many factors that contribute to the diabetes crisis; change in dietary choices and an increase in sedentary lifestyle are key factors that are driving obesity to record levels. The consequences of uncontrolled diabetes primarily effects chronic blood vessel damage, which can lead to heart attacks, strokes, kidney failure, blindness, and amputations. Budget priorities include funding for screening of younger populations for “pre-diabetes”, targeted interventions to reduce diabetes in all ages, as well as screening and aggressively treating high blood sugar, risk factors for cardiovascular complications of diabetes (like high blood pressure and poorly controlled cholesterol) and cardiovascular complications once they are identified.

### **4. Cardiovascular, Heart Disease, Stroke <sup>61</sup>**

The prevalence of risk factors for cardiovascular disease (CVD) (i.e., hypertension, current cigarette smoking, high cholesterol, obesity, and diabetes) among AI/AN is significant, with 63.7% of AI/AN men and 61.4% of AI/AN women having one or more CVD risk factors. Although, heart disease was once relatively uncommon

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<sup>61</sup> Discussion on this item included with Priority No. 2: Cardiovascular Disease since the issues associated with these two health priorities are often related.

in AI/AN populations, it is now the leading cause of death among AI/ANs. The sharp rise in diabetes prevalence unquestionably plays an important role in the increasing importance of heart and other cardiovascular diseases in Indian Country, both through blood vessel damage and through the close relationship of diabetes and obesity, high blood pressure and poorly controlled blood cholesterol levels. From a physiologic point of view, all of these problems cannot be reasonably separated and should be viewed as one reinforcing each other.

#### *5. Health Promotion/Disease Prevention (Childhood obesity)*

AI/AN people are challenged with health conditions and chronic diseases that are related to lifestyles choices resulting in obesity, physical inactivity, poor diet, substance abuse, and injuries. Health promotion disease prevention (HP/DP) efforts can effectively reduce these health conditions. IHS recognizes the value of prevention and has named HP/DP as an agency priority for several years. National health reform efforts also recognize the financial benefits and improved quality of life by supporting prevention programs.

The Portland Area Tribes believe that HP/DP efforts could help to eliminate our top six Portland Area Health Priorities; including asthma, nutrition, diabetes mellitus, heart disease, stroke, obesity, hyperlipidemia, hypertension, certain cancers (breast and colon, e.g.), and osteoporosis. Two in five AI/AN children are overweight and one solution is to support tribal communities in developing long-range, culturally competent, multidisciplinary, effective overweight and obesity treatments and preventative interventions for the diverse AI/AN population.

#### *6. Elder Health – Long Term Care*

*The treatment and medication management that is unique to the elder population requires the development of specialized geriatric capabilities within the I/T/U health care system. The care of elders is a culturally inherent trait that provides an important part of maintaining our cultural knowledge and wisdom to strengthen our families and communities. It was the consensus of the Portland Area Tribes that with the expanded authority of Long Term Care under the Indian Health Care Improvement Act, this needs to be fully supported and funded.*

- *Elder care accounts for approximately 18% of ambulatory visits for acute complaints, chronic disease follow-up or hospitalization.*
- *There is a need for expanded inpatient and outpatient clinical services. Including basic primary and secondary tertiary care, increased recruitment and retention for gerontology specialists, nurse practitioners, and social workers with specialized training in elder care.*
- *The growth of the elder population has increased and will continue to grow as the baby boomers age.*
- *Long-term care is not funded nor is it a service that IHS currently provides.*

#### *7. Dental*

Oral health is inextricably linked with overall health. AI/AN children in each age group have markedly higher rates of tooth decay (caries or cavities) and periodontal (gum) disease. Tooth decay among AI/AN children is as high as three to four times that of other races in the US. Over 80% of AI/AN children have tooth decay and over 90% of AI/AN adolescents have tooth decay that is untreated. A major factor behind this unacceptable state of dental health is the continuing crisis in access to dental care at facilities serving AI/AN populations. Significant and widespread shortcomings in dental facilities and staffing have resulted in long waiting lists of patients requiring even the most basic dental services. Often the inability to access routine services at the local facility results in the need for emergency room care, using up PRC funds in a highly inefficient manner. Portland Area Tribes support increased use of fluoride varnishes and other sealants, aggressive educational programs (for instance, to reduce sugared beverages consumption), and water fluoridation.

## 8. Injury Prevention

Injuries are the second leading cause of hospitalizations for AI/ANs. The age adjusted injury death rates for AI/ANs served by the Indian Health Service (IHS) were approximately three times the U.S. all races rates for each of the years 1981 through 1985. This discrepancy can be primarily attributed to an AI/AN poverty rate that is approximately two and one-half times the U.S. all races rate (the environment of poverty is a strong predictor for injury mortality) and the rural locations and associated disadvantaged proximity to emergency medical care within which a large proportion of AI/ANs live. The leading causes of AI/ANs injury death were motor vehicles (40%), homicide (13%), and suicide (13%) followed by drowning, fire/flames, and falls. For all injuries combined, the male to female ratio of death rates was three to one.

## 9. Maternal Child Health

*Serious health disparities among pregnant AI/AN women and their children have been documented in numerous publications.* AI/ANs experience some of the highest disparities in infant mortality in light of current medical and public health interventions within the Portland Area and across the country. Causes of death and risk factors for infant mortality within this population include Sudden Infant Death Syndrome (SIDS), infections, injury, limited access to health care resources, and exposure to other socioeconomic factors.

Chronic maternal stress and acute life events during pregnancy may contribute to the racial disparity in infant mortality. AI/AN women experience a disproportionate number of stressful life events during pregnancy. In the 2002-2006 Washington state Pregnancy Risk Assessment Monitoring Survey (PRAMS), a greater proportion of AI/AN women reported each stressor in the PRAMS survey compared to white women, and were 2.6 times more likely to experience five or more stressful life events during pregnancy than white women.

The rates of fetal and neonatal death, low birth weight, and babies born with developmental problems are also far higher among AI/AN women than the general US population. All of these outcomes are heavily impacted by the health status of the mother and whether or not prenatal care has been received. There is good evidence to support the fact that woman who receive medical care during their pregnancy are healthier, have better outcomes for themselves and give birth to healthier children.

## 10. Respiratory /Pulmonary

Respiratory disease was among the most prevalent infectious disease group associated with hospitalizations for infants and has been previously described as an important contributor to AI/AN infant morbidity and mortality. Some studies indicated that the rate for hospitalizations for the AI/AN infant population was more than double that for the general U.S. infant population. The disparity suggests a need for additional funding to identify risk factors for hospitalizations and potential prevention strategies among AI/AN infants.

# TUCSON

## 1. Purchased/Referred Care (PRC) +\$138 Million

The Tucson Area ranked funding Purchased/Referred Care Services as the highest ranked budget priority and recommends an increase of \$138 Million.

The Tucson Area ranked funding Purchased Referred Care as a priority, due to the increased cost of specialty services that must be contracted due to the limited scope of services provided at the service units and tribal programs. For the Tucson Area I/T/Us the screening, intervention, treatment, and prevention of commonly occurring diseases such as diabetes and cancers remain a high priority. Treatment and prevention for these services require PRC service referrals.

## **2. Hospitals & Health Clinics (H&HC) +\$94 Million**

Dental +\$24 Million

Urban +\$31 Million

Equipment +\$24 Million

The Tucson Area recommends in total an increase of \$174 Million to support current services and expand new services under the new provisions of the IHCI. The increased funding for Dental services by \$24 Million will reduce the current unmet needs. The Urban population continues to increase nationwide and is necessary to expand services and recommends an increase of \$31 Million. Equipment funds of \$24 Million will be required to update and replace obsolete equipment as services are expanded.

The access to quality Health Care and Improving Patient Care (IPC) requires an increase in H&HC funding. New H&HC funding would support expanding services and fund the authorized services in IHCI, in which new services were authorized however, there have been no new authorities to support funding these new provisions. In the Tucson Area, our number one health priority continues to be the prevention and treatment of Diabetes, aforementioned current SPDI funding is not sufficient to address all the health problems caused by Diabetes. Additional priorities include dental services to meet the current demands of dental health screening, early intervention, treatment and prevention as well as funding the increased Urban Population and medical inflation needs. The importance of the promotion of healthy lifestyles is a high health priority.

## **3. Alcohol & Substance Abuse (ASA) +\$109 Million**

Tucson Area I/T/U's recognizes the high prevalence of Alcohol & Substance Abuse and recommends a budget increase of \$109 Million to expand current services and fund New Programs related to Behavioral Health under the IHCI. The new funding would address Depression, Suicidality, and Violence occurring among the I/T/U communities. New funding would expand the scope of treatment, such as establishing group homes or inpatient treatment facilities and hiring more clinicians and case managers to address the alcohol & substance abuse problems.

## **4. Mental Health (MH) +\$109 Million**

Additional funding of \$109 Million is necessary to address the mental health problems and fund New Programs related to Behavioral Health under the IHCI. New funds would allow an increase in professional workforce to address the population, increase behavioral health training, and community education programs. The additional increase would fund the new provisions in the IHCI such as a Comprehensive Behavioral Health and Treatment Program, Fetal Alcohol Spectrum Disorders Programs, Indian Women and Youth Treatment Programs.

## **5. Health Care Facilities Construction +\$74 Million**

### **Maintenance and Improvement +\$23 Million**

The Tucson Area I/T/U's strongly supports funding \$74 Million for New Health Care Facilities in order for the Sells Hospital replacement to remain on the IHS Health Care Facilities Planned Construction Budget (HCFC priority list). The latest HCFC priority list shows funding required to begin the Sells Hospital replacement in FY 2022. We also recommend an additional increase of \$23 Million for M&I to maintain aging facilities. We strongly request additional funding be identified to implement the new mandated authorities.

**6. IHCIA Elderly Program +\$14 Million**

The Tucson Area I/T/U's request new funding to implement Sec. 124 for Long Term Care and Assisted Living Services. This funding will initiate feasibility studies to determine program requirements and fully evaluate the real cost in implementing this new provision.

**7. IHCIA Expand Urban Program +\$5 Million**

The Tucson Area I/T/U's request new funding to implement Sec. 161 for the Urban Program Facilities Renovation. The Tucson Indian Center has a building lease which will expire shortly and they are now in need of a new facility and under this new provision the Urban Programs now has the authority to be eligible for facility renovations, construction, and expansion.

**8. Sanitation Facilities Construction +\$37 Million**

The Tucson Area I/T/U's request additional SFC funding to continue meeting the backlog of projects for Essential Water and Sewer needs in Indian Communities. The Tohono O'odham Nation is the second largest reservation in Arizona in both population and geographical size, with a land base of 2.8 million acres and 4,460 square miles, approximately the size of the State of Connecticut. Most communities are in remote rural areas and access to clean water and sanitary conditions are very limited and in dire need.

**9. Contract Support Cost +\$7 Million**

The Tucson Area I/T/U's request additional Contract Support Cost funding in the event CSC does not become Mandatory by FY 2017. The additional funds will support any anticipated shortfall/needs for FY 2018.

**10. Health Care Facilities Construction +\$85 Million**

The Tucson Area I/T/U's request Construction funding to continue meeting the backlog of projects identified on the Priority Listing. According to the Annual Facilities Five-Year Plan it was estimated that \$185 Million was necessary for FY 2018, however the Worksheet for Binding Obligations only budgeted for \$100 Million. Tucson Area supports budgeting an additional \$85 Million to continue funding Health Care Facilities Construction as scheduled on the priority list. The latest HCFC priority list shows funding required to begin the Sells Hospital replacement in FY 2022. Once the projects on the priority listing are fulfilled the Sells Hospital replacement can start construction. In addition, we strongly request new funding be identified to implement the new mandated authorities.

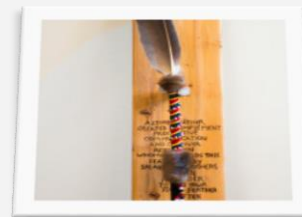


Chief Silent Drum-Vernon Lopez, Mashpee Wampanoag shares the meaning of his talking stick below:

Chief Vernon Lopez "Silent Drum"  
with Talking Stick on June 28, 2015  
(Photo courtesy Yvonne Avant)

*"The Talking Stick and Eagle Feather have been honored and carried by many Wampanoag leaders for a long time to control council meetings and sometimes for special gatherings of circle. You can design your own Talking Stick or feather by what it culturally means to you. My Talking Stick represents the Wolf who protects like our mothers do for their children and family. Beads at the top exemplify race of man and the four directions. Eagle illustrates Grandfather Sky and Grandmother Moon. Green Tree reflects Mother Earth. Shells characterize our bays, oceans and rivers. Corn represents one of our Three Sisters (Corn, Beans and Squash) while my small Eagle Feather embodies spiritual value. The red mini tied bags are prayer bags to the Great Spirit.*

*At the bottom of my stick are purple and white beads that personify the color of our quahog shell, and to me mean love, peace and family. When we traded Wampum with the colonists the color purple was of more value. This special family Talking Stick is made from the willow tree and wrapped partly with leather. Most of our folks made their Talking Sticks out of some of our local wood such as willow, cedar or maple which makes it easier for carving."*



An example of an American Indian Talking Stick & Alaskan Talking Feather

*Neshech' Kahtnuht'ana: "A story feather created to implement productive communication and discover resolution. Whomever holds this feather, may speak, while others listen. Remember to pass your story feather often."*

*Kenaitze Tribal Leader, Alaska*



## ***Acknowledgements***

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