



CREATING A
LEGACY OF HONOR
AND TRUST:

STRIVING FOR
HEALTH PARITY FOR
ALL AMERICAN
INDIANS AND
ALASKA NATIVES

THE NATIONAL TRIBAL BUDGET FORMULATION
WORKGROUP'S RECOMMENDATIONS ON THE
INDIAN HEALTH SERVICE
FISCAL YEAR 2015 BUDGET

May 2013

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EXECUTIVE SUMMARY

The federal government's trust responsibility, honored by decades of treaties and doctrines, is based on need. Funds to the Indian Health Service are prepaid obligations between the United States and indigenous Tribes and cannot be means-tested. American Indians and Alaska Natives have long experienced health disparities when compared with other Americans. Shorter life expectancy and the disproportionate disease burden exist because of inadequate education, disproportionate poverty, discrimination in the delivery of health services, and cultural differences. These are broad quality of life issues rooted in economic adversity, poor social conditions, and decades of historical trauma.

Although the Obama Administration and Congress have proven over the last few years that they are willing to take steps to address this crisis, the federal government must do more to meet its obligations to fully fund the urgent health care needs of American Indians and Alaskan Natives. Indian health care is not measured in dollars, but in lives. Sequestration causes a devastating blow to Indian health care clinics which, because of historical underfunding, cannot afford a single dollar lost. Lost dollars result in the loss of health care practitioners and services through staff reductions and reduced access to basic health care. Many American Indians and Alaska Natives, especially in rural communities where only one provider serves an entire community, ultimately suffer with the loss of a single doctor, midlevel, or community health aide. Now is the time for the federal government to partner with Tribes to ensure that the Indian health care system does not bear the brunt of the nation's current economic burden. The trust obligations, which impact the lives and future survival of Indians, must be a priority for funding within HHS and the Administration. Until the Indian Health Service is fully funded, the promised health care that American Indians and Alaska Natives deserve *will not* become a reality.

The National Tribal Budget Formulation Workgroup recommends the following budget for FY 2015:

Tribal Total Needs Based Request: \$27.6 Billion over 12 Years

FY 2015 Tribal Budget Recommendation: \$5.3 Billion

Highlights of the FY 2015 Budget Recommendations:

- ❖ Increase FY 2015 IHS Budget:
 - \$163.9 million for full funding of current services
 - \$178.8 million for binding fiscal obligations
 - \$528.4 million for program expansion increases
- ❖ Protect prior year health care gains and advance Tribal health.
- ❖ **NO** to sequestration and restore rescission amounts.
- ❖ Continue to fund the Special Diabetes Program for Indians, the Methamphetamine Suicide Prevention Initiative, and the Domestic Violence Prevention Initiative.
- ❖ Encourage the federal government to uphold its legacy of honoring the trust responsibility to provide parity in health care to all American Indians and Alaska Natives.

TABLES: FY 2015 TRIBAL RECOMMENDATIONS

FY 2015 National Tribal Recommendation	
(Dollars in Thousands)	
<i>Planning Base - FY 2014 Pres. Budget</i>	\$4,430,637
<i>Current Services & Binding Agreements</i>	\$342,671
<i>Current Services</i>	\$163,900
Federal Pay Costs	15,900
Tribal Pay Costs	18,701
Inflation (non-medical)	14,300
Inflation (medical)	65,900
Population Growth	49,099
<i>Binding Agreements</i>	\$178,771
New Staffing for Newly Constructed Facilities	31,458
Contract Support Costs - Shortfall	90,000
Health Care Facilities Construction (Planned)	57,313
<i>Program Expansion - Services</i>	\$470,296
Hospitals & Health Clinics	119,644
Dental Services	20,376
Mental Health	47,898
Alcohol and Substance Abuse	31,752
Contract Health Services	181,229
Public Health Nursing	8,585
Health Education	8,920
Community Health Representatives	10,115
Alaska Immunization	2
Urban Indian Health	3,487
Indian Health Professions	880
Tribal Management Grants	8
Direct Operations	35
Self-Governance	11
Contract Supports Costs - New & Expanded	37,354
<i>Program Expansion - Facilities</i>	\$58,068
Maintenance & Improvement	6,421
Sanitation Facilities Construction	16,447
Health Care Facilities Construction Authorities	30,000
Facilities & Environmental Health Support	1,400
Equipment	3,800
<i>GRAND TOTAL</i>	\$5,301,672
\$ Change over Planning Base	\$871,035
% Change over Planning Base	19.7%

**INDIAN HEALTH SERVICE
FY 2015 Tribal Recommendation**

(Dollars in Thousands)

Revised 5/31/13

	FY 2013 Full-Year Continuing Resolution	FY 2014 President's Budget (Plng Base)	FY 2015 - CURRENT SERVICES - Estimates										Program Expansion Subtotal	FY 2015 Recomm	Comparison		Comparison Change over FY 2014 PB	
			Federal Pay		Tribal Pay		Inflation		Population Growth	Staffing for New Facilities	CSC Shortfall	Health Care Facilities Constr			Current Services Subtotal	Comparison		
			CO, CS	Pay	Medical	Non- Medical	\$	%								\$		%
Sub Sub Activity																		
SERVICES																		
Hospitals & Health Clinics	1,849,310	1,865,630	10,269	12,077	2,143	22,574	24,399	31,458	0	0	102,920	238,884	12.9%	222,564	11.9%			
Dental Services	166,297	168,225	1,042	1,226	79	1,656	2,123	0	0	0	6,126	28,430	17.1%	26,502	15.8%			
Mental Health	78,131	79,873	452	532	45	863	1,008	0	0	0	2,900	52,540	67.2%	50,798	63.6%			
Alcohol & Substance Abuse	195,378	196,405	1,182	1,390	35	2,939	2,630	0	0	0	8,176	40,955	21.0%	39,928	20.3%			
Contract Health Services	897,582	878,575	0	0	0	33,029	11,785	0	0	0	44,815	207,057	23.1%	226,044	25.7%			
Total, Clinical Services	3,186,678	3,188,708	12,945	15,225	2,301	61,061	41,946	31,458	0	0	164,936	567,865	17.8%	565,835	17.7%			
Public Health Nursing	69,868	71,194	429	505	28	653	877	0	0	0	2,492	12,403	17.8%	11,077	15.6%			
Health Education	17,450	17,677	102	119	4	233	226	0	0	0	683	9,830	56.3%	9,603	54.3%			
Comm. Health Reps	61,531	61,661	397	466	4	919	817	0	0	0	2,603	12,848	20.9%	12,718	20.6%			
Immunization AK	1,927	1,931	12	15	0	29	26	0	0	0	82	88	4.6%	84	4.3%			
Total, Preventive Health	150,776	152,463	940	1,105	35	1,834	1,946	0	0	0	5,860	35,169	23.3%	33,482	22.0%			
Urban Health	42,988	43,049	188	221	45	643	581	0	0	0	1,678	5,226	12.2%	5,165	12.0%			
Indian Health Professions	40,598	40,602	11	12	559	4	0	0	0	0	586	1,470	3.6%	1,466	3.6%			
Tribal Management	2,577	2,577	0	0	0	95	0	0	0	0	95	103	4.0%	103	4.0%			
Direct Operations	72,867	71,845	456	536	391	0	0	0	0	0	1,382	395	0.5%	1,417	2.0%			
Self-Governance	6,044	6,049	11	12	21	109	0	0	0	0	153	169	2.8%	164	2.7%			
Contract Support Cost	476,446	477,205	0	0	6,646	0	0	0	90,000	0	96,646	134,759	28.3%	134,000	28.1%			
Total, Other Services	641,520	641,327	665	782	7,660	851	581	0	90,000	0	100,540	142,122	22.2%	142,315	22.2%			
Total, Services	3,978,974	3,982,498	14,550	17,113	9,997	63,746	44,473	31,458	90,000	0	271,336	745,156	18.7%	741,632	18.6%			
FACILITIES																		
Maintenance & Improvement	55,470	53,721	0	0	735	0	709	0	0	0	1,445	6,117	11.0%	7,866	14.6%			
Sanitation Facilities Constr.	79,582	79,582	0	0	1,369	0	990	0	0	0	2,359	18,806	23.6%	18,806	23.6%			
Health Care Fac. Constr.	81,489	85,048	0	0	1,198	0	0	0	0	57,313	58,511	92,070	113.0%	88,511	104.1%			
Facil. & Envir. Hlth Supp.	204,379	207,206	1,350	1,587	971	1,355	2,621	0	0	0	7,884	12,111	5.9%	9,284	4.5%			
Equipment	22,582	22,582	0	0	31	799	307	0	0	0	1,137	4,937	21.9%	4,937	21.9%			
Total, Facilities	443,502	448,139	1,350	1,587	4,303	2,154	4,627	0	0	57,313	71,335	134,040	30.2%	129,403	28.9%			
TOTAL, IHS	4,422,476	4,430,637	15,900	18,700	14,300	65,900	49,100	31,458	90,000	57,313	342,671	879,196	19.9%	871,035	19.7%			

INTRODUCTION

President Obama has demonstrated his understanding of the unique government-to-government relationship between the United States and sovereign Tribal Nations and has strived to live up to his promise to restore adequate funding across Indian Country. Under the Obama Administration, the Indian Health Service (IHS) has seen its first year-over-year budget increases in decades with a historical increase of 29% over the past four years. However, funding for Indian health care services and programs still falls significantly short of what is required to bring health parity to Native Americans.

The Obama Administration has the historic opportunity to not only *reduce*, but to *eliminate* the vast chasm between the health conditions of Native peoples and other Americans. In a 2013 speech to the National Congress of American Indians (NCAI), the Department of Health and Human Services (HHS) Secretary Sebelius acknowledged that, "...we should be proud of the progress we made in the President's first term. But we have more work to do in his second."

"So let me be clear, I believe treaty commitments are paramount law, I will fulfill those commitments as President of the United States. That's why I've co-sponsored the Indian Health Care Improvement Act and that's why I am fighting to ensure full funding for the Indian Health Care Service."

*Then-Senator Barack Obama
Crow Agency, Montana
May 19, 2008*

The target for the **IHS budget of \$27.6 billion over twelve years** described here offers a path forward and a clear direction. As a first step, the National Tribal Budget Formulation Workgroup (Workgroup) recommends that the administration seek **a 19.7% increase over the Fiscal Year (FY) 2014 President's Budget for a total of \$5.3 billion for the IHS FY 2015 budget**. This is both fair and reasonable. Any lesser amount perpetuates the practice of pitting Tribe against Tribe for what little health care dollars are available. If per capita funding for IHS was on par with health care allocations for federal employees, IHS medical services would receive a budgetary allocation of \$13.0 billion versus

the \$3.0 billion received in FY 2012. This defies the government-to-government relationship between the United States and Tribes when this obligation is not honored and appropriations are not enacted, which would finally eliminate this fiscal gap in Indian Health Services. To many Tribal Leaders, this inaction continues the "termination policies" of previous administrations.

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.

Instead, this administration, in partnership with Tribes, can make the changes that move health care in Indian Country toward a brighter future. Nothing can undo the damage done in the past, but we can use the lessons learned through history to guide our future. Together, we can ensure our children have the opportunity to have healthy and productive lives, while our elders can leave this life with dignity. Today, we can restore the **legacy of honor, trust, and parity** between the United States and the First Peoples of this great nation.

Honor

To Indian people, the federal budget is not just a fiscal document, but also a moral and ethical commitment. The budget request for Indian health care services reflects the extent to which the United States honors its promises of justice, health, and prosperity to Indian people. For the Tribes to recommend a budget that falls short of providing even the most basic of health care services to all our people is no different from asking a parent to decide which child to feed and which to go hungry.

"I understand the tragic history. Our government has not always been honest or truthful in our deals."

*Then-Senator Barack Obama
Crow Agency, Montana
May 19, 2008*

Washington must not continue to neglect or ignore its trust responsibility to Tribal Nations. Instead, Congress and this administration must begin a new era of honoring its promise to Indian Country. These are not duties to be grudgingly accepted, but must be embraced in a manner that defines the character of this great nation. It is a matter of honor.

Trust

The provision of federally funded health care services to American Indians and Alaska Natives (AI/ANs) is the direct result of treaties that were made between the United States and the many Tribes and which were reaffirmed by Executive Orders, Congressional Acts, and two centuries of Supreme Court case law. Through the cession of lands and the execution of treaties, the federal government took on a trust responsibility to provide for the health and welfare of Indian peoples. This federal trust responsibility is the foundation for the provision of federally funded health care to all members of the 566 federally recognized Indian Tribes, bands, and Alaska Native villages in the United States.

"We shall continue to fulfill the federal trust responsibility for the physical and financial resources we hold in trust for the Tribes and their members. The fulfillment of this unique responsibility will be accomplished in accordance with the highest standards."

*President Ronald Reagan
1983 Statement on Indian Policy*

Parity

Although the Indian health care system has made significant improvements by reducing mortality and morbidity rates for AI/ANs, serious health disparities remain. Much more needs to be accomplished before we finally eliminate the long-standing inequities in health status for First Americans. The fact that AI/ANs die at higher rates than other Americans from tuberculosis (500% higher), alcoholism (514% higher), diabetes (177% higher), unintentional injuries (140% higher), homicide (92% higher), and suicide (82% higher) still remains to be true.

"We are going to keep working together to make sure that the promise of America is fully realized for every Native American."

*President Barack Obama
White House Tribal Nations Summit
December 2012*

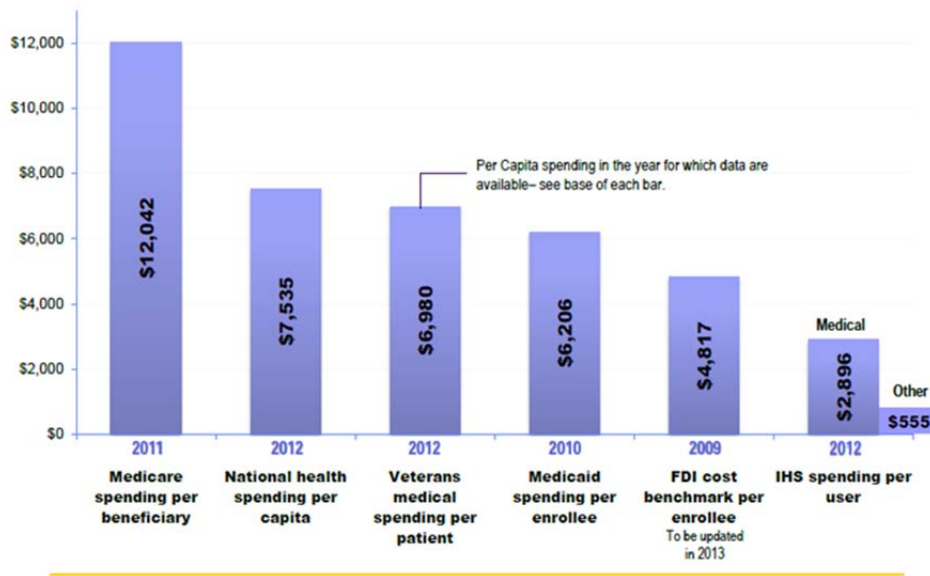
About the Indian healthcare delivery system:

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 2.6 million individuals. Currently, the IHS FY 2012 budget is \$4.3 billion. That is only (on average, system wide) 56% of the level of need.

The Indian health care delivery system, in addition to significant health disparities, also faces significant funding disparities, both in per capita spending between the IHS and other federal health care programs and within IHS, among IHS Areas, and among sites within IHS Areas. In 2012, IHS per capita expenditures for patient health services were just \$2,896, compared to \$7,535 per person for health care spending nationally. The Federal Employee Health Benefits program (FEHB) serves as the benchmark for the Federal Disparity Index (FDI). While the benchmark is scheduled to be updated in 2013, total IHS per person spending for 2012 represented only 60% of FEHB per capita spending for calendar year 2009. If the comparison is limited to medical spending, this percentage drops to 20%.



2012 IHS Expenditures Per Capita and Other Federal Health Care Expenditures Per Capita



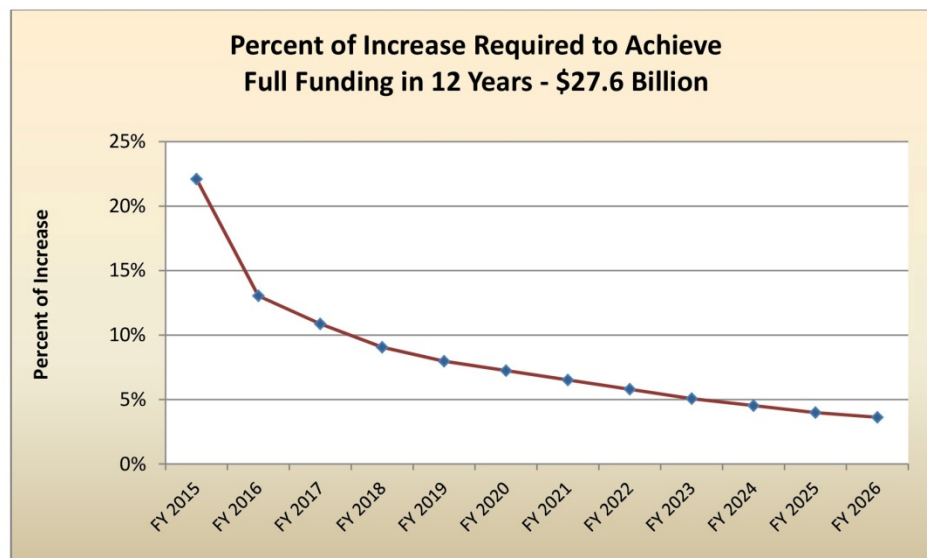
In FY 2010, the latest year for which data is currently available, the average Level of Need Funded (LNF) for IHS as a whole was just 56% of identified need. Among the 12 IHS Areas, the LNF ranged from a low of 50% for the Bemidji Area to a high of 62.2% for the Alaska Area. Developing and successfully executing a plan to achieve funding parity is critical to addressing devastating and growing health disparities in Indian country and is essential to fulfilling the United States’ trust responsibility to AI/ANs.

FY 2015 TRIBAL BUDGET RECOMMENDATIONS AND PRIORITIES

❖ 1ST RECOMMENDATION: PHASE-IN FULL FUNDING OF IHS - TOTAL NEEDS BASED BUDGET OF \$27.6 BILLION OVER 12 YEARS

Early in 2003, the Workgroup met to develop the national Tribal budget recommendations for FY 2005. Tribal leaders were disheartened that the planning base for the IHS budget was \$2.85 billion, less than 15% of the total funding required to meet the health care needs of AI/ANs. This level of funding was not even sufficient to maintain current services in the face of inflation and the increase in the Indian population. Tribal leaders warned that continued under-funding would thwart the Tribes and IHS efforts to address the serious health disparities experienced by our AI/AN people. To address this shortfall, IHS, Tribes and Tribal organizations, and urban Indian organizations (I/T/Us) worked together to develop, for the first time, a true Needs Based Budget (NBB) and for FY 2005, proposed an IHS NBB totaling \$19.5 billion.

The 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 other national priorities. Furthermore, IHS and Tribal health programs lacked the health infrastructure to accommodate such a large program expansion at one time. The Workgroup proposed a 10-year phase-in plan, with substantial increases in the first two years and more moderate increases in the following years. The most significant aspect of the 10-year plan was that it would require a multi-year commitment by Congress and the Administration to improve the health status of AI/ANs.



That was 10 years ago. In the intervening years and with failure to produce necessary funding to fulfill this 10-year plan, the health disparities between AI/ANs and other populations continued to widen, and the cost and amount of time required to close the funding disparity gap has grown. The Workgroup has updated the NBB 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 2015* is now **\$27.6 billion**, based on the FY 2012 estimate of 2.6 million eligible AI/ANs served by I/T/Us. Due to the lack of adequate increases over the years, the phase-in of the NBB at \$27.6 billion would require a full 12 years.

FY 2015 AI/AN Needs Based Funding Aggregate Cost Estimate

GROSS COST ESTIMATES

Source of Funding is not estimated

FY 2012 Need for Existing Users at I/T Sites	FY 2012 Need Expanded for Eligible AIAN at I/T/U Sites*
1,560,517	2,600,000

SERVICES	\$ Per Capita	Billions	Billions
Medical Services	\$5,395	\$8.42	\$14.03
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 2015 @4% per year	\$ Per Capita * Users	\$ Per Capita* Eligible AIAN
Dental & Vision Services	\$565	\$0.88	\$1.47
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 2015 @4% per year		
Community & Public Health	\$1,266	\$1.98	\$3.29
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, \$1,217 per capita = (.19/.81*\$5,395).		
Total Annualized Services	\$7,226	\$11.28	\$18.79
FACILITIES	\$ Per Capita	Billions	Billions
Facility Upgrades Upfront Costs		\$6.51	\$8.77
Annualized for 30 year useful Life		\$0.38	\$0.51
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.			
TOTAL			
Total Annualized Services + One-time Upfront Facilities Upgrades		\$17.79	\$27.56

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 IT sites.

❖ 2ND RECOMMENDATION: INCREASE FY 2015 IHS BUDGET TO \$5.3 BILLION

While the Workgroup's primary recommendation remains full funding of the IHS NBB, Tribes in each Area were asked to prepare budget recommendations at specific funding levels. Acting on the Area recommendations, the Workgroup recommends an increase of **19.7%** or **\$871.1 million** over the FY 2014 President's proposed IHS Budget. This increase includes **\$163.9 million** for *Current Services*, **\$178.8 million** for *Binding Fiscal Obligations* to Tribes and **\$528.4 million** in *Program Expansion* increases. Current Services and other Binding Fiscal Obligations provide the basis for program increases designed to expand services. These base costs must be accurately estimated and fully funded before any real program expansion can begin. Program expansion increases are the additional funding needed to address critical health services and new facility authorities aimed at slowing the growing health disparity rates in Tribal communities.

Full Funding of Current Services

Current services are the fixed costs that are necessary simply to maintain services at the same level as the previous year. If sufficient funding is not appropriated to cover these fixed costs, programs will have to absorb these mandatory cost increases within their existing programs by reducing services or by investing other Tribal resources that take away from education, elder services, or other Tribal programs.

The Workgroup recommends *full funding of Current Services* at an estimated **\$163.9 million** over the FY 2014 President's Budget to include the following funding priorities:

- \$15.9 million increase for Federal Pay Costs
- \$18.7 million increase for Tribal Pay Costs
- \$14.3 million increase for Non-Medical Inflation
- \$65.9 million increase funding for Medical Inflation
- \$49.1 million increase for Population Growth
- Funding for Binding Fiscal Obligations

We recommend an increase of **\$178.8 million** to meet existing obligations to Tribes. This funding is critical to fulfill commitments made through annual funding agreements in prior years for Contract Support Costs (CSC), health care facility construction, and staffing for new facilities. Specifically, the Workgroup recommends the following:

- Increase funding for Staffing for New and Replacement Facilities by \$31.5 million
- Increase funding to cover existing Contract Support Cost shortfall by \$90.0 million
- Increase funding for planned Health care Facility Construction projects by \$57.3 million

Program Expansion Increases

Additional *Program Expansion Increases* totaling **\$528.4 million** are needed to address the ever-widening AI/AN health disparity and funding gap. Top Tribal priorities are reflected by the critical line item increases listed below. The Hospitals & Clinics (H&C) line item includes funding for the Indian Health Care Improvement Fund, Health Information Technology, and Long Term Care (LTC), as well as general H&C increases.

- Increase funding for *H&C* by \$119.6 million
- Increase funding for *Mental Health* by \$47.9 million
- Increase funding for *Purchased/Referred Care (PRC)** by \$181.2 million.
- Increase funding for *Contract Support Costs (CSC)* new and expanded programs by \$37.3 million
- Increase funding for *Alcohol & Substance Abuse Services* by \$31.7 million.
- Increase funding for new *Health Care Facilities Construction (HCFC)* authorities by \$30.0 million

If the requested Program Expansion Increases are not funded, AI/ANs will continue to die younger than other American citizens and drain existing available resources for costly urgent, emergent, and chronic care at higher rates than other populations. The prospect of a better future, the dream of healthy communities, and a fair shake at improving the health status of all AI/ANs will remain out of reach for most Tribal Nations.

**Congress requested that the name of the Contract Health Services (CHS) program be changed to Purchased/Referred Care (PRC) program to more accurately reflect the purpose of the program.*

IHS IMPROVING CARE THROUGH THE IPC INITIATIVE

American Indian and Alaska Native (AI/AN) people face high rates of illness, disability, and death from chronic and preventable diseases. The Improving Patient Care (IPC) program supports IHS, Tribal, and Urban Indian health programs in reducing these health disparities. IPC sites are improving the quality of, and access to, care through the development of a system of care called the “Indian health medical home.”

Through their focus on building client-provider rapport and integrated screening and initial assessment, two separate rural IPC behavioral health-Medical care teams recently identified a history of traumatic brain injury (TBI) as a possible contributing factor to previously unmanageable symptoms of depression, psychosis, and reduced cognitive functioning in two different clients.

Both clients had rotated between costly mental institutions and outpatient services and had burned bridges with family, friends, community agencies. Most had pretty much given up on them and they had become annoyances. But through the IPC team collaboration, potential effects of TBI were identified, caught in screening and initial assessments, and now both are being recommended for neuropsych evaluations to determine the presence and extent of TBI. This collaborative approach to care will now allow these two clients to receive the right treatment and has the promise to improve their quality of life.

Current Services & Binding Agreements

The Tribes believe that all known expected cost obligations must be transparent in the budget request in order to demonstrate the true funding base required to sustain current services and meet obligated fiscal requirements. It is from this true funding base that recommendations for real program increases can begin. These cost obligations include actual federal & Tribal pay costs, true medical and non-medical inflation, population increases, “must have” staffing and construction project requirements, Contract Support Cost (CSC) shortfalls, and all expected off-the-top mandatory assessments. Understating the amount necessary to meet these fiscal obligations creates a false expectation that increased funding is available to expand program services when, in fact, funding levels may not even be sufficient to maintain the status quo.

Current Services: \$163.9 Million

The FY 2013 President’s Budget request included a 1.7% pay increase for federal commissioned officers at a cost of \$2.4 million, but no funds were budgeted for federal civil service or Tribal employees, who remain under a pay freeze enacted by Congress. The President offered a partial remedy to this situation by including funding for civil service and Tribal employee pay costs as well as for commissioned officers in his FY 2014 budget request, but at significantly lower levels than those recommended by the Tribes. The FY 2015 Tribal budget request includes an increase of \$15.9 million for Federal Pay Costs and \$18.7 million for Tribal Pay Costs. Competitive pay for both Tribal and federal employees is crucial to ensuring that the Indian health system is able to recruit and retain qualified staff, which directly affects our ability to provide quality care to patients. In addition, the Workgroup feels strongly that commissioned officers, civil service, and Tribal employees should be exempted from any federal employee pay freeze that may be imposed in FY 2014 or 2015.

The Current Services request also includes \$14.3 million for Non-Medical Inflation and \$65.9 million for Medical Inflation above the \$35 million included in the FY 2014 President’s Budget, which proposed to address a 1.5% non-medical inflation rate and a 3.6% medical inflation rate, and aimed primarily at increases in PRC program costs. However, 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), inpatient hospital care is currently at 4.1% and outpatient hospital care is at 5.6%. 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. Otherwise, the estimates developed by IHS underestimate the true level of funding needed to maintain current services.

Another \$49.1 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 1.9% annually.

Binding Fiscal Obligations: \$178.8 Million

Funding must be appropriated to enable IHS to meet its existing contract support and facilities program obligations to Tribal communities.

The Workgroup recommends \$31 million for Staffing for New and Replacement Facilities. This funding allows the IHS and Tribes to provide the necessary services associated with operating these facilities. In the case of Joint Venture projects, Tribes have taken on great risks in financing the construction of new or replacement facilities. This was done with a commitment from IHS to fund necessary staffing and operating costs upon completion of facility construction. Failure to fund staffing and operating costs in a sufficient and timely manner leaves Tribes without the means to safely operate these facilities, compromising their ability to service loan agreements while jeopardizing the health and safety of communities.

The FY 2015 Contract Support Cost (CSC) Shortfall request of \$90 million is needed to address the estimated shortfall associated with programs already operated by Tribes and Tribal organizations. Presently, there are more than 300 ongoing Tribal contracts and compacts with the IHS.

The Health Care Facility Construction (HCFC) program plays an essential role in ensuring access to comprehensive health care for the most vulnerable AI/AN populations. The facilities investments assure that localized care is effective, thereby, improving health outcomes and reducing overall health care delivery costs. The \$57.3 million FY 2015 Tribal budget request is the funding increase for additional construction projects currently on the HCFC program priority projects list to be continued or completed. Additional funding is requested under Program Expansion to support the implementation of new facility construction authorities under the Indian Health Care Improvement Act (IHCIA).

Program Expansion Increases - Services

Tribes request that the Obama Administration commit to the goal of achieving full funding of the Tribal needs based budget of \$26.2 Billion over the next 12 years. To accomplish this, the Workgroup recommends the FY 2015 Budget Program Increases outlined in this section of the budget request which will continue the significant progress made by this Administration in the past 4 years to bring AI/AN into parity with other citizens of the United States.

Hospital & Clinics: \$119.6 Million

Adequate funding for Hospitals & Clinics (H&C) is a critical Tribal budget priority for the 650 hospitals, clinics, and health programs that operate on or near Indian reservations. I/T/U-managed facilities are predominantly located in rural settings with service at many locations limited to primary care.

The demands on the IHS H&C are continuously challenged by a number of factors such as the increased demand for services related to trends in significant population growth, the increased rate of chronic diseases, rising medical inflation, difficulty in recruiting and retaining providers in rural health care settings, and the lack of adequate facilities and equipment. IHS H&C funding supports essential personal medical services, including inpatient care, routine and emergency ambulatory care, and medical support services, such as laboratory, pharmacy, nutrition, diagnostic imaging, medical records, physical therapy, and other services. H&C funds also support community health initiatives targeting health

conditions disproportionately affecting AI/ANs, such as specialized programs for diabetes, maternal and child health, women's health, and elder health.

H&C funding is critical to supporting health information technology systems in and among I/T/U health programs. This health IT system provides data for program planning quality improvement efforts, monitoring trends in population health and documenting need and performance measurements for grant-funding,

Dental Services: \$20.4 Million

Dental health is a top Tribal health priority. Dental disease can affect overall health and school and work attendance, nutritional intake, self-esteem, and employability. This disease is preventable when appropriate public health programs are in place. 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.

GPRA Clinical Measures	2013 IHS Target	2012 IHS Target	2012 IHS Result	2012 Area Range
Dental Access General	26.9%	26.9%	28.8%	21.9% - 42.5%
Topical Fluorides	Baseline *	161,461	169,083	3,555 – 27,122
Dental Sealants	Baseline *	276,893	295,734	9,144 – 58,433

Importance of the Dental Health Aide Therapist Model

Where authorized under state law, the Dental Health Aide Therapist (DHAT) model can provide services in areas where regular dental care is not available. DHATs live and work in the communities they serve and provide continuity of care, increase dental health literacy, and serve as healthy role model for younger generations. As a pioneer in this cost-efficient and effective method of providing much needed dental services, Alaska has 27 certified DHATs providing direct access to care to over 35,000 AI/AN people. This program provides a viable career for people who wish to live in remote villages. The program also provides two-year post high school dental provider education targeted at rural Alaska students from areas where access to dental care is limited. Students complete two years of education, before returning to Tribal Health Dental Programs to provide basic dental restorative services (fillings and extractions) and prevention program implementation. A supervisor provider works as part of a team led by a licensed dentist. The DHAT Educational Program has annually generated an average of 76 jobs (dental assistants, training program faculty, management, and ancillary staff) and generated \$9 million in economic activity in rural Alaska (Scott and Co., 2010 Survey of Tribal Health System Dental Directors). The DHAT model is one that has proven effectiveness and great potential, but the existing DHAT Educational Program is primarily grant funded and at risk of closing down unless a continuous source of funding is secured.

Mental Health: \$47.9 Million

Access to qualified behavioral health/mental health providers, inpatient, outpatient and prevention services is essential to the overall health of Tribal communities and each community member. The high incidence and disturbing trend toward even greater increases in the prevalence of a wide spectrum of mental health disorders and illnesses among AI/ANs demands both a comprehensive approach to addressing community mental health challenges and a respective increase in mental health appropriations.

Early intervention is as essential in mental health treatment as it is in general health care, including the provision of a wide array of services designed to address the very individualized needs of AI/AN. Services provided by IHS and Tribal facilities currently include comprehensive outpatient mental health treatment, crisis response services, prevention programming, collaborative treatment planning with alcohol and substance abuse treatment providers, group therapies, and traditional healing methodologies, in addition to other evidence-based approaches to mental health treatment. Services generally not available at IHS or Tribally-operated facilities, but which must be procured through third party contracts, include inpatient and residential treatment services, group homes, and independent living centers.

As with all professional disciplines, requiring specialized training, the recruitment and retention of qualified fulltime psychiatrists and psychiatric nurse practitioners, continues to be a challenge, especially in rural areas. Expanding behavioral health training, recruitment and retention options, and opportunities will provide increased access to quality patient-centered services, resulting in improved outcomes.

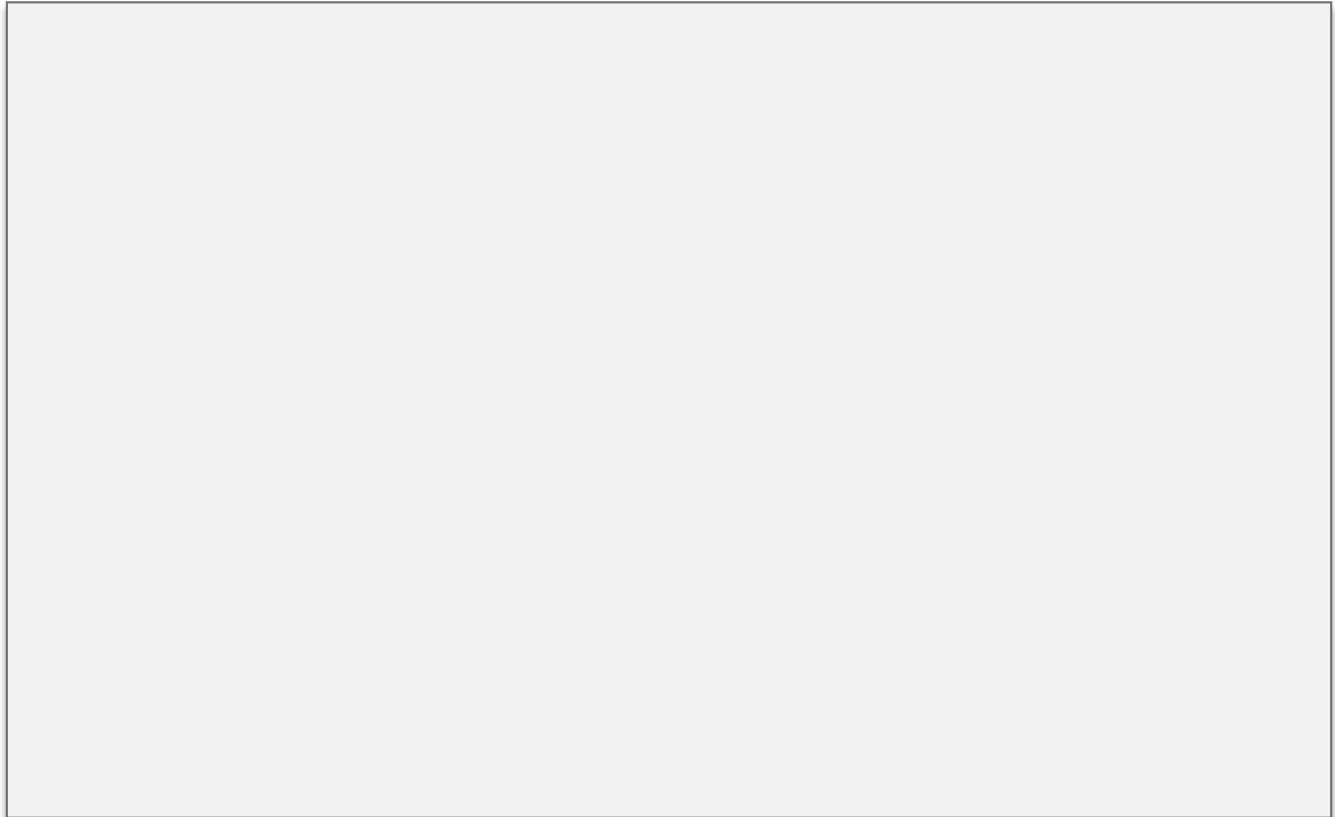
Alcohol and Substance Abuse Treatment: \$31.8 Million

Of the challenges facing AI/AN communities and people, no challenge is greater or more far reaching than the epidemic of alcohol and other substance abuse. AI/AN people are consistently over represented in statistics relating to alcohol and substance abuse disorders. IHS and Tribal alcohol and substance abuse programs employ a variety of treatment modalities consistent with evidenced-based approaches to address substance abuse disorders and addictions through individual and group counseling, peer support, and inpatient and residential placement. Treatment approaches also include traditional healing techniques designed to improve outcomes and to tie back the services provided to valuable cultural practices and the individual AI/AN's spiritual journey. IHS funding supports the operation of adult and youth residential facilities and placement contracts with third party agencies, but limited funding often results in placement decisions based on the availability of alternate resources and the providers' clinical recommendations. IHS-funded alcohol and substance abuse programs continue to focus on integrating primary care, mental health and substance abuse services, and the exploration and development of partnerships and alliances with other community stakeholders.

Congress and this Administration recently highlighted the need to address the major issue of violence against women in Tribal communities through the inclusion of specific language in the recent re-authorization of the Violence Against Women Act (VAWA). Alcohol and other substance abuse is often a precursor to domestic violence in Tribal communities.

A comprehensive approach to addressing and preventing violence against women must include the expansion of funding in the area of alcohol and substance abuse treatment.

GPRA Clinical Measures	2013 IHS Target	2012 IHS Target	2012 IHS Result	2012 Area Range
Depression Screening	58.6%	56.5%	61.9%	49.6% - 85.4%
Alcohol Screening (FAS)	61.7%	58.7%	63.8%	53.0% - 84.9%



Purchased/Referred Care Program (PRC): \$181.2 Million

Congress requested that the title of the Contract Health Services (CHS) program be changed to Purchased/Referred Care (PRC) program to more accurately reflect the purpose of the program. PRC funds are used to purchase health care services from non-IHS providers when:

1. IHS-funded direct care facility does not exist or
2. The direct care facility cannot provide the required emergency or specialty care or
3. The facility has more demand for services than it can currently meet and funding is needed to supplement alternate resources available to the patient to pay for the referred care.

Funding for PRC remains a critical priority for all Tribes. PRC provides access to essential inpatient and outpatient health care services, including emergency 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. Funding increases received in 2010 and 2012 resulted in increased purchasing power and an increase in services, but many local programs still continue to struggle. At current funding levels, most IHS and Tribally operated programs are only able to cover Priority One services to preserve life and limb and are often unable to fully meet patients' needs of even this one PRC service category.

Public Health Nursing: \$8.6 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.

Health Education: \$8.9 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.

Community Health Representatives (CHR): \$10.1 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.

Alaska Immunization: \$2 Thousand

Hepatitis B Program: Hepatitis and other liver diseases continue to be a health disparity for AI/AN. The Hepatitis B Program was initiated in 1983 because of the need to prevent and monitor hepatitis B infection among a large population of Alaska Natives with or susceptible to the disease. The Hepatitis B program is the only program that contains all of the elements recommended by the Institute of Medicine's 2010 report on liver cancer and chronic viral hepatitis. The Hepatitis B Program also conducts the largest and longest follow-up vaccination studies on Hepatitis A and B that has demonstrated prolonged protection up to 30 years for these vaccines.

Immunization (Hib) Program: Immunization is a fundamental health prevention activity for Alaska Native people and dedicated immunization funding has ensured access to vaccines and high vaccine coverage for Alaska Native children and adults. The Alaska Native Tribal Health Consortium (ANTHC) Immunization and Hepatitis Programs led Hepatitis B immunization efforts from the 1980s forward and Alaska Native people have progressed from having the highest rate of symptomatic Hepatitis B infection in the 1970s to currently having the lowest rate of any US racial group.

Urban Indian Health: \$3.5 Million

Thirty-eight Urban Indian Health Programs provide health care services in fulfillment of the federal trust responsibility to more than 100,000 AI/ANs each year. Operating in 21 states, these programs are funded from an IHS line item of only \$43 million. 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. Urban Indian Health Programs serve Native patients from over 200 federally recognized Tribes each year.

Indian Health Professions: \$880 Thousand

The Indian Health Professions program manages the IHS Scholarship and Loan Repayment programs, health professions training related grants, and recruitment and retention activities for IHS and intern/externship programs. The program enables AI/ANs to enter into health care professions through a system of preparatory, professional, and continuing educational assistance programs that serve as a catalyst for community development by enabling AI/AN health care professionals to further Indian self-determination through the delivery of health care. The program also assists in the recruitment and retention of qualified health and mental health professionals to work in the Indian health system. The program utilizes technology to provide educational and training opportunities virtually as well as clinical experience and continuing education credits. Statewide support through Locum pools help with personnel for "hard to fill" and high demand professions. The program helps fund statewide-centralized databases for professionals to allow efficient tracking and reporting of continuing education and training.

Tribal Management Grants: \$8 Thousand

The Tribal Management Grant program provides discretionary competitive grants to Tribes and Tribal organizations to establish goals and performance measures for current health programs. The program assess current management capacity to determine if new components are appropriate, analyzes programs to determine if management by a Tribe or Tribal organization is practicable and develops infrastructure systems to manage and organize programs, services, functions, or activities. 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 audit material weaknesses.

Direct Operations: \$35 Thousand

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.

Self-Governance: \$11 Thousand

The Self-Governance budget supports negotiations of Self-Governance compacts and funding agreements, oversight of the Agency Lead Negotiators (ALN), technical assistance on Tribal consultation activities, analysis of IHCA new authorities, and funding to support the activities of the Tribal Self-Governance Advisory Committee.

Contract Support Costs (CSC) New & Expanded: \$37.4 Million

The Workgroup recommends a \$37.4 million increase to fund CSC in FY 2015. An additional \$90 million is required to address past year's CSC shortfalls due to the hiring of 300 Tribal contractors and compactors. The Indian Self-Determination and Education Assistance Act of 1975 authorized Tribes to enter into contracts or self-governance compacts to manage federal programs previously administered by IHS. The well-documented achievements of the Indian self-determination policies have consistently improved service delivery, increased service levels, and improved third-party reimbursements. This policy has strengthened Tribal governments, institutions, and improved services for Indian people. Every Administration since 1975 has embraced this policy and Congress has repeatedly affirmed it through extensive amendments to strengthen the Self-Determination Act in 1988 and 1994.

The choice of Tribes to operate their own health care systems and their ability to be successful in this endeavor depend upon the availability of CSC funding to cover fixed costs. Absent full funding, Tribes are forced to reduce direct services in order to cover the government's CSC shortfall. Adequate CSC funding assures that Tribes, under the authority of their contracts and compacts with IHS, have the resources necessary to administer and deliver the highest quality health care services to their members without sacrificing program services and funding. Due to CSC shortfalls, Tribally administered IHS programs end up with less funding and fewer personnel than non-contracted IHS facilities providing the same services. Every dollar in CSC shortfalls leads to reduced services and positions in Tribally operated programs and mitigates the potential for third party collections from Medicare, Medicaid and private insurance (all of which fund additional services and positions). This compounds the damage suffered by Tribal programs. No similar impact is comparable upon direct federal agency operations.

Program Expansion Increases-Facilities

The Workgroup recommends a program expansion increase of \$58 million for Indian Health Facilities over the FY 2014 President's Budget and Binding Fiscal Obligations for a total of \$115.4 million.

Maintenance & Improvement (M&I): \$6.4 million

The recommended amount represents a program increase of \$6.4 million above the FY 2014 President's Budget request for the M&I line item. All Tribal Area budget formulation sessions reported the critical need for a funding increase in this category. The recommended increase is to address a portion of the Backlog of Essential Maintenance, Alteration, and Repair (BEMAR) of existing health care facilities, although much more funds are needed. M&I funds support, enhance the delivery of health care services, and protect real property investments from costly deterioration. This amount would allow IHS to meet needed basic facilities' maintenance requirements and begin to make long overdue facility improvements. For example, the current inventory of deferred maintenance for the Billings Area Facilities Management Program is approximately \$9.1 million and the documented backlog reported by the Phoenix Area alone is \$40.5 million.

Sanitation Facilities Construction (SFC): \$16.4 million

The recommended amount represents a \$16.4 million program increase above the FY 2014 President's Budget for the SFC line item. Due to the remoteness of many Tribal communities and lack of infrastructure, the need for constructing and upgrading water and sewer systems is great. The estimated cost to provide all AI/ANs with safe drinking water and adequate sewer systems in their homes is almost \$2.8 billion. With inflation, the importance of meeting environmental requirements and population growth, the current Sanitation appropriations are not reducing the backlog. An \$18.8 million increase would help reduce this backlog needed to serve existing homes and would address the need cited for eligible new homes being constructed annually. The Navajo Nation alone reports that 6,050 homes lack adequate water and sewer facilities, and if economically feasible projects were funded, it would require an outlay of \$276 million. The situation among Alaska Native communities is also very critical. The SFC program is a preventative program that yields positive results by improving environmental conditions and making an impact on reducing medical costs.

Health Care Facilities Construction (HFC): Current: \$57.3 Million & New Authorities: \$30 Million

The recommended amount of \$87.3 million represents additional resources needed for the HCFC line item, which in the FY2014 President's Budget totaled \$81.5 million. Tribal recommendations from several IHS Areas expounded on the lack of access to adequate health care that would be partially remedied by constructing the projects on the IHS health care facility priority list adopted in the IHCIA and through implementing the new health care facility planning and construction system required under the IHCIA. The dedication of resources for construction should be one of the highest priorities of the

IHS and DHHS and is necessary to improve quality of and access to health care for hundreds of thousands of American Indians. The IHS has 17 new inpatient and outpatient facilities planned for construction with only three facilities currently recommended for various phases of construction in fiscal year 2014. These are located at San Carlos, Arizona; Kayenta, Arizona; and the Youth Regional Treatment Center in Southern California. Other facilities waiting for funding are located in the Phoenix Area, the Navajo Area, the Albuquerque Area, the Aberdeen Area, and the Tucson Area. The Tribes in the California Area have also waited for many years for appropriations to construct the Youth Regional Treatment Center (YRTC) in Northern California.

A great concern of the Tribes who do not have projects on the priority list is the enormous amount of time that it will take the United States to complete projects that are now listed and finally address their needs. Tribes in the Portland Area and the Oklahoma Area have also expressed concern that the needed appropriations for staffing packages required to initiate the operation of new facilities should not reduce resources needed to maintain current services, which benefit all Tribes. Overall, the Tribes' attention to the issues and recommendations surrounding the Health care Facility Construction program is a current and timely Tribal consultation issue.

The Tribes recommend the distribution of HCFC funding increases to the following projects:

- Kayenta Health Center, Kayenta, Arizona - \$11.5 million to complete staff quarters
- Fort Yuma Health Center, Yuma, Arizona - \$23.1 million to begin construction
- Gila River Southeast PIMC Ambulatory Facility - \$22.7 million to begin construction

New Authorities: \$30 million

- Area Distribution Fund - \$15 million
- Innovative Health Facility Demonstration Projects - \$15 million
- Indian Health care Delivery Demonstration Projects
- Indian Country Modular Component Facilities Demonstration Program
- Mobile Health Stations Demonstration Program

Facilities & Environmental Health Support: \$1.4 Million

The recommended amount represents a \$1.4 million program increase above the FY 2014 President's Request for the Facilities & Environmental Health Support line item. Facilities and Environmental Support programs provide real property, health care facilities and staff quarters construction, maintenance and operation services, community and institutional environmental health, injury prevention, and sanitation facilities construction services. Facilities Support provides funding for related Area and Service Unit operating costs, such as utilities, building operation supplies, facilities-related personal property, and biomedical equipment repair and maintenance. It has also engaged in aggressive efforts to reduce energy related consumption at IHS managed facilities to help stem the growth in utility costs. The Environmental Health Services (EHS) program specializes in addressing injury prevention and institutional environmental health, identifying hazards and risk factors in Tribal communities and proposing control measures to prevent adverse health effects. The Injury Prevention Program works

with Tribes to collect and analyze injury surveillance data, develop community coalitions, and build local capacity to implement proven and promising community-based strategies to prevent elder falls, motor vehicle accidents, and other causes of injury. Unintentional injuries identified as a major health risk by Tribes nationwide, especially due to motor vehicle accidents, are a leading cause of death among AI/ANs from ages 1-44 years. They are major expenditures of IHS PRC (formerly CHS) funds.

Equipment: \$3.8 Million

The recommended amount represents a \$3.8 million program increase above the FY 2014 President's Request. Funds are needed for new facilities line in FY 2015 and to replace outdated equipment in IHS and Tribal health programs. This amount would help IHS to provide more preventative screening services and relieve the need to refer these types of services to PRC providers. Secondly, some Tribal clinics have benefitted from the American Reinvestment and Recovery Act funding to enhance information technology. Additional resources are needed to complete the implementation of Electronic Health Records (EHR), including adding necessary staff and the required security infrastructure for this investment.

❖ 3RD RECOMMENDATION: PROTECT PRIOR YEAR HEALTH CARE GAINS AND ADVANCE TRIBAL HEALTH

The Workgroup is thankful for the support in recent years from Congress and the Administration for significant increases to the IHS budget. However, the IHS budget has been subject to proposed budget cuts in the past. This was detrimental not only to the agency's budget, but to the lives and well-being of AI/ANs. With a budget base that is already at only 55% of need, any budget cuts in any form will have harmful effects on the health care delivery to AI/ANs and its true cost will be measurable in lives as well as dollars.

Partnership w/ DHHS Agencies

As we work to improve access and quality of care, we must leverage existing funding through partnerships, taking full advantage of proven strategies and promising practices. Extending self-governance to non-IHS programs within the DHHS provides tremendous opportunities for collaboration, synergy and maximization of resources. When Congress enacted The Tribal Self-Governance Amendments of 2000, P.L. 106-260, it included a provision requiring the DHHS to conduct a study to determine the feasibility of extending Tribal Self-Governance to non-IHS programs within the Department of Health & Human Services (DHHS). In the final study submitted to Congress in 2003, DHHS concluded that it was feasible to extend Tribal Self-Governance to eleven select programs within the Department, and recommended that Congress do so. Assuming that Self-Governance, as a practice, provides a greater benefit than federally administered programs, supporting the expansion of this practice, via Title VI is a priority for Tribes. Some benefits of Title VI Self-Governance Amendments include:

- Expands Tribal Self-Governance, the most successful policy in the history of Tribal-Federal relations.
- Builds on the well-documented successes of Tribes and Tribal organizations in delivering IHS health care programs and services under Title V.
- Determined to be feasible and desirable by DHHS in its 2003 study.
- Allows Self-Governance in DHHS analogous to that in the Department of the Interior, where Title IV allows Tribes to compact non-Bureau of Indian Affairs (BIA) programs and services.
- Provides an integrative, holistic approach to ensuring healthy communities by providing services that enhance individual and community well-being.
- Described by the Senate Committee on Indian Affairs as "the next evolution in Tribal self-governance."

In 2012, DHHS Secretary Sebelius took another step toward expanding Tribal access to DHHS programs by establishing the Self-Governance Tribal/Federal Workgroup (SGTFW) charged with identifying barriers to Tribal Self-Governance within the DHHS. While the Workgroup's establishment is a step in the right direction, the work of the SGTFW must be allowed to be completed and its recommendations must be adopted to establish a Self-Governance Demonstration project to encourage greater Tribal participation in DHHS programs. In addition, the Secretary's Tribal Advisory Group would serve as an excellent partner for this Workgroup to share recommendations and insights with, as well as serve to elevate the shared priorities of each group.

SPECIAL BUDGET CONSULTATION TOPICS

During the Area Budget Formulation Sessions held during the fall of 2012, IHS, in addition to asking for input on the budget priorities, solicited recommendations from each Area on the following specific funding topics.

- *Recommendations on priorities for Indian Health Care Improvement Act (IHCIA) provisions.* IHS asked each Area to identify top priorities to fund IHCIA provisions.
- *Sequestration.* Areas were requested to indicate whether an across-the-board cut or targeted cuts are preferred if sequestration was not averted. If targeted cuts were preferred, the Areas were requested to indicate which budget line items should be cut.
- *Contract Support Costs (CSC).* Areas were asked to discuss how the Ramah decision should be addressed and how the decision affects appropriations/budget recommendations/priorities.
- *Funding Distributions.* Areas were also asked to indicate preferences on funding allocations for the MSPI / DVPI funds (distribution for 2013), CHS, and SDPI.

The Workgroup appreciates the opportunity to discuss these important topics, but as reflected by the summary of each topic below, the Workgroup did not develop a unanimous recommendation on these important issues. The Areas provided various perspectives on these key issues, which did not lead to consensus recommendations. In addition, not all Areas provided input on each issue due to lack of time provided to address the issues, lack of background information, and other factors. The Workgroup recommends further consultation on these issues. In addition, there are existing workgroups and advisory committees specifically dedicated to many of these topics, and the Workgroup recommends that the recommendations of the existing workgroups be provided as a resource to Tribes in future consultations on these topics.

Implementation of the Indian Health Care Improvement Act (IHCIA)

The full and complete implementation of the Indian Health Care Improvement Act (IHCIA) remains a top priority for Indian Country. The IHCIA provides the authority for Indian health care, but does not provide any funds to implement the act. Additional funding is required to realize the promise of the IHCIA. While Indian Country awaited reauthorization of the IHCIA years passed, the nation's health care delivery system was being revolutionized. Mainstream American health care increased its focus on the prevention of disease, recognized the impact of social determinants on health status, and coordinated mental health, substance abuse, domestic violence, and child abuse services into comprehensive behavioral health programs. Reflecting these improvements in the IHCIA has been a critical aspect of the reauthorization effort, and though challenging, the time and resources invested paid off with the permanent reauthorization of IHCIA.

Highlights of what is contained in the IHCIA reauthorization include:

- Updates and modernizes health delivery services, such as dialysis, cancer screenings, home and community based services, and long-term care for the elderly and disabled.
- Authorizes demonstration projects to address workforce shortages and increase access to care.
- Establishes a continuum of care through integrated behavioral health programs (both prevention and treatment) to address alcohol/substance abuse problems and the social service and mental health needs of Indian people.

Seven of the twelve IHS Areas submitted recommendations for funding priorities of the currently unfunded IHCIA. The Areas identified many important provisions, but not one was identified as the top priority. As a result, the Workgroup agrees that all of the provisions of the IHCIA are important to advancing the health care of AI/AN and should be implemented in a timely manner. The Workgroup recommends that adequate funding for the implementation of these long awaited provisions is needed now.

IHCIA PROVISION: LONG TERM CARE SUPPORT AND SERVICES PROVISIONS

The authority for IHS to provide and fund long-term care services offers great promise for meeting the needs of our Elders and those with disabilities. Native elders and those with disabilities should have access to the long-term services and support necessary to remain healthy and safe while retaining as much independence as possible in their communities. However, their ability to do so is often limited by chronic health problems exacerbated by issues ,such as lack of transportation for regular monitoring and minimal specialized geriatric capabilities within the I/T/U healthcare system. Services for these individuals include residential care, such as nursing homes and assisted living facilities, culturally based home and community-based services, palliative and end of life care, fall and injury prevention efforts, caregiver services, case management, and respite care.

Beyond funding, there is a need to support and coordinate the efforts of IHS and CMS. To address reimbursement and certification/regulatory issues, there is a need for Tribes and Tribal organizations to collaborate with federal agencies, as well as for collaboration among federal agencies themselves. Most LTC programs are reimbursed under Medicaid, and the regulations and specific programs differ from state to state, creating difficulties in applying federal guidelines.

Contract Support Costs (CSC)

Ten of the twelve areas submitted recommendations addressing contract support costs (CSC). However, since the Area budget formulation sessions, the Obama Administration released the IHS FY 2014 Congressional Justification, which proposes harmful language on CSC. This proposed language intends to cap CSC payments to Tribes and Tribal organizations and to prevent their ability to pursue contract claims for underpayments in a court of law. This is a radical and unfortunate reaction to the recent *Ramah* court decision. The proposal references a "table" that has been submitted to the appropriations committees showing each Tribe's and Tribal organization's capped amount of CSC for 2014. The tables have not been disclosed to Tribes nor have they been included in any form of Tribal consultation. This proposed policy is inconsistent with the President's Executive Order on Tribal Consultation and in violation of IHS's own Tribal Consultation policy. Thus, the IHS Budget Formulation Workgroup respectfully requests that the Administration's proposal be withdrawn until the Tribes can be consulted regarding this matter.

Sequestration

Eleven of the twelve IHS areas provided recommendations on whether IHS should implement an “across-the-board” cut or to target specific programs and line items within the IHS budget. There was no consensus on the approach, but the Workgroup agrees that the IHS must be exempt from these automatic cuts in future years. Currently, the IHS is not exempt from the automatic across the board cuts unlike federal programs that serve the health of our nation’s populations with the highest need, such as Social Security, Medicare, Medicaid, the Children’s Health Insurance Plan (CHIP), and the Veterans Administration (VA). Although the American Taxpayer Relief Act reduced the level of the sequester reduction for the IHS from 8.2% to 5.0% for FY 2013, these cuts must be achieved over seven months instead of twelve, making the effective percentage of reductions approximately 9%. Even at that revised level, the IHS budget suffered a devastating cut of \$220 million.

The Tribes are still assessing the true impact of these cuts for FY 2013 and are beginning to plan for cuts for future years if sequestration is not addressed. Before the sequester went into effect, it was estimated that the IHS and Tribal hospitals and clinics would be forced to provide 3,000 fewer inpatient admissions and 804,000 fewer outpatient visits. Likely, these figures will be higher. In addition, the billions in cuts to funding for other key health agencies, such the Centers for Disease Control and Prevention (CDC), Substance Abuse and Mental Health Services Administration (SAMHSA), and the Health Resources and Services Administration (HRSA) will further increase the blow to the health of AI/ANs, as these programs have become critical to the Indian Health care System. In total, this cut translates into lost funding for primary health care and disease prevention services for AI/ANs, which is certain to produce tremendous negative health impacts.

Funding Distribution

Methamphetamine Suicide Prevention Initiative & Domestic Violence Prevention Initiative

The Methamphetamine Suicide Prevention Initiative (MSPI) and the Domestic Violence Prevention Initiative (DVPI) programs target much-needed IHS resources to community-driven prevention and intervention demonstration projects to address serious health problems and significant health disparities in Indian communities across the country:

- AI/AN people have a methamphetamine use rate that is 3 times the rate for the general population (IHS, 2008)
- AI/ANs have higher methamphetamine use rates than any other racial group except Native Hawaiians and Pacific Islanders (SAMHSA 2005)
- The suicide rate for AI/ANs is 32% higher than the overall U.S. rate (CDC, 2011)
- Suicide is the 2nd leading cause of death for AI/ANs between the ages of 10 and 34 (CDC, 2011)
- Approximately 40% of AI/AN women have experienced intimate partner violence at some time during their lifetime (CDC, 2009)
- More than 1 in 3 AI/AN women will be sexually assaulted in their lifetimes (Bureau of Justice Statistics, 2004)
- AI/AN women are 2.5 times more likely to be raped or sexually assaulted than other women in the United States (Bureau of Justice Statistics, 2004)
- AI/AN women are 5 times as likely to die from domestic violence-related injuries than women of any other race (Bureau of Justice Statistics, 2004)

Nine of the twelve Areas provided input and overall, Tribes strongly support the continuation and expansion of the MSPI and DVPI programs, broadening the scope of the projects, and increasing funding to permit more Tribal communities to participate in the initiatives. Tribes support continuation of the existing funding formula, which distributes program funds to all 12 IHS Areas based on: 1) area population, 2) poverty burden, and 3) disease burden, but do not believe that renewing these programs with another non-recurring grant-like funding mechanism is administratively efficient or consistent with the intent or spirit of self-governance and self-determination.

MSPI and DVPI funds are considered Tribal program awards, not grants and are incorporated into existing ISDEAA contracts and funding agreements. Separate modifications to funding agreements were negotiated with contracting/compacting Tribes in 2012 to address the special terms and conditions that currently govern MSPI and DVPI funding. Tribes recommend that, starting in FY 2013, a brief MSPI/DVPI scope of work needs to be added to the funding agreements and that funding for both MSPI and DVPI be allocated to the recurring base and distributed as part of the lump sum payment.

GPRA Clinical Measures	2013 IHS Target	2012 IHS Target	2012 IHS Result	2012 Area Range
BH-Depression Screening	58.6%	56.5%	61.9%	49.6% - 85.4%
DV/IPV Screening	58.3%	55.3%	61.5%	49.6% - 84.5%

Purchased/Referred Care (Contract Health Service)

Increased funding for PRC is a critical necessity, but it will also be necessary to examine payments to external providers and the distribution formula for PRC program funding and to address current IHS funding and health disparities and future unmet needs.

IHS and Tribally operated programs are large purchasers of medical services from outside providers. Hospitals are required to accept payment at Medicare-like-rates from federal and Tribal PRC programs, while physicians and other non-hospital providers either are paid by billed charges or negotiated reduced rates.

The Government Accounting Office (GAO) recently completed a study of IHS federal PRC programs and found that 81% of physicians and 77% of other types of non-hospital providers were paid 100% of billed charges. GAO estimated that IHS's federal PRC programs paid twice as much as what Medicare would have paid for the same physician services in 2010. If federal PRC programs had paid Medicare rates for these services, they could have used the estimated \$32 million in savings to pay for additional off-site services. Savings for the overall program would be even higher, as the GAO analysis did not include other types of non-hospital services or Tribal PRC programs. The VA pays Medicare-Like-Rates for inpatient, outpatient, and physician charges across the board without special legislation. Despite being an agency/agents of the federal government, the IHS and Tribes required special legislation to pay Medicare rates for inpatient services and must negotiate individually with other providers for Medicare-Like-Rates or other rate reductions. The GAO recommended that Congress consider capping PRC program payments for non-hospital and physician services "at rates comparable to other federal programs." HHS concurred with GAO's conclusions and recommendations and added in its comments that imposing a cap at Medicare rates would allow IHS to fund additional patient services.

The Affordable Care Act (ACA) also required the GAO to study the administration of the PRC program, including the allocation of funds. The GAO found that per capita PRC funding for FY 2010 ranged from \$299 in the Oklahoma Area to \$801 in the Billings Area. They found that adjustments (4%) and program increases (14%) accounted for just 18% of PRC funding, while base funding accounted for 82% of the funds allocated to Area offices. The GAO noted that base funding incorporates all PRC funding from the prior year to establish the new base. For example, the 2009 base + adjustments + program increases were used to establish the 2010 funding base. They also pointed out that the allocation of program increases is driven by the active user count, which includes all users who obtained at least one Direct or PRC service from an IHS-funded facility in the last 3 years. They concluded that because of the predominant influence of base funding and the relatively small contribution of program increases, it would take many years to achieve funding equity just by revising the method for distributing PRC program increases. The GAO recommended that Congress consider requiring IHS to develop and use new methods to allocate PRC program funds to address variations across areas.

The GAO also recommended that DHHS require IHS to use actual counts of PRC users (not Direct and/or PRC users) in methods for allocating PRC funds. DHHS did not concur with GOA's recommendation to use actual counts of PRC users. DHHS stated that IHS combined count of all users is intended to reflect the health care needs of those who are eligible for PRC. GAO reported that IHS own Data/Technical Workgroup found that the current IHS active user count does not measure the number of people who are eligible for PRC, in part; because not all users of IHS Direct care services are eligible for PRC services.

Tribes currently manage 54% of the total PRC budget, and therefore must play a major role in determining what, if any, changes will be made in the methodology for allocating and distributing PRC funding. Ten of the twelve provided recommendations that addressed different aspects of this issue, but again, the Workgroup strongly recommends against changing the PRC formula through the budget formulation process. This work should be addressed by the IHS Contract Health Services Workgroup and those recommendations should be shared with Tribes during national Tribal consultation.

ACCESS TO HEALTH CARE IN INDIAN COMMUNITIES IS UNIQUELY CHALLENGING

Some Tribal leaders have testified that they must drive hundreds of miles, by-passing available private and VA hospitals, in order to seek care at IHS facilities. Contract care, if available to these patients, could mean the difference between life or death, or saving of a limb, or early detection of preventable or treatable conditions.

Other Tribes have testified that due to the lack of contract health dollars, and despite recent necessary increases in PRC funding, they can still only provide Priority I level of care until August.

The IHS Medical Priorities Levels:

- I. Emergent or Acutely Urgent Care Services
- II. Preventive Care Services
- III. Primary and Secondary Care Services
- IV. Chronic Tertiary Care
- V. Excluded Services

One mother testified that her child was labeled throughout his school years as developmentally delayed; later she learned that he had a preventable hearing loss, which was not detected due to the lack of PRC funding for Medical Priority II. This mother is angry that her child will live the rest of his life at a disadvantage and hopes her testimony will prevent this from happening to other families

CONCLUSION

It is reasonable and achievable to fully fund health services for AI/AN at \$27.6 billion. Health programs, services, functions and activities provided to AI/ANs through compacts, contracts, and direct operations of the IHS are Tribal trust and treaty obligations grounded in the Constitution and numerous federal laws. This obligation to fund IHS administered services must be treated differently than any other federal programs. To do this, the Tribal budget recommendation is to utilize a phased-in approach to realistically begin to address the true health needs in Indian Country. The Tribal Needs Based Budget, if fully funded, would be *less than three percent* of the DHHS \$941 billion budget. The impact of this comparatively nominal investment in the lives of our First Americans justifies making this the highest priority for this Administration and Congress.

The President's second term represents an opportunity to finally bring true reform for the Indian Health System. For too long, we have been working to repair a starved system - a system that continues to perpetuate unacceptable third world health status for our people. While we celebrate the steps this Administration has already taken to strive for improvement in the health status of AI/ANs, more must be done to achieve true health parity.

Legacy– Champion for Indian Health

President Obama has secured a legacy in reforming America's health care system. President Obama should not only be known as a champion of health, but as a champion of change in Indian health. However, the task of reforming the Indian health care system so our people can benefit on the same basis as other Americans can only be achieved if this Administration proposes a budget that fulfills its obligation to Tribes and fully funds the Indian health care system. We understand that this presents a challenge, but we believe that the commitment this Administration has shown in working towards the American Dream for all can and should be applied to health care for its First Peoples.

"We haven't solved all our problems. We've got a long road ahead. But I believe that one day, we're going to be able to look back on these years and say that this was a turning point."

President Barack Obama
White House Tribal Nations
Conference
December 2, 2011

We ask this Administration to stand up with us and move forward on a path toward health parity for all our people, a turning point as envisioned by President Obama in his address to the 2011 White House Tribal Nations Conference. Let this second term be the turning point for Indian health care.

ACKNOWLEDGEMENTS

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APPENDIX

❖ APPENDIX A: HOT ISSUES BY IHS SERVICE AREAS

During the fiscal year, IHS receives data call requests from DHHS and OMB regarding issues of concern that impact a particular Service Area (i.e., national emergencies, etc.). Each Area was requested to identify “hot issues” facing its regional Tribes. Any significant issues (non-budgetary, current and/or lingering) were described in brief by the IHS Area with the intention of elevating Area concerns during the National Work Session. The IHS Areas submitted the following “hot issues” topics.

Aberdeen

- ❖ CMS
- ❖ CHS Delivery Area
- ❖ Data Sharing with States
- ❖ Prescription Drug Abuse / Addiction
- ❖ VA – IHS MOU

Alaska

- ❖ Behavioral Health - Alcohol and Substance Abuse
 - Pilot Heroin Pain Management Rehab Center
- ❖ CSC
 - Shortfalls, New and Expanded Services (including staffing packages)
- ❖ Dental Health Aide Therapist Training Center
- ❖ Health Promotion & Disease Prevention including Injury Prevention
- ❖ IHS Advance Appropriations
- ❖ IHCIA Improve Access and Unmet Needs
 - Behavioral Health Access to Tele-BH
 - LTC / Elder Care
- ❖ Joint Venture Projects Staffing Packages
- ❖ Village Built Clinic Leases Shortfalls

Albuquerque

- ❖ CHS & User Population Numbers
- ❖ Mental Health
- ❖ MSPI Pilot Program
- ❖ SDPI
- ❖ Utility Infrastructure – Water and Sewer

Bemidji

- ❖ CHS
- ❖ Facilities Construction
- ❖ Funding Parity
- ❖ Health Disparities

Billings

- ❖ Health care Funding Disparity

California

- ❖ CHS Service Funds for New Tribes

Nashville

- ❖ CHR Training for Urban Programs
- ❖ IHS Ability to Accept GPRA Data from Non-RPMS Sites
- ❖ IHS Personnel Hiring Model
- ❖ IHS / VA Master Agreement
- ❖ Implementation of an Area Prescription Drug Abuse Action Plan
- ❖ Obesity Prevention

Navajo

- ❖ Elder Care Services
- ❖ HIV Prevention Program
- ❖ Methamphetamine Babies and Synthetic Drugs
- ❖ Level Three Trauma Center and Cancer and Cardiology Specialty Services
- ❖ Rocky Mountain Spotted Fever Education and Prevention
- ❖ Veteran's Health care Services

Oklahoma

- ❖ IHS Home Inventory Initiative
- ❖ Medicaid Expansion

Phoenix

- ❖ Adult Male Residential Treatment
- ❖ Chronic Pain Management
- ❖ Diabetes Care Management
- ❖ Fort Yuma Ambulatory Health care Center
- ❖ Home Health Services (Elders)
- ❖ Women's Health care

Portland

- ❖ CSC
- ❖ Environmental Health
 - Hanford Nuclear Plant
 - Sledge from Timber Mills
 - Zinc, Arsenic, Cadmium and Mercury
- ❖ IHS & VA MOU
- ❖ Medicaid Payment Policy and Alternate Delivery Systems
 - Encounter Rate
 - Accountable Care Organization (ACO) and Community Care Organization (CCO) Delivery Models
 - Fee for Service (FFS) Moving to Global Budgets
 - Money Follows the Person (MFP)
- ❖ Public Health / Emergency Preparedness

Tucson

- ❖ Replacement of Sells Hospital
- ❖ Recovering Costs to Provide Health Care to Undocumented Immigrants who Receive Care at the Sells Service Unit
- ❖ Rocky Mountain Spotted Fever Education/Prevention.

HOT ISSUES NARRATIVES SUBMITTED BY IHS SERVICE AREAS

Aberdeen

ISSUE: IHCA's unfunded mandate for all counties in North Dakota (ND) and South Dakota (SD) to be Contract Health Service Delivery Area (CHSDA).

BACKGROUND: Headquarters has determined that appropriations are required to expand the Service Unit's CHSDAs to include all counties in ND and SD, as required in the IHCA.

RECOMMENDATION: The Great Plains Tribal Chairman's Health Board, Board of Directors requests the following:

- The Aberdeen Area Office or Headquarters should prepare an analysis of the estimated cost to implement this provision in the IHCA.
- The User Population calculation process should be modified to count all users in the ND and SD CHSDA. This change should be retroactive if possible. If not possible, it should be put into effect such that the estimated users who receive services, but are not currently counted in ND and SD user populations, are included in the next fiscal year's official user counts.
- IHS Headquarters should calculate the funding lost to ND and SD Tribes by not including these users in the user population. The dollar amount of these funds should be provided to ND and SD Tribes in proportion to their adjusted user counts. The funds should be taken off the top of the next appropriation.
- A report should be provided to ND and SD Tribes showing how the adjustments have been made prior to the following year's appropriation.

ISSUE: Veterans Affairs / IHS MOU

BACKGROUND: IHS Headquarter is familiar with this issue.

ISSUE: IHS and Tribal Data – Sharing Collaborative Agreements with States

BACKGROUND: IHS has voluntarily shared reportable disease and other public health data with State health departments for decades. CDC funded studies have shown that Tribes and IHS rarely receive these surveillance data back in a useable format. Specifically, data are not aggregated for AI/AN living in the reservation counties or CHSDA counties. SD Department of Health (DOH), ND DOH and Nebraska (NE) Department of Health and Human Services (DHHS) are willing to aggregate data by reservation counties, but because these data will then identify Tribal communities, the state health departments and GPTCHB need guidance from Tribes.

RECOMMENDATION: Area of guidance might include:

- Can reservation specific data be shared with other Tribes?
- Are some reservation specific data considered too sensitive to be shared publically, such as suicide or STI data?
- Who is the Tribal Point of Contact for communication and dissemination regarding reservation specific data?
- If a party wants to use reservation specific data to seek funding, what is the Tribal process for collaboration?
- If the Tribe is “direct service,” is there someone at the Tribal level that should be included for an appropriate public health response to the surveillance information? If so, what level of information do they need to know?

Formal public health data sharing agreements would be a foundation step to integrating Tribal public health into the US Public Health System comprised of CDC, State, and local health departments. The unique sovereign nature of Tribal governments and the current lack of Tribal integration in this system call for a systematic approach to close wide gap in sharing public health data with Tribes.

ISSUE: CMS

RECOMMENDATION: There is a need for a clear definition between “direct services” and “638.”

ISSUE: Prescription Drug Abuse/Addiction

BACKGROUND: IHS and Tribes need strategies for predicting, preventing, and managing prescription drug abuse/addiction. Opioid abuse and addiction continues to expand in its impact. The following excerpt was taken from the Med-IQ: Strategies for Predicting, Preventing and Managing Opioid Abuse and Addition: Opioid consumption in the US has increased more than 125% in the past decade. The US makes up 4.6% of the world population, but Americans consume 80% of the world’s opioid supply.¹ It is estimated that 3% of Americans 12 years of age or older use prescription-type psychotherapeutic drugs (i.e., pain relievers, tranquilizers, stimulants, or sedatives) for nonmedical purposes. This translates to 7 million people and is second only to the number of Americans who are current marijuana users.²

As a result of this increase in use, opioid-related complications and diversion have correspondingly increased. Emergency department visits associated with nonmedical opioid use have more than doubled between 2004 and 2008 and increased from 145,000 to 306,000 in 2008.² In addition, recent preliminary data from the US CDC have shown that drug-related deaths have surpassed motor-vehicle accidents as one of the leading causes of death. This rise in drug-related deaths is fueled in large part by prescription

¹ Trescot AM, Helm S, Hansen H, et al. Opioids in the Management of Chronic Non-Cancer Pain: An Update of American Society of the Interventional Pain Physicians’ (ASIPP) guidelines. *Pain Phys.* 2008; 11 (Suppl 2):S5-S62.

² Substance Abuse and Mental Health Services Administration. Results from the 2010 National Survey on Drug Use and Health: Summary of Nation Findings, NSDUH Series H-41, HHS Publication No. (SMA) 11-4658. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2011.

opioids.³ Given these circumstances, health care professionals must not only understand the benefits associated with appropriate opioid therapies, but how to properly and safely prescribe them.

RECOMMENDATION: Tribal communities need to be aware of the public health impact of this growing problem in order to respond appropriately.

Alaska

ISSUE: Behavioral Health

Behavioral Health—Workforce Development (Staff Recruitment & Retention)

BACKGROUND: Alaska experiences the highest rate of suicide per capita in the United States with Alaska Natives experiencing a higher risk of suicide than any other ethnic group. In addition, Alaska continually ranks as one of the most dangerous states for women with victimization of intimate partner or sexual violence. Furthermore, Alaska ranks one of the highest of alcohol consumption rates per capita. Moreover, evidence suggests that individuals that are addicted or abuse substances—use this as a coping mechanism to deal with a history of trauma. Also, traumatized individuals experience difficulty with trusting others including behavioral health providers to begin their healing processes especially when staff turnover is significant. Furthermore, Alaska is fortunate to expand services through its Behavioral Health Aide Model focusing on prevention, intervention, treatment, case management and aftercare for those who are affected by substance use and mental illness.

However, 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.

RECOMMENDATION: Increase funding for support of recruiting, retaining and training culturally responsive Alaska Native behavioral health providers; including supporting Alaska Native students studying within the field of psychology through initiatives such as Alaska Native Community Advancement in Psychology with the mission is 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.

Pain Management Rehab Center - similar to Fond du Lac and Mayo Clinic center

BACKGROUND: Despite consensus on the need to develop the capacity for delivering Pain Management services, there is a current lack of resources to coordinate and carry out these services. Development and implementation of common standards of care, uniform protocols, and best practices are necessary to effectively deliver these services, but a lack of workforce expertise and coordination among Tribal providers makes this delivery impossible.

³ LA Times. Drug Deaths Now Outnumber Traffic Fatalities in US, data show. September 17, 2011. <http://articles.latimes.com/2011/sep/17/local/la-me-drugs-epidemic-20110918>. Accessed October 14, 2011.

Within the Alaska Tribal Health System, a steering committee is being developed to address the issues surrounding Pain Management services; however without funding to dedicate staff to manage this initiative, as well as funding to train providers, both the committee and initiative's potential is limited.

RECOMMENDATION: Because a systematic approach to Pain Management does not currently exist within the Alaska Tribal Health System, patient safety is jeopardized as he or she moves through the referral system and differing treatment methods are carried out.

Models of success, both in tribal and non-tribal facilities alike, do exist, with Fond du Luc and the Mayo Clinic being notable examples. However, funding is needed to coordinate the inherently multi-disciplinary nature (e.g. Physical Therapy, Behavioral Health, Nutrition, Pharmacy, Acupuncture, Massage, Chiropractic, Traditional Healers) of pain management services.

It is critical to build on the research of Mayo and other programs to investigate what works and what doesn't. The IHS should partner with I/T/Us to investigate policy and funding opportunities to enable a coordinated effort among providers to delivery effective pain management services.

ISSUE: Contract Support Cost - Shortfalls, New and Expanded Services (including staffing packages)

BACKGROUND: Contract Support Costs (CSC) are utilized to cover administrative and overhead costs associated with operating a contract or compact. With the failure to fully fund all CSC requirements, IHS is treating its contractual agreements as optional or discretionary agreements. This practice punishes tribes and tribal organizations for taking on contracts to carry out the agency's services and is contrary to the principles of self-governance and self-determination. This reduction in services results in a decrease in billings and collections from Medicare, Medicaid and private insurers. The lost revenues compound the decreased availability of resources to tribal providers and ultimately result in further reduction of available staff and health care services.

RECOMMENDATION: Increase the IHS Contract Support Cost line-item to fully fund CSCs, including any CSC requirements associated with new or expanded IHS programs and associated federal mandates. Allocate sufficient funds to also meet contract support cost requirements associated with the operation of facilities expected to operate in FY2015 (i.e. the joint venture facilities that are currently under construction), plus CSC requirements associated with other program expansions expected by FY2015. Budgeting for such requirements in advance will prevent the recurrence of contract support cost shortfalls in the future.

ISSUE: Dental Health Aide Therapist Training Center

BACKGROUND: Alaska Native people experience the highest rates of dental disease of any race in the US. The impact of dental disease spans all ages and communities, with at least 75% of rural Alaskans experiencing dental cavities or gum disease in their lifetime. Dental disease can affect school and work attendance, nutritional intake, self-esteem, and employability. This disease is preventable when appropriate public health programs are in place. DHATs are the ideal type of provider to address this enormous disparity. They live and work in their communities providing continuity of care, increased dental health literacy and a healthy role model for the younger generations.

Currently the DHAT Educational Program is primarily grant funded and at risk of closing down unless a continuous source of funding is secured.

Two year post high school dental provider education targeted at rural Alaska students from areas where access to dental care is limited. Students complete two years of education, then return to Tribal Health System (THS) Dental Programs to provide basic dental restorative services (fillings and extractions) and prevention program implementation. They are a supervised provider who works as part of a team lead by a licensed THS dentist. Currently, there are 27 certified Dental Health Aide Therapists working in Alaska providing direct access to dental care to over 35,000 American Indian and Alaska Native people. This program provides a viable career for people who wish to live in remote villages. The DHAT Educational Program and its graduates annually generate 76 jobs (dental assistants, training program faculty, management, staff) with half of these jobs and the related \$9m economic activity in rural Alaska (Scott and Co., 2010 Survey of THS Dental Directors).

RECOMMENDATION: There is an estimated need of a \$2 million operating budget per year to support 10-12 students per class capacity, enabling two staggered classes running at all times.

ISSUE: Health Promotion & Disease Prevention including Injury Prevention

BACKGROUND: By far, unintentional injury is the leading cause of premature deaths, as measured by potential life years lost, followed by our most prevalent intentional injury, suicide. Next are cancer and heart disease, both conditions that are influenced by health behaviors for which prevention through physical activity, healthy diet, tobacco avoidance, and regular screenings play a significant role. In measuring potential years of life lost, these four leading causes among Alaska Native people all fall within the scope of Health Promotion and Disease Prevention programs.

RECOMMENDATION: Funding Health Promotion & Disease Prevention is perhaps the most effective measure of ensuring that Alaska Native people remain able to lead a high quality of life and contribute within their communities. While the majority of health indicators can be measured in terms of the resulting procedure or necessary health care-related service needed, adequately funding Health Promotion & Disease Prevention activities benefits all areas of healthcare spending by keeping individuals out of the hospitals and clinics entirely. In terms of funding individual areas of the Indian Health Service, few areas offer such budgetary value as adequately funding Health Promotion & Disease Prevention programs.

ISSUE: IHS Advance Appropriations

BACKGROUND: 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. 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, tribes and tribal organizations have similar concerns about the IHS health system.

RECOMMENDATION: 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.

Late funding 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 health care for American Indian and Alaska Native people.

ISSUE: IHCA Improve Access and Unmet Needs

Behavioral Health Access to Tele-BH

BACKGROUND: Tele-behavioral health capabilities (Video Tele-conferencing—VTC) are essential to Alaska to expand services to rural communities. Many of our Alaskan villages reside in remote areas off the road system which contribute to the lack of access to care. Furthermore, we have difficulty recruiting and retaining clinicians, psychiatrists and other behavioral health providers statewide. 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.

Tele-behavioral health is a significant and crucial component to the spectrum of resources within Alaska's Behavioral Health programs. Moreover, it offers access to many forms of care including the following examples:

- Communities without local psychiatric services often utilize VTC as their primary source of psychiatry;
- VTC is vital for providing emergency services for urgent situations that otherwise would have a longer waiting periods to receive an in-person assessment and intervention;
- VTC is innovatively being utilized to offer group therapy across several villages at once—allowing villages to start groups without having to identify all client participants within one community;
- VTC has been instrumental in connecting clients with their families while away for residential treatment; in addition, it has been a vital resource for treatment planning and family therapy;
- Currently there are several forms of technology (i.e., web-cam, Skype, etc.) which do not offer the level of security and protocols for maintaining client confidentiality that VTC provides;
- VTC offers clients who want to maintain their anonymity by having access to a provider outside their rural community;

- VTC offers the ability to provide long-distance supervision by a licensed provider to a village based counselor in a remote community;
- Rural communities have been experiencing an increase of prescription drug abuse and other types of drug use which have required an increase in services that can be addressed through VTC; and
- Many of our regional sites use VTC for staff debriefings after critical incidents, staff meetings including team development, discussing challenges and celebrating successes.

RECOMMENDATION: Increase funding for tribal behavioral health programs to appropriately supply clinics throughout the state with Video Tele-Conferencing equipment in efforts to expand service delivery access to village based services.

Long-term Care Support Services

BACKGROUND: Organizations are opting for nursing rather than assisted living because the rates are cost based in Alaska. More organizations might be interested in assisted living if IHS provided some operating funding for individuals needing care, but not 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 for IHS to offer and fund long-term care services offer great promise for meeting the needs of our Elders and those with disabilities.

RECOMMENDATION: Alaska Native elders and those with disabilities should have access to the long-term services and support necessary to remain healthy and safe while retaining as much independence as possible in their communities. ANHB urges the IHS to target funds to implement LTC services as authorized under the IHCIA.

Beyond funding, there is a need to support and coordinate the efforts of IHS and the Centers for Medicare & Medicaid Services. To address reimbursement and certification/regulatory issues, there is a need for tribes and tribal organizations to collaborate with federal agencies, as well as collaboration among federal agencies themselves. Most LTC programs are reimbursed under Medicaid, and the regulations and specific programs differ from state to state, creating difficulties in applying federal guidelines and working through federal programs.

ISSUE: Joint Venture Projects Staffing Packages

BACKGROUND: All new and joint venture facilities should receive staffing package funds in advance of the facility's completion. It takes considerable time to recruit appropriate personnel and from an operational standpoint, tribal providers should not have to wait for the facility's staffing package funding until after it opens.

Because of inadequate funding related to staffing, multiple tribal organizations in the Alaska area are at a point where their ability to carry out health care services is significantly compromised. Beyond reducing access to health care services, it puts these tribal organizations in danger of being unable to service the debt incurred in constructing joint venture facilities.

RECOMMENDATION: We urge the IHS Director to enable tribes and tribal organizations to adequately plan for respective facility operations and for the IHS to outline its challenges to do so and work with Congress, tribes and tribal organizations to ensure that funds are available in a timely manner. Additionally, the IHS should discontinue the practice of requesting less than the full amount (derived from IHS's own calculated staffing costs) of necessary staffing funds from Congress. When the IHS requests, and subsequently receives, less than the amount it needs to meet its contractual commitments to individual tribal providers, funds must be diverted from other areas to make up for the difference. Before IHS requests, and before Congress funds, discretionary increases in other IHS accounts, contractually committed staffing packages should be paid in full.

In entering joint venture construction agreements with tribal organizations, IHS agreed to request funding from Congress on the same basis as IHS requests funding for other facilities. Tribal organizations have held up their end of the agreements and ask that IHS and Congress do the same.

ISSUE: Village Built Clinic Leases Shortfalls

BACKGROUND: The Village Built Clinics (VBCs) are essential to the IHS carrying out the Community Health Aide Program (CHAP) in villages in rural Alaska. The Indian Health Care Improvement Act mandates that IHS develop and operate the CHAP. The community health aides and practitioners use the VBCs to provide CHAP services in the villages. However, the inadequate condition of the VBCs has become an increasingly difficult obstacle to carrying out the mandated CHAP.

In many situations, the CHAP is operated in unsafe facilities and in some villages, the VBCs have to be closed and CHAP services suspended because of safety hazards to the employees and patients.

The IHS has a legal responsibility to fully fund the VBCs and has available appropriations to meet that responsibility.

IHS's failure to maintain the VBCs and upgrade them directly hampers the ability of the co-signers to the Alaska Tribal Health Compact to meet the "meaningful use" standards set by the Centers for Medicare and Medicaid Services in order to be eligible for incentive payments for electronic health records technology. IHS should ensure that VBCs are brought up to the appropriate technological capability for tribal providers qualify for needed incentive payments to implement the electronic health record, which will improve patient health and fulfill an important congressional initiative.

RECOMMENDATION: The majority of VBC lease rentals have not increased since 1989 and current funding is not sufficient to cover inflationary increases and in particular, the cost of repair and renovation needed to keep them in a safe condition. As the CHAP has evolved to provide additional staffing and updated equipment the inadequacy of the VBCs has become an increasingly difficult obstacle to providing health care to Alaska Native people. By FY 2006, the lease rentals paid by the IHS to the villages covered only 55 percent of operating costs. To alleviate this chronic underfunding and meet its contractual requirements, the IHS must allocate an additional \$8.2 million annually to cover maintenance and operation costs.

Albuquerque

ISSUE: Over the last several years the Canoncito Band of Navajos have been evaluating the feasibility of expanding its existing health care programs and have been confronted with federal policy barriers and lack of financial resources for adequate health care. The first issue concerns SDPI. The second issue concerns the funding formula for CHS and the user population numbers. The third issue is the pilot MSPI grant program.

BACKGROUND: The Canoncito Band of Navajos through its non-profit corporation, the Canoncito Band of Navajo Health Center, Inc., is evaluating the feasibility to expand its existing health care programs and the related health care infrastructure. The corporation has contracted through 638 the Substance Abuse program and the Community Health Representative program and receives the SDPI grant for Diabetes. The objective is to provide better health care services than what the current IHS health care system offers and to leverage the funds with other Federal, Tribal, State and private sector funds to establish the most efficient operation. The corporation also works very closely with the local IHS to improve health care services. There are three hot issues areas that can be improved with the help of the Federal Government, which includes the SDPI grant program, the CHS system, and the MSPI grant program.

RECOMMENDATION: The first hot issue is the SDPI grant program and the reauthorization of funding every three or four years. The funding of SDPI should continue and become a permanent part of the IHS health care program. The grant program should be converted to a contract program and it should be non-competitive. This would allow Native Tribes to contract the health program through the 638 process and provide the health care services at the local level. The current program is a competitive grant program and has to be reauthorized every three or four years. Diabetes is the leading causes of death for American Indians in the State of New Mexico and it will diminish in three or four years. The annual appropriation of \$200 million should be made for the Native people and the majority of funds (80%) should come down to the grass roots level.

The second hot issue is the funding formula for CHS and how the user population is used. The CHS budget for the Acoma Canoncito Laguna Service Unit has been declining and the cost of specialized health care has also been increasing at a higher rate. A priority system has been established and specialized health care is provided to those people who have a disease or illness on the priority list. These specialized medical services are not provided on the reservation facilities by in the larger cities. Therefore, to keep up with the cost of specialized medical services, the formulas and values for calculating user numbers need to be kept updated based upon the Tribes population and returned to the home service unit. The community of To'Hajiilee is located 30 miles from a major metropolitan city and three other neighboring Tribes with health care facilities. Some of the To'Hajiilee community members are counted as users for these other Tribal facilities and not for the home service unit. This creates less funding for the home service unit as some Tribal members are counted for other health care facility users. The local service unit needs to receive more funding for CHS or the local service unit should be allocated more funds to hire additional medical specialists.

The third hot issue is the funding of MSPI pilot program. The MSPI project is a very good project for the community of To'Hajiilee. Our main objective is suicide prevention and the community receives a \$30,000 grant per year. This community is like many other Indian reservations in that we have a much undeveloped reservation, no education or job opportunities, we have a lot drugs and alcohol problems on

the reservation, and suicide, crime, and violence are major problems. Historical trauma is also a major concern when Indian people remember what the US Government did not do for our people in the past. The MSPI program should continue to be funded as a permanent health care program under the IHS. All Indian Nations should be allowed to participate in this health care program and not just Tribes who apply for the pilot project grant.

ISSUE: The Pueblo of Zuni (POZ) and the Ramah Navajo School Board, Inc., Pine Hill Health Clinic (RNSB, Inc.-PHC) have dire utility infrastructure needs that include water and sewage systems. The POZ is in the early construction phase of a new elementary school to serve 700 plus students and faculty with 25 new residential homes. This will require the installation of new water and sewer systems. The RNSB, Inc. has a water emergency due to their water system going down. The Pine Hill Health Clinic ceased seeing patients until the water pressure is at an acceptable level. The Ramah Navajo community water system had been installed by IHS and the BIA over thirty (30) years ago. The water system has made it difficult and expensive to operate and maintain the systems. In addition, the EPA has cited numerous violations regarding the Pine Hill water system. EPA has threatened the operations of the health center and the school system.

BACKGROUND: The funding increases received in prior years did not keep pace with inflation costs of operation increases then and now at 3.5% to 6%. In some years, budget cuts (rescissions) occurred in all line items program except H&C and CHS.

The alternate resources, Medicare, Medicaid, and private insurance supplement these funding shortfalls. However we must keep in mind the buildings and structures that are in need of repair and/or renovation. These alternate resources are used for repairs and renovation of these facilities. Renovations are needed due to increase in user population and expansion of services. This results in increase in staffing and space. Most facilities are not on the priority list to receive renovation funds thereby the service units must self-initiates and self-supports much needed renovations using alternate resources. One example is at Zuni-Ramah Service Unit where three major and several minor renovations projects were completed solely with alternate resources. There are other renovation projects being planned. However, with CHS deficits of \$1,493,357 in FY-2011 and \$2,232,174 in FY-2012, the deficits were covered using alternate resources. The result is that much needed renovations will be delayed for several years and/or canceled.

RECOMMENDATION: Proposed funding amount: \$13,500,000.

ISSUE: Mental Health

BACKGROUND: The goal of the IHS Mental Health Program is to promote, provide, and manage a comprehensive system of mental health services that offer a diverse range of culturally sensitive services at all levels of mental health needs.

Over the previous years, there have been slight increases to the mental health program, but positions specific to addressing mental illness have remained vacant and limited at the ACL Service Unit. Our community suffers tremendously with mental illness, such as depression, post-traumatic stress disorder, grief alcoholism, bi-polar disorder, suicide, etc. The Pueblo of Acoma continues to work collaboratively with the ACL Service Unit to address issues of concern to mental illness; however, the level of care needed is very high amongst our community members. With the on-going absence of credentialed and licensed staff (i.e. psychologist, psychiatrists, clinical staff, social workers, etc.) it is very difficult to determine a patient's level of care. In the absence of such services, patients are placed on waiting lists

and eventually become frustrated from waiting for an appointment and not having their mental needs met, which leads to clients abusing alcohol or other substances to temporarily manage their own mental health. In addition, patients with severe mental health needs are left untreated and become a danger to themselves or the community at large.

The IHS Mental Health Program is charged with identification of mental illness, administering appropriate case management and treatment to patients. The Pueblo of Acoma would like to see the current vacant positions in the mental health program filled and most importantly, actual mental health service provisions rendered to our community.

RECOMMENDATION: Given the high need for mental health services in our community, it is imperative that the IHS-ACL Service Unit continue to promote, recruit, and fill positions for mental health clinicians and other staff members skilled in addressing mental illness. Thus, it is requested that the mental health component be increased at \$72,020. Proposed funding amount: \$72,020.

Bemidji

ISSUE: Funding Parity (H&C, CHS, CSC, Urban)

BACKGROUND: The Bemidji Area is, and has been, the lowest funded Area in the entire Agency; Current Level of Need Funded (LNF) is 50.0%, while the Agency average is 56.6%. Twenty Tribes residing in the Bemidji Area are either at 45% or at lower of LNF.

RECOMMENDATION: The Area needs increased funding to meet the demand of a growing population.

ISSUE: Health Disparities (Dental, MH, ASA, LTC):

BACKGROUND: The Bemidji Area leads the Agency with some of the highest death rates related to cancer and heart disease. In addition, a child born in the Bemidji Area can expect an average life of up to 10 years less than other IHS Areas.

RECOMMENDATION: The Area needs increased funding to address the severe health disparities and chronic disease burden. In addition, the Area needs increased funding to address the behavioral health needs to include suicide prevention, mental health emergencies, substance abuse prevention and treatment, and accidental deaths.

ISSUE: CHS

BACKGROUND: Demand continues to outpace Bemidji Area CHS capacity with necessary services not available at the IHS or Tribal facilities, such as emergency or specialty care. The burden on CHS funding is further stressed due to the remoteness of Tribal locations to needed health care services.

RECOMMENDATION: The Area continues to utilize CHS in the federal and Tribal programs. 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 CHS to provide services that are equivalent to and beyond the scope of a clinic. Coupling this reality with rural locations and difficult recruitment efforts to fill vacant positions only increases the demand on CHS appropriations.

ISSUE: Facilities Construction (M&I):

BACKGROUND: The Bemidji Area has significant need for new health care facilities construction at federal and Tribal sites (approximately \$300M). However, the Bemidji Area also has significant need for services appropriations to raise the federal health care disparity index for all Bemidji Area Tribes. Faced with a need to prioritize potential IHS budget increases across both appropriations (Service and Facilities), the Bemidji Area is unable to prioritize additional construction funding to alleviate the national need until such time that the average level of need funding rises to a point greater than the Federal Disparity Index of 55%.

RECOMMENDATION: While some Area Tribes have received Small Ambulatory grants, none has qualified for Joint Venture agreements. The triad of underfunding (reference LNF), remoteness, and Tribal size, creates a cost prohibitive environment for many Tribal programs to pursue capital investments. Federal funding and a facilities construction methodology that empirically addresses this triad need to be considered in order to promote equity and advancement for Bemidji Tribes. *IHS and the Tribes have developed an empirical methodology to address construction needs (total need is \$8.5B). The revised Health Care Facilities Construction Priority.*

Billings

ISSUE: Health Care Funding Disparity

California

ISSUE: New Tribes, including restored federally recognized Tribes, seek temporary non-recurring CHS funds and recurring funds for IHS direct care and CHS resources.

BACKGROUND: The Indian Health Service Manual), Chapter 4, New or Restored Federally Recognized Tribes, states that the Area Director has the responsibility (Section 6-4.2 Responsibilities (C, 3)) “preparing a budget request for funding through either the annual or the supplemental appropriations”. Federal budget requests are made two years in advance of the appropriations period. For example, the fiscal year (FY) 2013 budget request will be for funds appropriated for FY 2015. Therefore, if Congress decides to appropriate new Tribe funding, the new Tribe request made during the FY 2013 budget formulation cycle would receive such funding beginning in FY 2015. In the meantime, Tribal members of the newly federally recognized Tribes need health care. In California, there are no federally ran health care clinics that new Tribe members can seek care. In addition, the federally recognized Tribes who already have with IHS a compact or P.L. 638 contract do not want their funds deluded to support newly federal recognized Tribes; they are already underfunded.

Current Situation: Newly federal recognized Tribes in California receive no funds, including any interim funds, until an appropriation for new Tribes is granted by Congress. There are two restored federally recognized Tribes seeking recurring IHS appropriated funds for direct health care and CHS: Tejon Indian Tribe and Wilton Rancheria.

RECOMMENDATION: IHS/California Area Office submitted an Appropriation Request on behalf of the two Tribes: the FY 2015 budget request for the Tejon Tribe for 377 unduplicated users is for \$987,905; the FY 2015 budget request for the Wilton Rancheria for 317 unduplicated users request is for \$855,599.

Nashville

ISSUE: Personnel Hiring

BACKGROUND: The Nashville experienced a large backlog of vacant positions with long hiring times in 2011. Federal positions and vacancies increased in 2011/early 2012 with the emergence of new service units in Mashpee, Massachusetts. Additional resources were applied to the problem with two additional HR staffing specialists hired in 2012. The Area made tremendous improvements in decreasing hiring times in 2012. The average hiring time decreased by more than 120 days (-40%), and the number of positions filled increased by 15 (+68%).

RECOMMENDATION: Nashville is committed to meeting the 80-day federal hiring model and will continue to improve the performance of human resources in 2013 through the following initiatives:

- Continued use of a creative baseball-themed scorecard with improved metrics to monitor and report HR performance monthly.
- A 10-day performance target for hiring managers to interview and make selections formalized into all hiring managers' performance plans.

Training delivered to hiring managers on how to write position descriptions and navigating the hiring process in general.

ISSUE: IHS/ VA Master Agreement

BACKGROUND: Comment from Area budget priorities survey: "all possible effort should be put into the negotiation of a Master Agreement between the VA and IHS on behalf of all I/T/U clinics to ensure that we are all paid at the Medicaid Comprehensive Rate rather than procedure by procedure using Medicare rates".

RECOMMENDATION: IHS and VA signed a national reimbursement agreement on December 5, 2012. This historic agreement authorizes VA reimbursement to IHS facilities at the all-inclusive rate and provides further direction and support to Tribal programs in their efforts to negotiate local reimbursement agreements.

ISSUE: Training for Urban CHRs

BACKGROUND: Community Health Representatives (CHR), also known as Community Health Workers, are vital members of the health care team in IHS and many other parts of the nation and the world. They provide a myriad of community based functions including, but not limited to:

- Home visits
- Patient education
- HPDP planning, activities, education
- Transportation

- Case management assistance
- Patient advocacy

Nashville has had many questions concerning the CHR program and utilization of CHRs in Urban Programs, specifically in regards to training opportunities. These questions are also prevalent in many other locations in the country.

RECOMMENDATION / STATUS: The questions below were posed to the National Coordinator of the IHS Community Health Representative Program with corresponding answers.

Q1. Can we have CHR's in Urban Programs?

Yes, IHCIA as amended gave Urban Indian Health Programs authority to include CHRs as part of their services. [§ 1660f. Community health representatives]

The Secretary, acting through the Service, may enter into contracts with, and make grants to, urban Indian organizations for the employment of Indians trained as health service providers through the Community Health Representative Program under section 107 [25 USCS § 1616] in the provision of health care, health promotion, and disease prevention services to urban Indians.

Q2. Can Urban Programs send staff to the IHS CHR training?

Yes, per the HQ CHR Program training announcements. The January/February Basic and Refresher courses are already filled, but we anticipate another course being scheduled for later in the summer, perhaps late July or early August 2013. We are also working with the Urban Program to come up with other options, and NICUIH is working on a community health worker training project for which it's received funding from the Office of Minority Health.

Q3. Is there funding for Urban Programs in regards to CHR training?

No line items are specifically "set-aside" in either the Urban line item, CHR line item or anywhere else. Funding for training and options available are key issues that Urban and CHR Program staff, along with Office of General Council staff members, are discussing at headquarters. The Areas will keep stakeholders apprised as developments occur.

SUMMARY: Candidates can be sent to the IHS CHR training program; funding is the responsibility of the candidates home Urban Program.

ISSUE: Prescription Drug Abuse/Alcohol & Substance Abuse/Cardiovascular Disease/Smoking Cessation

BACKGROUND: Preliminary data gathered by the United South and Eastern Tribes Incorporated (USET), in collaboration with Nashville Area, suggest that prescription drug abuse is an emerging threat to the health and safety of Nashville Area Tribes. However, baseline clinical data do not reflect these concerns, as only 1.0% of all patients seen in quarter 2, 2012 had a diagnosis of prescription drug abuse.

RECOMMENDATION: In an effort to mitigate this threat and to improve data, the Office of Public Health and USET propose the implementation of an Area prescription drug abuse action plan. This plan (which is currently under review) includes elements from two sources: the Nashville Area Substance Abuse Prevention Planning and Resource Guide (2009) and the Obama Administration's National Drug Control Strategy (www.whitehouse.gov/ondcp/prescription-drug-abuse), and focuses on community assessment, provider/community education, capacity-building, and evaluation.

Provider education commenced in FY'12 within the context of the Area's Annual Behavioral Health Meeting, and will continue in FY'13 with the offering of a series of planned webinars for Area providers. Community assessments have been initiated and evaluation is ongoing.

ISSUE: Obesity epidemic

BACKGROUND: Two-thirds of U.S. adults and nearly one in three children struggle because they are overweight or have obesity. The effects of the nation's obesity epidemic are immense. Taxpayers, businesses, communities and individuals spend hundreds of billions of dollars each year due to obesity, including an estimated \$168 billion in medical costs. Obesity is the reason that the current generation of youth is predicted to live a shorter life than their parents. The problem is even worse in Indian country. In 2009 AI/AN children had the highest prevalence of obesity (20.7%), followed by Hispanic (17.9%), non-Hispanic white (12.3%), non-Hispanic black (11.9%), and Asian/Pacific Islander (11.9%) children. (U.S. Department of Health and Human Services, 2009). Obesity is not just a risk factor for other disease, such as diabetes and heart disease; Obesity is a chronic disease.

RECOMMENDATION: Targeted IHS investments are needed in adult and child obesity prevention, weight management, and weight loss programs.

ISSUE: IHS's ability to accept GPRA data from non-RPMS sites

BACKGROUND: Currently IHS only includes data submissions for GPRA from RPMS sites. At this time, RPMS is considered the only valid way to report GPRA. While non-RPMS sites can provide manually reported data, the information is not included in the Area and Agency reports that are submitted for budget requests. The information submitted only represents sites who are on RPMS. In recent years, this number has decreased as Tribes make the decision to get off RPMS and use a commercial off the shelf (COTS) product to meet their clinical needs.

RECOMMENDATION: Update the data transmission criteria to include more specific data elements for GPRA reporting and continue work on the Agency-Level Performance Measurement Reports (ALPMR) Data Mart, which uses data from the National Data Warehouse (NDW). Utilizing the NDW for GPRA reporting will allow non-RPMS sites who submit data to the NDW to be included in Area and Agency reporting.

Navajo

ISSUE: Rocky Mountain Spotted Fever

BACKGROUND: Rocky Mountain Spotted Fever (RMSF) is a bacteria carried and transmitted by infected Brown Dog ticks that can be transferred to dogs and humans. If a human is bit from an infected tick, the disease can range from a moderate clinical presentation to severe illness and death from multi-system organ failure if not treated during the first few days of symptoms.

Since 2002, in Arizona there have been over 250 reported cases and 19 deaths due to RMSF, primarily on Arizona Indian reservations (Fort Apache, San Carlos, Gila River and Tohono O'odam). In 2012, the Navajo Nation Foreign Animal Disease (FAD) Task Force collaborated with CDC to conduct a

reservation wide dog serology study, in which they tested 337 dogs and identified 54 positive dogs. Examining dog blood for evidence of past exposure to RMSF is a good substitute for looking for human cases, as dogs experience tick bites more frequently than people. There were five Navajo Chapters identified that had high seroprevalence of RMSF in the dog population. Early and aggressive efforts have been successful in halting the spread of RMSF on other reservations. Although there have been no confirmed human cases of RMSF reported on the Navajo reservation, there were two suspect cases in late 2012 that have not yet been confirmed. Navajo Nation President Ben Shelly signed a proclamation that recommended the prevention and public health education of RMSF, as well as requesting all Navajo Nation residents to protect themselves against tick infestation, tick bites, and the incidence of RMSF. The Navajo Nation has taken measures to reduce the likelihood of any cases of illness or death due to RMSF, but due to the large size of Navajo Nation, more needs to be done.

RECOMMENDATION: Additional funding is requested to continue RMSF education and prevention efforts, including community outreach, school visits, chapter house presentations, and health care provider education. RMSF educational brochures, veterinary services brochures, and pesticide information flyers will be disseminated to dog owners, youth in school, and concerned community members.

The underlying issue is the overpopulation of stray dogs and inadequate enforcement of animal control, partly due to the fact that there are only four animal controls officers to cover the entire Navajo Nation, which is as large as the state of West Virginia. RMSF is a consequence of not effectively addressing these issues and by continuing education and community outreach the Navajo Nation will not only be better protected from RMSF cases and fatalities, but also will be better able to raise awareness on the stray dog problem. With this financial support, the Navajo Nation Division of Health, Veterinary and Livestock Program and Animal Control Program will work with communities and health care providers to provide education on prevention methods, information of current dog control laws, and support existing dog spray and neuter efforts.

ISSUE: Methamphetamine Babies and Synthetic Drugs

BACKGROUND: Methamphetamine is a very addictive stimulant that is closely related to amphetamine. It is long lasting and toxic to dopamine nerve terminals in the central nervous system. Methamphetamine is a white, odorless, bitter-tasting powder taken orally, by snorting, injecting, or using a rock “crystal” that is heated and smoked. The street names are speed, meth, chalk, ice, crystal, and glass. The effect of methamphetamine increases wakefulness and physical activity, produces rapid heart rate, irregular heartbeat, and increased blood pressure and body temperature. Long-term use can lead to mood disturbances, violent behavior, anxiety, confusion, insomnia, and severe dental problems. All users, but particularly those who inject the drug, risk infectious diseases such as HIV/AIDS and hepatitis. In 2009, 1.2 million Americans age 12 and older had abused methamphetamine at least once in the year prior to being surveyed. Source: *National Survey on Drug Use and Health (Substance Abuse and Mental Health Administration website)*. The National Institute on Drug Abuse (NIDA)-funded 2010 Monitoring the Future Study showed that 1.2% of 8th graders, 1.6% of 10th graders, and 1.0% of 12th graders had abused methamphetamine at least once in the year prior to being surveyed. Source: *Monitoring the Future (University of Michigan website)*. On the Navajo Nation there have been babies born from meth mothers at all available hospitals providing obstetrical services, which causes the Tribal Division of Social Services to develop complicated case plans and follow-up activities for families and children.

Synthetic drugs are the cause of growing numbers of injuries and deaths, particularly in young people across the country. Synthetic drugs are chemically laced substances akin to marijuana, cocaine, and methamphetamine that are sold over the counter at convenience stores, gas stations, and tobacco shops. Based on their chemical make-up, these drugs are commonly divided into two categories: 1) *Cannabinoids*, popularly known as “K2 or Spice”, are chemically formulated versions of synthetic marijuana that consist of lab-manufactured tetrahydrocannabinol (THC). 2) *Cathinones*, often known as “bath salts,” contain chemical compounds that mimic the effects of cocaine or meth. Though the drugs’ packaging states the products are not intended for human consumption, their design, labeling, and marketing clearly allude to the products being smoked and inhaled as a drug. One reason that synthetic drugs are extremely dangerous is that buyers don’t know what chemicals they are ingesting. Individual products can contain a vast range of different chemical formulations and potencies, some of which can be two to 500 times stronger than THC. According to the American Association of Poison Control Centers, calls nationwide indicate a dramatic rise in synthetic drug abuse over the past several years. Calls from around the country to poison control centers regarding severe reactions to synthetic marijuana numbered 2,915 in 2010 and more than 6,300 in 2011. Synthetic bath salt use is also on the rise. In 2010, poison control centers received 303 calls about injuries and deaths caused by bath salts and in 2011, there were over 5,800 reports. Though states have implemented bans on specific formulas of synthetic marijuana and bath salts, drug makers can easily sidestep these regulations. Manufacturers adapt simply by replacing the chemical compound of a banned synthetic cannabinoid or cathinone with a newer formulation that is not yet known to authorities. This modification process poses an increased risk to young users who are unaware of the reactions the new chemical may cause. There is confidential information shared by clients to social workers that reveal the increased use of synthetic drugs on the reservation.

RECOMMENDATION: Synthetic drugs awareness needs to be provided on the Navajo Nation and within program such as Social Services, the morbidity and mortality of youth and young adults can be prevented.

ISSUE: Navajo Area Patient Needs for Funding of Trauma, Cancer, and Cardiology Services.

BACKGROUND: Currently, the three Navajo Area leading causes for mortality and morbidity are cardiovascular disease, cancer, and injuries resulting from trauma.

SITUATION: Injuries resulting from trauma are the leading cause of mortality and morbidity for patients aged 2 to 29 years old. IHS has concentrated and done a good job at developing Primary Care Services. These services should have continued support. There remains a great need to develop programs and support for specialized services in the above three service categories. It is time to develop Regional Centers for these Service categories.

Because of the distances involved and the necessity to meet current medical standards of care (example: Acute Myocardial Infarction patients in a catheterization lab within 90 minutes) on the Navajo Nation, two regional programs should be developed for Level Three Trauma Centers and Cancer and Cardiovascular treatment.

- a. Cardiovascular Centers should initially provide preventive and diagnostic modalities, as well as medical and surgical oncology treatment services.
- b. Cancer Centers could provide comprehensive patient screening and diagnostic modalities, as well as medical and surgical oncology treatment services.

- c. Specialized nursing services (chemotherapy infusion) would be provided in these centers.
- d. Level Three Trauma Centers would be staffed and provide services as defined by the American College of Surgeons.

Presently, the funding for IHS is based on historical appropriation distributions supplemented by CHS funding and Third Party resources collections. Unfortunately, these collective funds cannot support the above specialized services. At present, Navajo area sites rely on CHS funding to provide these services at off-reservation facilities. Initially, the centers may share or collaborate on services, such as the specialized Oncology professions. In time, if proven viable, each center could offer these specialized services. Currently Non-Native services providers that supply these specialties to Navajo Area Indian Health Services (NAIHS) have centralized units in Albuquerque and Flagstaff that operate as such and provide these services to satellite clinics. NAIHS and 638 facilities cannot provide these services directly because of the need for facility requirements and sustainable funding support requirements.

This may not be an appropriate approach for all Tribal reservations, but the size and population and the distances inherent to the Navajo Nation would be an appropriate solution to the need for trauma, cardiovascular, and cancer services.

ISSUE: Increased services and local health care delivery for Veterans reduce the patients need for long-distance driving to Albuquerque, Phoenix, and Prescott Veteran Administration Hospitals (VAHs) for health care services.

BACKGROUND: Veterans health care has always been provided for mainstream society. It was only as recent as 15 years ago that some Navajo veterans began to receive health care services more regularly at VAHs in AZ and New Mexico. Many WWII veterans were not educated enough to realize and access availability of military health care, and therefore did not receive proper health care services no matter their sacrifices. One example is a local veteran who was finally declared by VA for compensation and almost immediately following the declaration of eligibility, the veteran became ill and died without any chance to use his benefits.

Over the years, veterans have had to travel to Albuquerque, Phoenix, or Prescott, Arizona to receive health care from veteran's hospital that required sometimes overnight stay without having the necessary resources to accommodate themselves. Some often spend the night in their vehicles. Many veterans are now older Americans and can no longer drive long distances, and instead, are forced to have their children or grandchildren provide transportation. Closer health care facilities for veterans would alleviate much of this long distance driving and travel. It would be far more advantageous for veterans to receive local medical care and other special attention. Combat trauma is a major issue and needs addressing. Many veterans have had their lives gravely compromised to the point that some have taken their own lives because of poor intervention and lack of assistance by appropriate services and authorities.

RECOMMENDATION: A new Dilkon Health Care Center in Dilkon, Arizona and a replacement IHS Hospital in Gallup, New Mexico will be constructed within the next few years. Veteran's health care services should be added to these facilities. This can be achieved through collaboration and agreement with the VA. According to federal CFR 38, there should be a veteran's health care service within an 80

mile radius, and this situation does not exist for many Navajo Veterans, particularly for specialty care services provided by the VA.

ISSUE: Currently, the Navajo Nation is experiencing an enormous need for elder care services, including housing among Navajo Nation communities.

BACKGROUND: To address this very important issue, more elder group homes need to be constructed. Currently, there are not enough centers on Navajo to care for elders. The elders are displaced off reservation in places like Winslow, Flagstaff, Payson, Showlow, Phoenix, Gallup, and Albuquerque. The Navajo Nation strives to serve the elder population so they can age in familiar surroundings and around family.

Elder group homes will serve elder clients from across the vast Navajo Nation. There is a beautiful facility in the Tsidi To'ii (Birdsprings, Arizona) community, but it lacks startup funds for operation. Although elders and people in general have multiple needs, elder care group homes on familiar grounds will meet one of those needs. Winslow Indian Health Care Center provided demographics from December 2011, which show 1550 elders from eight Navajo communities in Arizona that are of age 55 and older living in the southwest region of the Navajo Nation. An estimated 1200 are currently residing off the reservation. If this data were extrapolated to include all Navajo Nation chapters with a total population of over 200,000 individuals, the unmet need for safe elder care homes would rank as one of the largest unmet public needs for the Navajo people.

RECOMMENDATION: By improved access and continuity of care, decreased utilization of emergent and urgent care and improved health care outcomes as measured by Government Performance and Results Act measures IHS facilities demonstrate the availability of quality Health care, where facilities are located presently. By coordinating patient care, patients achieve improved health outcomes. IHS also addresses chronic conditions to the extent resources are available, which consumes a large piece of the annual health care spending.

ISSUE: A 100% increase in new HIB cases was reported for 2009 with 30 new cases; 20 cases reported the previous year. The Navajo Incidence rate for new cases is at 15.73 case per 100,000 individuals.

BACKGROUND

Since 1987 to 2011 (25 year span) the Navajo Area IHS documented 350 new human immunodeficiency virus (HIV) cases. For the past three years, new HIV cases have increased from 40 cases in 2009 to 50 new cases annually. Twenty years ago, HIV patients reported acquiring HIV from metropolitan areas; the current state of HIV transmission does not follow that trend anymore, and HIV is now transmitted Navajo to Navajo. In 1999 there was an average of 10 cases reported for the year, and most HIV infections were among Men having sex with Men (MSM). However, in 2011 risk factors in heterosexuals and MSM have resulted in more females becoming infected with HIV virus than before, representing 1/3 of the cases (⁴). The 2008 Navajo Youth Risk Behavior Report noted 61% of 12th graders are sexually active and 36% of 12th graders did not use a condom the last time they had sex,

⁴ Iralu, Johnathan. 2011 NAIHS HIV Annual Report

increasing their chances of contracting HIV (⁵). Alcohol consumption is a co-morbidity to HIV. The characteristics of most patients with high viral loads included a frequent consumption of alcohol and incarceration. When patients learn of their HIV status, many express fear, suicidal ideation, depression, and devastation, which can lead to alcohol consumption. Social Media has become a new venture for anonymous hook-ups, coined as the “pick-up artist” by using a popular internet site to connect and network for anonymous hook-ups.

RECOMMENDATION: Lifetime treatment of HIV infected individuals, costs approximately \$600,000 or approximately \$25,000 annually. For a fraction of the cost of treatment, investing in education programs can help individuals learn how to prevent sexually transmitted diseases (STDs), including HIV. The cost of testing and treatment are often significant barriers for infected individuals. Affordable health care access eliminates these roadblocks and hastens entry to care. Therefore, prevention services provided by HIV Health Educators through HIV rapid screening in the community and jail settings are a cost – effective approach to early diagnosis and treatment.

Budget cuts to the Navajo Nation HIV Prevention Program will only lead to higher incidence rates due to a decrease in preventive services and education. The HIV Prevention Program since 2008 has not seen an increase to the base level of funding; currently there are five HIV Health Educators to cover the entire Navajo nation. Professional research articles document early intervention improves the quality of life. Research (evidence-based sciences) documents HIV infected persons who are linked to primary care reduces their viral load, which reduces the risk for that individual transmitting the virus to others (⁶) HIV Counseling is linked to primary care & community screening. Without funds for travel, conducting community screenings & counseling services will be compromised (⁷). To receive maximum benefits, however, people living with HIV must receive a diagnosis as early in the course of the disease as possible, enter into quality HIV care, and remain in care indefinitely.

Education with prevention messages will reduce the spread of HIV for all Navajos. An informed Navajo who knows how to reduce their risk has the knowledge to make informed decisions about their sexual health and to prevent and eliminate HIV.

Finally, funding is needed for social media use, which is critical to address sexually active youth and high risk groups in education and prevention. The current state of the HIV prevention program budget is insufficient to address prevention messages.

Oklahoma

ISSUE: IHS Home Inventory Initiative

⁵ Navajo Nation Youth Risk and Resiliency Report, 2008

⁶ Metsch, Lisa, et.al. *HIV Transmission Risk Behaviors Among HIV-Infected Persons Who Are Successfully Linked to Care*, CID 2008:47.

⁷ Iralu, Johnathan, et.al. *Risk Factors for HIV Disease Progression In a Rural Southwest American Indian Population*, Public health Reports/2010 Supplement 4/Volume 125.

BACKGROUND: In 2010, IHS was mandated to locate and identify all the AI/AN homes within the Oklahoma City Area (OCA). The OCA Tribes are concerned about the IHS Home Inventory Initiative and the lack of funding the OCA has received to complete this home inventory mandate. According to IHS RPMS data, there are approximately 117,791 homes within the OCA, of which an estimated 17,250 have a rural route or post office box number that requires a street address so OCA can verify AI/AN homes. To date, the OCA Office of Environmental Health and Engineering has identified only 26,000 homes within the OCA. The OCA Office of Environmental Health and Engineering estimate that 90,000 homes need a survey of sanitation need. The lack of resources will require Tribes to use their funds and/or resources to complete the IHS Initiative as the FY2013 Sanitation Deficiency System Projects will require association with reportable homes initiative. The Home Inventory Initiative will impact future funding resources for the OCA Tribes.

RECOMMENDATION: The OCA Tribes recommend additional funding to identify and complete the surveys. In addition to funding, the OCA Tribes request a follow-up report showing how the other Service Areas are doing on this initiative and the impact of the initiative on future funding.

ISSUE: Medicaid Expansion

BACKGROUND: The OCA Tribes are interested in learning additional information on how IHS is working with HHS Secretary Kathleen Sebelius on advancing the Medicaid Expansion within Indian Country. Oklahoma is one of the states that decided not to have a state-based exchange or Medicaid Expansion. Estimates of costs to the State for Medicaid expansion vary widely. One significant point has been left out of the discussion: the Federal Government is already responsible for 100 percent of the cost for Native American Medicaid patients.

RECOMMENDATION: Therefore, the cost to the State for expansion of Medicaid for Native Americans is negligible. While the additional cost is not applicable to Native Americans, the additional funding would provide an increase in services for those most in need. According to a July 25, 2012 study published by the New England Journal of Medicine, New York, Maine, and Arizona experienced a 6.1 percent reduction in adult mortality after they expanded Medicaid coverage for adults. Clearly, expanding Medicaid for Native Americans in Kansas, Oklahoma, and Texas could have a significant effect on the health of our vulnerable population.

Phoenix

ISSUE: Chronic Pain Management

BACKGROUND: There is a major need to address the debilitating effects of chronic pain that many patients experience on a daily basis. Chronic pain results from the varying health problems and requires effective pain relief and other physical and alternative therapies to improve health functioning. Patient education, medication management, and adjustments to physical therapies are components of Chronic Pain Management.

ISSUE: Diabetes Case Management

BACKGROUND: While much has been accomplished through SDPI, instituting a Diabetes Case Management program would improve individual patient care. The types of assistance offered to patients would include information diabetes self-care, weight loss assistance and behavioral health support. Care

managers would focus on prevention to reduce the health related impacts of diabetes, work with physicians, pharmacists, and other staff to help the patient understand the importance of early detection and treatment of the heart disease, and assist the patient access specialty cardiac and hypertension management services when needed.

ISSUE: Home Health Services (Elders)

BACKGROUND: Many Tribes are developing plans for elder health care programs, and they are seeking funds to initiate best practices for the care of their elders. It is recommended that the IHS establish elder health care protocols within its scope of services and collaborate with Tribes to develop Tribally and culturally based home health care services that coordinate care with IHS, Tribal, and urban providers.

ISSUE: Women's Health Care

BACKGROUND: Some of the needed obstetrical and gynecological services, such as mammography and other preventive screening tests, are not available in many direct care settings and therefore, contract health dollars are used to refer patients to the private sector in order to seek care. These services need to be enhanced, especially in the Phoenix Area to meet GPRA standards. Further it is expected that obstetrical care and gynecological services, and other preventive screening tests such as mammography will be included in the ACA EHB package. In preparation for ACA implementation in the Indian health system, what the medical profession deems as a basic health care service and included in the EHB package must be accessible in Indian country.

ISSUE: Fort Yuma Ambulatory Health Center

BACKGROUND: The aged facility has been declared unsafe, which has been substantially damaged due to seismic activity. The Phoenix Area IHS has monitored the structure for several years, but recent earthquakes in the region have intensified concerns; it is apparent that patients and staff are at greater risk. The process to lease space and relocate services temporarily while waiting for the construction funding has begun in the last few months. Both the Tribal councils of the Quechan Tribe and the Cocopah Tribe have recently conducted special sessions to address their concerns.

ISSUE: Adult Male Residential Treatment

BACKGROUND: There are few resources available for these adult males in need of alcohol and substance abuse treatment to obtain these services in the Phoenix Area. Treatment dollars are generally available for youth and women with children, but resources for men for needed treatment and support for family involvement in the healing process is glaringly inadequate.

Portland

ISSUE: CSC

BACKGROUND: The Tribes need to be paid their full CSC and back pay. The determination was made and somehow this needs to be paid to the Tribes.

ISSUE: Environmental Health

- Hanford Nuclear Plant
- Sledge from Timber Mills
- Zinc, Arsenic, Cadmium, and Mercury

BACKGROUND: For years, the Colville Tribes have fought to protect and clean up the Columbia River. Since 2004, the Tribes, along with the State of Washington, have been engaged in litigation to hold Tech Metals, Ltd, Trail British Columbia accountable for releasing hazardous materials into the Columbia River. Tech Metals has conceded that it discharged millions of tons of smelting waste known as slag and other hazardous waste into the Columbia River and Lake Roosevelt. It conceded that hazardous substances including lead, zinc, arsenic, and cadmium in those wastes have leached into the environment.

RECOMMENDATION: In order for the Columbia River to be enjoyed and depended on again, we hope the river is cleaned and protected soon.

ISSUE: IHS Veteran Affairs MOU

BACKGROUND: Why is it taking so long to deal with the VA on the MOU and billing processes? This needs to be looked into.

ISSUE: Medicaid Payment Policy and Alternate Delivery Systems

- Encounter Rate
- ACO-CCO Delivery Models
- FFS Moving to Global Budgets
- MFP

BACKGROUND: We need to ensure that we all abide by the rules of the Medicaid encounter rate and protect it.

Numerous issues were brought forward by Tribal Representatives on the status of the IHS RPMS system. While some praise the system as a data rich system, others continue to voice concerns about the billing package associated with RMPS. The Jamestown S’Klallam Tribe stated that they were working with Providence Medical on joining “Epic.” Another Tribe Shoalwater Bay voiced their concerns about the billing system not being adequate while the Cowlitz Tribe stated that they were having to sink \$50,000.00 into their RPMS billing package. The Health Director from the Swinomish Tribe stated that the RPMS is old, antiquated, and has poor data transfer issues. The PA Tribes agree that something needs to be done with RPMS to bring it up to date.

Recognition from Medical Providers to who we refer patients to that Contract Health Dollars (IHS) is the payer of last resort. We are not an insurance, Recognition from Medical Providers to whom we refer patients that Medicare-like payments are sufficient.

ISSUE: Public Health / Emergency Preparedness

Recommendation: Funding for Emergency Preparedness

ISSUE: Exemption from Mandated Health Care Requirements

BACKGROUND: Confederated Tribes of the Grand Ronde Reservation states that with all of the health care changes, IHS and Tribes of the United States should be exempt from any red tape to ensure that there is not a disruption in the health care that is provided to Native Americans.

ISSUE: Self Governance Principles

BACKGROUND: We hope that the Spirit of the principles of Self Governance are relayed to all Federal Agencies, the Department of Education, and Housing and Urban Development.

RECOMMENDATION: Federal Agencies and departments need to be reminded to promote Self Governance.

ISSUE: Traditional Healing Practices

RECOMMENDATION: We need to continue to place a special emphasis on Traditional Healing Practices. We also need to ensure better counseling services.

ISSUE: Medical Marijuana

BACKGROUND: With the passage of the recent Washington State voter initiative to legalize marijuana, where does that leave the Tribes and IHS federally operated Clinics in Washington State? When will we receive guidance? Will our Clinics be responsible for disbursing this through our pharmacies? What will happen to our employees who use marijuana? If we are required to follow federal guidelines and have a drug testing policy in order to maintain our federal funding, will we need to discipline these employees?

RECOMMENDATION: We need guidance.

Tucson

ISSUE: Sells Hospital Replacement

BACKGROUND: The current hospital was constructed in 1961. Although the Sells Hospital Replacement is on the IHS Facilities Replacement Priority list, there is no assurance of a timeframe for replacement, which impacts maintenance decisions on the current facility.

ISSUE: Undocumented Immigrants at Sells Service Unit

BACKGROUND: Undocumented immigrants receiving care requires the Sells Service Unit to divert significant portions of funds that Congress appropriated to be used for providing health care to AI/ANs.

ISSUE: Rocky Mountain Spotted Fever

❖ APPENDIX B: DHHS GRANTS SUMMARY

Tribes and Tribal organizations receive a disproportionately low number of DHHS grant awards. AI/ANs are approximately 1.5% of the U.S. population, but AI/AN entities serving them receive only 0.51% of total grant funds awarded by DHHS agencies.⁸

The IHS awarded 72% of its total grant funding to Tribes and Tribal organizations in 2004 and the Administration on Aging awarded 2% of its total funding to AN/AI groups that year. The National Institutes of Health awarded only 0.01% of total available grant funds to AI/AN groups, and made only eight awards to these groups out of a total of 55,822 grants awarded. HRSA, CDC, and SAMHSA fund disproportionately fewer grants to AI/ANs.⁹

The barriers identified and the strategies presented to address these barriers are generally related to statutory, regulatory, administrative, or policy issues and to resources of Tribes and Tribal organizations.

Statutory barriers to access DHHS grant funds include

- 1) Distribution of DHHS funds through state block grants that may not be distributed by recipient states to organizations serving under-represented population groups;
- 2) Requirements for matching funds that may be prohibitive for under-served groups that lack resources for the match; and
- 3) Programs with allocation formulas based on numbers of clients or anticipated costs that may be biased against small or rural communities with small numbers of participants and the inability to spread costs across a larger client base. (However, statutory requirements are often necessary to design programs that meet the need identified by Congress.)

A regulatory barrier is the lack of available data required to establish eligibility and meet reporting requirements at the rural and small community level. Several administrative, policy, and resource barriers include:

- 1) lack of resources to track and identify grant opportunities;
- 2) each DHHS program requires unique grant application formats and have different grants management requirements;
- 3) program funding is inadequate for small community-based organizations to administer and provide services to special populations and to those in remote areas;

⁸ <http://taggs.hhs.gov/Reports/GrantsByRecipClass.cfm>

⁹ Barriers to American Indian, Alaska Native, and Native American Access to HHS Programs: Final Report prepared for US DHHS Office of the Assistant Secretary for Planning and Evaluation April 2006 <http://aspe.hhs.gov/hsp/06/barriers2access/report.pdf>

- 4) the inherent advantage previous DHHS grantees have in the award process; and
- 5) lack of explicit statements about eligibility in grant announcements.

A number of barriers related to the limited resources and capacity include

- 1) potential applicants may not have resources or the experience to track and identify grant opportunities, prepare grants, or gain access to experienced grants writers; and
- 2) many community-based programs for people who are homeless, rural populations, and faith-based organizations do not have administrative or service capacity to meet program requirements or to successfully apply and compete for grants, due to limited workforce numbers, lack of computer and internet technology and experience, and transportation barriers.

Many Tribes and organizations have very limited resources and as a result, are unable to administer a program that is not fully funded by DHHS with respect to indirect costs. Few Tribes and Tribal organizations have access to funds that could be used to provide even a relatively low level of matching funds. Some grant programs require grant applicants to provide a plan to demonstrate the sustainability of the program after grant funding ended. Sustainability of some components of the program may be possible, but some grant announcements require a plan for sustainability of the full program. If Tribes had the necessary resources to sustain a program, they would already have the program in place.

The requirements in some grant announcements for specific detailed data on prevalence of disease conditions or “need” for services are a barrier for some Tribes and Tribal organizations, particularly those in rural areas. For example, some grant announcements require that only evidence-based practices be used in a grant program; however, traditional Tribal practices may not be evidence-based or not yet researched as such. Language in the announcement needs to recognize these traditional practices and/or set up alternative standard of proof for evidence-based practice. Language such as “Tribal/ethnic/culturally-specific approaches are acceptable” could be incorporated into the grant announcement to encourage culturally appropriate responses.

Other grant announcements require the proposed program director and/or staff to have specific academic credentials. In most rural areas and reservations, there may not be a supply of people with these credentials. As a result, some Tribal staff members learn “on the job” and build extensive experience in other ways, but do not meet the specific academic or credential requirements for the grant program.

RECOMMENDATIONS:

- Increase use of annual or multi-year program announcements, with multiple due dates.
- Increase use of planning grants by DHHS agencies that may provide opportunities to build capacity and infrastructure.
- Include explicit statements about minimum population base requirements in grant announcements, if applicable.
- Include explicit statements in grant announcements that experience may substitute for academic credentials of key staff
- Increase training and technical assistance on grants processes and grants preparation skills, provided by DHHS and/or national and regional AI/AN organizations, including possible

knowledge transfer between successful AI/AN grantees and less experienced Tribes and organizations.

Regarding the grant review process, some grant reviewers have very limited or no understanding of AI/AN history, culture, geography, and resource limitations. In addition, even when no minimum population base was specified in the eligibility criteria, some reviewers ranked AI/AN applications lower because of the small number of people that would be reached by the grant program. Those that have applied for grants that were primarily research-oriented or had a significant evaluation component also stated that DHHS agencies relied heavily on academic reviewers who placed disproportionate emphasis on academic credentials and degrees and discounted extensive experience of proposed staff because they did not have academic experience. Finally, some DHHS agencies sometimes do not provide adequate information on the reasons their application was rejected, and this is a barrier to learning how to improve future applications.

Recommendations: Grant Review Processes

- Consider reducing reliance on academic reviewers who place disproportionate emphasis on academic credentials of grant applicant staff, where such credentials are not necessary for successful performance and where alternative forms of expertise are demonstrated.
- Increase use of AI/AN grant reviewers and those familiar with AI/AN subjects, when AI/AN grant applications are to be considered.
- Provide orientation for grant reviewers to help them understand unique AI/AN issues and circumstances.
- Provide clear information on reasons for rejection of application.
- Follow-up contact with DHHS program staff by AI/AN organizations to clarify reasons for rejection or to obtain summary statements, if not provided by agency.

Collaboration among DHHS agencies and organizations involved in grant implementation is a way to build the infrastructure necessary to successfully administer programs and manage grant funds. For example, the Native American Research Center for Health (NARCH) is a cooperative program using funds from IHS and various research agencies such as the National Institute of Health (NIH) and the Agency for Health Care Research and Quality (AHRQ) to fund research activities and training at Tribal organizations. There can be partnerships between operating divisions; for example, if a Tribe has received a SAMHSA grant, they would then be eligible to apply for a NIH research grant/clinical trial that focuses on the purpose of the SAMHSA grant. SAMHSA and NIDA currently have this type of an arrangement.

Recommendations: Additional Issues

- Consider AI/AN "set-asides" or special grant initiatives within grant programs, including ways to address the needs of smaller/poorer Tribes and organizations.
- Improve capacity for DHHS to track grant submissions and awards by AI/AN Tribes and communities.
- Increase the number of grants targeted specifically to AI/AN Tribes/organizations.

- Require evidence that states and academic institutions have support and participation of AI/AN Tribes and organizations, if they are included in grant application.¹⁰

Title VI Self-Governance Legislation (as a means to aide non-IHS funding streams):

When Congress enacted The Tribal Self-Governance Amendments of 2000, P.L. 106-260, it included a provision requiring the DHHS to conduct a study to determine the feasibility of extending Tribal Self-Governance to non-IHS programs within DHHS. In the final study submitted to Congress in 2003, DHHS concluded that it was feasible to extend Tribal Self-Governance to eleven select programs within the Department, and recommended that Congress do so. Making the assumption that Self-Governance as a practice provides a greater benefit than federally-administered programs and supporting the expansion of this practice, via Title VI, is a priority for Tribes.

Benefits of Title VI Self-Governance Amendments include:

1. Expands Tribal Self-Governance; the most successful policy in the history of Tribal-Federal relations.
2. Builds on the well-documented successes of Tribes and Tribal organizations in delivering IHS health care programs and services under Title V.
3. Determined to be feasible and desirable by DHHS in its 2003 study.
4. Allows Self-Governance in DHHS analogous to that in the Department of the Interior, where Title IV allows Tribes to compact non- BIA programs and services.
5. Provides an integrative, holistic approach to ensuring healthy communities by providing services that enhance individual and community well-being.
6. Described by the Senate Committee on Indian Affairs as "the next evolution in Tribal self-governance."¹¹

¹⁰ Barriers to American Indian, Alaska Native....

¹¹ National Tribal Self-Governance Strategic Plan & National Priorities 2011-2013 Self-Governance Communication and Education Tribal Consortium
http://www.Tribalselfgov.org/___NEWSGCE/___documentsdownload/Tribal%20Strategic%20Plan%20-%202011-13.pdf
http://www.Tribalselfgov.org/___NEWSGCE/___documentsdownload/Tribal%20Strategic%20Plan%20-%202011-13.pdf

❖ APPENDIX C: ABBREVIATIONS

ACA-Affordable Care Act	DHHS-Department of Health & Human Services
ACO-Accountable Care Organization	DVPI-Domestic Violence Prevention Initiative
AHRQ- Agency for Health Care Research and Quality	EHR-Electronic Health Record
AI/AN-American Indian & Alaska Native	EHS-Environmental Health Services
ALN-Agency Lead Negotiators	FDI-Federal Disparity Index
ALPMR-Agency-Level Performance Measurement Reports	FEHB-Federal Employee Health Benefits Program
ANTHC- The Alaska Native Tribal Health Consortium	FFS-Fee for Service
ARRA-American Reinvestment and Recovery Act	FY-Fiscal Year
BEMAR-Backlog of Essential Maintenance, Alteration and Repair	GAO-Government Accounting Office
CCO-Community Care Organization	GPRA- Government Performance and Results Act
CDC-Centers for Disease Control & Prevention	H&C-Hospitals & Clinics
CHR-Community Health Representative	HCFC-Health Care Facility Construction
CHS-Contract Health Service	HIV-Human Immunodeficiency Virus
CMS-Centers for Medicare & Medicaid Services	HRSA-Health Resources and Services Administration
COPS-Office of Community Oriented Policing Services	I/T/Us- Indian Health Service, Tribes and Tribal organizations, and urban Indian organizations
CPI-Consumer Price Index	IHCIA-Indian Health Care Improvement Act
CSC-Contract Support Costs	IHS-Indian Health Service
CTAS-Coordinated Tribal Assistance Solicitation	ISDEAA- Indian Self-Determination and Education Assistance Act
DHAT-Dental Health Aide Therapist	LNF- Level of Need Funded
	LTC-Long Term Care

M&I-Maintenance & Improvement	SGTFW-Self-Governance Tribal/Federal Workgroup
MFP-Money Follows the Person	
MHBG-Mental Health Services Block Grant	STD-Sexually Transmitted Diseases
MOU- Memorandum of Agreement	TAGGS-Tracking Accountability in Government Grants System
MSPI-Methamphetamine Suicide Prevention Initiative	THC-Tetrahydrocannabinol
NARCH-Native American Research Center for Health	THS-Tribal Health System
NBB-Needs Based Budget	TLOA-Tribal Law and Order Act
NDW-National Data Warehouse	USET- United South and Eastern Tribes Incorporated
NIH-National Institute of Health	VAHs-Veteran Administration Hospitals
NNAIHS-Navajo Area Indian Health Services	VA-Veterans Administration
OCA-Oklahoma City Area	VAWA-Violence Against Women Act
OJP-Office of Justice Programs	Workgroup- National Tribal Budget Formulation Workgroup
OMB-Office of Management & Budget	YRTC-Youth Regional Treatment Center
OVW-Office on Violence Against Women	
PHN-Public Health Nursing	
PRC-Purchased/Referred Care	
RMSF-Rocky Mountain Spotted Fever	
RPMS-Resource and Patient Management System	
SAMHSA-Substance Abuse and Mental Health Services Administration	
SDPI-Special Diabetes Program for Indians	
SFC-Sanitation Facilities Construction	