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THE FEDERAL TRUST RESPONSIBILITY TO TRIBAL NATIONS:

A Strategy to Advance Indian Health Care

THE NATIONAL TRIBAL BUDGET FORMULATION WORKGROUP'S REQUEST FOR THE INDIAN HEALTH SERVICE FISCAL YEAR 2027 BUDGET

TRIBAL CO-CHAIRS:

VICTOR JOSEPH Executive Director, Native Village of Tanana

STEVE KUTZ *(Cowlitz)* Health Clinic Director, Suquamish Tribe

Acknowledgments

FY 2027 NATIONAL TRIBAL BUDGET FORMULATION WORKGROUP AREA REPRESENTATIVES

Alaska Area
- **VICTOR JOSEPH**
  Executive Director, Native Village of Tanana
- **ALBERTA UNOK**
  President/CEO, Alaska Native Health Board

Albuquerque Area
- **LANE OKA**
  Assistant Controller, Jicarilla Apache Nation
- **BIRDENA SANCHEZ**
  Councilwoman, Pueblo of Zuni

Bemidji Area
- **DEBRA DANFORTH, RN, BSN**
  Oneida Comprehensive Health Division Director of Operations, Oneida Nation
- **MR. ROBIN CARUFEL**
  Assistant Health Director, Sokaogon Chippewa Community

Billings Area
- **LEVI BLACK EAGLE**
  Secretary, Crow Tribe
- **LEN TWOTEETH**
  Vice Chairman, Confederated Salish and Kootenai Tribes
- **NIZHONI FRIESZ**
  Tribal Council, Northern Cheyenne Tribe (Alternate)

California Area
- **MICHAEL GARCIA**
  Vice Chairman, Ewiiaapaayp Band of Kumeyaay Indians
- **CHRIS DEVERS**
  Tribal Representative, Pauma Band of Mission Indians

Great Plains Area
- **PETER LENGKEEK**
  Chairman, Crow Creek Sioux Tribe
- **RYMAN LEBEAU**
  Chairman, Cheyenne River Sioux Tribe

Nashville Area
- **DEE SABATTUS**
  Health Director, Passamaquoddy Health Center, Passamaquoddy Indian Township
- **STEVEN TUPPONCE**,
  Upper Mattaponi Indian Tribe

Navajo Area
- **DR. BUU NYGREN**
  President, The Navajo Nation
- **GERMAINE SIMONSON**
  Vice Chairperson, Navajo Nation Council Health, Education and Human Services Committee

Oklahoma City Area
- **PRESIDENT DEBORAH DOTSON**
  Delaware Nation
- **VICE PRESIDENT TASHA MOUSSEAU**
  Wichita and Affiliated Tribes

Phoenix Area
- **JEROME KASEY III**
  Vice Chairman, White Mountain Apache Tribes
- **CATHERINE WILLIAMS-TUNI**
  Chairwoman, Fallon Paiute Shoshone Tribe

Portland Area
- **STEPHEN KUTZ** (Cowlitz),
  Health Clinic Director, Suquamish Tribe
- **AARON HINES**, Northwest Portland Area Indian Health Board Delegate

Tucson Area
- **CARLA JOHNSON**
  Vice-Chairwoman, Tohono O'odham Nation
- **COUNCILWOMAN HERMINIA FRIAS**
  Pascua Yaqui Tribal Council Member and Health Oversight Co-Chair

IHS NATIONAL TRIBAL BUDGET FORMULATION WORKGROUP

FY 2027 RECOMMENDATION DETAIL OF CHANGES

(DOLLARS IN THOUSANDS)

Sub IHS Activity	FY 2024 Enacted (P.L. 117-328)	FY 2025 President's Budget	Detail of Changes			FY 2027 National Recomm. Total
			Current Services	Binding Obligations	FY 2027 Program Expansion	
SERVICES						
Hospitals & Health Clinics	2,550,514	2,929,915	131,275	75,000	15,738,479	18,495,268
Electronic Health Record System	190,564	435,102	7,097	0	488,775	686,436
Dental Services	252,561	276,085	15,733	0	3,520,852	3,789,146
Mental Health	129,765	138,746	6,187	0	5,276,388	5,412,340
Alcohol & Substance Abuse	266,636	291,389	11,181	0	3,965,317	4,243,134
Purchased/Referred Care	996,755	1,053,576	39,615	0	11,596,426	12,632,796
Indian Health Care Improvement Fund	74,138	0	0	0	4,505,330	4,579,468
Total, Clinical Services	**4,460,933**	**5,124,813**	**211,088**	**75,000**	**45,091,567**	**49,838,588**
Public Health Nursing	112,034	120,955	6,672	0	1,115,739	1,234,445
Health Education	24,417	26,144	962	0	712,572	737,951
Community Health Representatives	65,212	69,628	2,980	0	1,152,183	1,220,375
Alaska Immunization	2,183	2,308	94	0	46,603	48,880
Total, Preventive Health	**203,846**	**219,035**	**10,708**	**0**	**3,027,096**	**3,241,650**
Urban Health	90,419	94,992	5,464	0	998,116	1,093,999
Indian Health Professions	80,568	81,252	268	0	299,902	380,738
Tribal Management	2,986	2,987	0	0	467	3,453
Direct Operations	103,805	111,966	2,506	0	24,948	131,259
Self-Governance	6,174	6,187	15	0	1,673	7,862
Total, Other Services	**283,952**	**297,384**	**8,253**	**0**	**1,325,106**	**1,617,311**
TOTAL, SERVICES	**4,948,731**	**5,641,232**	**230,049**	**75,000**	**49,443,769**	**54,697,549**
FACILITIES						
Maintenance & Improvement	170,595	174,355	3,641	0	1,728,290	1,902,526
Sanitation Facilities Construction	123,650	200,485	3,652	0	1,027,882	1,155,184
Health Care Facility Construction	182,679	260,919	41	100,000	2,260,407	2,543,127
Facility & Environmental Health Support	303,661	324,192	13,303	0	478,042	795,006
Equipment	32,598	33,874	1,081	0	609,588	643,267
TOTAL, FACILITIES	**813,183**	**993,825**	**21,718**	**100,000**	**6,104,209**	**7,039,110**
	5,761,914	**6,635,057**	**251,767**	**175,000**	**55,547,978**	**61,736,659**
CONTRACT SUPPORT COSTS						
Total, Contract Support Costs	1,051,000	979,000	0	8,958,520	0	10,009,520
SECTION 105(l) LEASES						
Total Section 105(l) Leases	**149,000**	**348,876**	**0**	**581,656**	**0**	**730,656**
Special Diabetes Program for Indians	**155,484**	**260,000**	**0**	**0**	**374,962**	**530,446**
TOTAL, IHS	**7,117,398**	**8,222,933**	**251,767**	**9,715,176**	**55,922,940**	**73,007,281**

**The Fiscal Year (FY) 2027 National Recommendation Total column combines the FY 2024 Enacted, FY 2027 Program Expansion, Binding Obligations, and Current Services across each Sub IHS Activity.*

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EXECUTIVE

Summary

Tribal leaders on the National Tribal Budget Formulation Workgroup (NTBFW), serving all 574 federally recognized sovereign Tribes throughout the twelve Indian Health Service (IHS) Areas, met on February 11-12, 2025, to exercise their right to provide meaningful input on IHS budgets and policy in the formulation of the President's FY 2027 Budget Request to Congress. This meeting marked the 50th anniversary of the Indian Self-Determination and Education Assistance Act (ISDEAA) of 1975, which gave Tribal governments the right to administer and oversee the implementation of federal programs, thus encouraging self-determination and self-governance.

Our political status, reaffirmed by the U.S. Constitution, treaties, statutes, court decisions, and federal administrative law, creates opportunities for Tribal Nations to advance the health status of American Indian and Alaska Native (AI/AN) people. AI/AN populations continue to experience unique determinants in health outcomes, which can be addressed through our innovative and culturally appropriate health care delivery system. In 2024, the Chickasaw Nation Department of Health received the renowned Malcolm Baldridge National Quality Award, setting new standards and best practices for health care delivery to AI/ANs. The Indian health care system is inherently resilient, building upon our innovations to deliver unique, whole-person care and improves health outcomes for our people.

In 2024, we also celebrated the approval of section 1115 Demonstration Waivers, which provide expenditure authority through Medicaid and the Children's Health Insurance Program (CHIP) to cover traditional health care practices provided through the Indian health care system.[1] This long-time request honors traditional practices our communities have utilized since time immemorial that improve the mental, physical, and spiritual health of AI/AN citizens. Our clinics continue to implement effective and efficient health care services, programs, research, operations, and community events as solutions to bring AI/ANs through our doors to receive culturally competent, high-quality care.

For the first time, the Medicare Outpatient Prospective Payment and Ambulatory Surgical Center Payment System (OPPS) Final Rule[2] created a regulatory fix allowing Indian health care clinics to get reimbursed at the facility rate for services provided outside the four walls. The OPPS Final Rule also included a high-cost drugs provision to reduce the burden on Tribes paying out-of-pocket for medications critical to Native beneficiaries. These fixes maximize resources desperately needed for the Indian health system and allow clinics to extend their resources further to deliver high-quality and culturally appropriate care to AI/AN citizens.

Indian Country has made major improvements in the government-to-government relationship and the acknowledgement of the federal trust responsibility to deliver health care services to AI/AN beneficiaries. Tribal self-determination has and will continue to improve the health status of our people. Still, as promised and legally mandated, we must receive appropriate funding resources under the federal trust responsibility to continue implementing our strategies and solutions to advance the health care and health status of Indian Country.

1 Centers for Medicare & Medicaid Services Newsroom. (October 16, 2024). Groundbreaking Action to Expand Health Care Access by Covering Traditional Health Care Practices.

2 Federal Register. Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs, Including the Hospital Inpatient Quality Reporting Program; Health and Safety Standards for Obstetrical Services in Hospitals and Critical Access Hospitals; Prior Authorization; Requests for Information; Medicaid and CHIP Continuous Eligibility; Medicaid Clinic Services Four Walls Exceptions; Individuals Currently or Formerly in Custody of Penal Authorities; Revision to Medicare Special Enrollment Period for Formerly Incarcerated Individuals; and All-Inclusive Rate Add-On Payment for High-Cost Drugs Provided by Indian Health Service and Tribal Facilities. (89 FR 93912). November 27, 2024.

INDIAN HEALTH CARE LEADERS

The Chickasaw Nation Department of Health and Southcentral Foundation earned the prestigious Malcom Baldrige Award. This award focuses on organizational resilience and long-term success. The Malcolm Baldrige Award is the nation's only presidential award for performance excellence. The Baldrige Award recipients are role-model organizations that help address some of the most critical needs while demonstrating the resilient spirit of the American people. Receiving this award exemplifies the efforts made by the Chickasaw Nation Department of Health and Southcentral Foundation to bettering the lives of First Americans, strengthening infrastructure and improving the quality of life in communities.

IHS NATIONAL TRIBAL BUDGET FORMULATION WORKGROUP

PROGRAM EXPANSIONS FY 2027 BUDGET COMPARISON TABLE

Rank	Program Expansion	FY 2024 Enacted Amount	FY 2027 Program Expansion	FY 2027 National Recomm. Total	Percent Change
1	Hospitals & Health Clinics	2,550,514	15,738,479	18,495,268	625%
2	Purchased/Referred Care	996,755	11,596,426	12,632,796	1,167%
3	Mental Health	129,765	5,276,388	5,412,340	4,071%
4	Indian Health Care Improvement Fund	74,138	4,505,330	4,579,468	6,077%
5	Alcohol and Substance Abuse	266,636	3,965,317	4,243,134	1,491%
6	Dental Services	252,561	3,520,852	3,789,146	1,400%
7	Health Care Facilities Constr./Other Authorities	182,679	2,260,407	2,543,127	1,292%
8	Maintenance & Improvement	170,595	1,728,290	1,902,526	1,015%
9	Community Health Representatives	65,212	1,152,183	1,220,375	1,771%
10	Public Health Nursing	112,034	1,115,739	1,234,445	1,002%
11	Sanitation Facilities Construction	123,650	1,027,882	1,155,184	834%
12	Urban Indian Health	90,419	998,116	1,093,999	1,110%
13	Health Education	24,417	712,572	737,951	2,922%
14	Equipment	32,598	609,588	643,267	1,873%
15	Electronic Health Record	190,564	488,775	686,436	260%
16	Facilities & Environmental Health Support	303,661	478,042	795,006	162%
17	Special Diabetes Program for Indians	155,484	374,962	530,446	241%
18	Indian Health Professions	80,568	299,902	380,738	373%
19	Alaska Immunization	2,183	46,603	48,880	2,139%
20	Direct Operations	103,805	24,948	131,259	26%
21	Self-Governance	6,174	1,673	7,862	27%
22	Tribal Management Grants	2,986	467	3,453	16%
	Subtotal, Program Expansions	**5,917,398**	**55,922,940**	**62,267,106**	**952%**
	Contract Support Costs	1,051,000		10,009,520	852%
	105 (l) Lease Cost Agreements	149,000		730,656	390%
	GRAND TOTAL	**7,117,398**	**55,922,940**	**73,007,281**	**926%**

PROGRAM EXPANSIONS

1 Hospital and Health Clinics: $18.49 billion (+15.73 billion)

Sufficient funding for Hospitals and Health Clinics (H&HC) remains the top priority for FY 2027, as it provides the base funding for 43 Indian hospitals (51 percent of which are Tribally operated) and 650 Indian health centers, clinics, and health stations (86 percent of which are Tribally operated) in urban, rural, and remote settings. When the construction of a new health facility is completed, IHS must also offer new staffing packages that require increases to the H&HC account to meet these binding obligations. Within H&HC, the NTBFW also calls for the national expansion of the Community Health Aide Program (CHAP), which grows the mid-level health workforce to increase access to services for Tribal communities.



2 Purchased/Referred Care: $12.63 billion (+11.59 billion)

Purchased/Referred Care (PRC) was established to allow IHS and Tribally operated facilities to secure essential health care services from private sector providers when such services, especially emergent and specialty care services, are unavailable within the Indian health care system. PRC funding has been essentially flat for years. With no annual program increases to PRC and no adjustments for population growth or medical inflation, Tribal Nations are forced to absorb these costs. For the IHS Areas with few or no IHS-funded hospitals (PRC Dependent Areas) specialty and tertiary care may be rationed because of a lack of financial resources. The consequences of rationing health care are crippling.

3 Mental Health: $5.41 billion (+5.27 billion)

The mental health disparities in Tribal communities are a direct result of ongoing historical trauma from past U.S. policies and perpetually underfunded health services. Part of COVID-19's legacy includes a heightened behavioral health crisis, making total access to behavioral health care that much more difficult for Indian Country. The NTBFW calls for more resources for mental health programs and treatment, including culturally-informed care, youth treatment centers, in-patient treatment, and improved step-down services.

4 Indian Health Care Improvement Fund: $4.57 billion (+4.5 billion)

The Indian Health Care Improvement Fund (IHCIF) was established to support access to care and resources for health care operations based on a calculation known as "level of need" funding along with other factors designed to promote equity in the provision of health services for Tribal citizens. Unfortunately, this account created to fix inequities is funded at a fraction of the need by Congress – perpetuating the very issue it legislated to fix. The FY 2024 and FY 2025 advance appropriations provided to the IHS excluded this account. The IHCIF is necessary for eliminating the deficiencies in the health resources and health status of Tribes.

5 Alcohol and Substance Abuse: $4.24 billion (+$3.96 billion)

The COVID-19 pandemic exacerbated alcohol and substance abuse rates among AI/AN due to the lack of readily available behavioral health services, isolation from social and cultural activities, mental health co-occurring disorders, and stigma associated with treatment. Tribally-based treatment services are limited, with many Tribal resources exhausted from existing operations. Tribal Nations with behavioral health services have been successful in integrating culturally appropriate prevention and intervention methods to address alcohol and substance abuse and the opioid and fentanyl crisis. However, Tribal Nations' resources are finite and require additional investments to create and expand solutions that are rooted in Indigenous ways of knowing.

6 Dental Services: $3.78 billion (+$3.52 billion)

Dental services are critical to the overall health of AI/ANs. Routine oral health care reduces tooth decay and gum disease. The lack of access to traditional foods, limited availability of dental services, and government provided commodity rations have contributed to AI/ANs experiencing poor oral health. Dental services provided by the Indian health care system offers culturally appropriate services, and trusted dentists and dental health aide therapists to support the oral health needs of AI/AN patients.

7 Health Care Facilities Construction and Other Authorities: $2.54 billion (+$2.26 billion)

Data from the IHS show that their medical facilities range in age from 1 to 171 years, with a median age of 39 years.[1] The Indian Health Care Improvement Act (IHCIA) was intended to provide comprehensive health care services to AI/AN people, and provide full funding for facilities construction, programs and services contained within in the IHCIA. The total financial need for facilities construction, for example, was projected at $26.6 billion dollars in the 2021 IHS Facilities Needs Assessment Report to Congress, which is more than four times the IHS overall budget of $6.5 billion in FY 2021.[2] The facilities replacement rate at current funding levels is approximately 290 years.[3] These figures are understated as data is lacking for Tribally operated facilities. The current facilities infrastructure available for the IHS are outdated and insufficient space for modern health care delivery needs. Many facilities have a condition index rating lower than U.S. Department of Health and Human Services (HHS) goal and the maintenance and repair backlog is growing. These conditions create difficulties for staff and patients, increase wait times, and contribute to inefficiencies within the Indian health care system that are become problematic and can no longer be ignored.

8 Maintenance and Improvement: $1.9 billion (+$1.72 billion)

Maintenance and Improvement (M&I) funding is consistently ranked a top priority of the Areas due to its essential purpose to ensure that patients receive services in well-functioning health care facilities that meet building and life safety codes, conform to laws and regulations, and satisfy accreditation standards. From 2018 to 2022, IHS' estimates of its backlog of deferred maintenance and repairs more than doubled from $366 million to $737 million.[4] Without sufficient M&I funding, the continued deterioration of critical health facilities is the reality that AI/AN people experience across the nation whether they are served at an IHS facility, a Tribally owned clinic, or leased building.

1 Government Accountability Office, *Indian Health Service: Many Federal Facilities Are in Fair or Poor Condition and Better Data Are Needed on Medical Equipment*, 2023, available at: : https://www.gao.gov/assets/gao-24-105723.pdf,, accessed on: February 25, 2025.

2 Indian Health Service. The 2021 Indian Health Service and Tribal Health Care Facilities Needs Assessment Report to Congress. December 2020. Page 1. also see IHS Budget Appropriation FY 2021 accessed January 29, 2025.

3 Ibid.

4 Ibid.

9 Community Health Representatives: $1.22 billion (+$1.15 billion)

During the COVID pandemic, Community Health Representatives (CHRs) demonstrated tremendous value by connecting AI/AN patients with medical care. As highly trusted members in the community for the last 50 years, CHRs deliver preventive health education and case management to Tribal members in home and community settings. The 1,600 CHRs employed across Indian Country reach AI/ANs in rural and remote areas to provide health education, training, and screenings within their communities. Their services are critical to improving the health status of AI/AN populations.

10 Public Health Nursing: $1.23 billion (+$1.11 billion)

The Public Health Nursing (PHN) program is a community health nursing program that focuses on promoting health and quality of life through culturally sensitive primary, secondary, and tertiary health promotion and disease prevention nursing services to individuals, families, and community groups throughout Indian Country. Home-based services, where available, are most often related to chronic disease management, safety and health maintenance care for elders, investigation and treatment of communicable diseases, breastfeeding promotion, pre/postnatal education, parenting education, and screening for early diagnosis of developmental problems. PHN is essential for filling in service gaps within the Indian health care system.

11 Sanitation Facilities Construction: $1.15 billion (+$1.02 billion)

The Sanitation Facilities Construction (SFC) Program brings water supply, wastewater disposal, and solid waste disposal to Tribal homes and communities. Sufficient resources for the SFC account prevent communicable and environmentally related diseases such as pneumonia, influenza, and respiratory syncytial virus. The Infrastructure Investment and Jobs Act (IIJA) provides the program with $3.5 billion over five years (FY 2022-2026) to address a point-in-time deficiency list. This level of investment is necessary to improve the environment for AI/AN people. However, additional resources and investments are required for long-term maintenance and operation of these facilities.

12 Urban Indian Health: $1.09 billion (+$998.11 million)

The United States has a trust responsibility to improve the health of AI/ANs beneficiaries regardless of where they reside.[5] To meet this obligation in urban areas, the IHS contracts with 41 Urban Indian Organizations (UIOs), which operate over 80 facilities in 22 states nationwide. As Native-led organizations, UIOs serve patients from over 500 federally recognized Tribes[6] and provide critically needed primary care, behavioral health, traditional medicine, and social and community services to AI/ANs living in urban areas. Despite the critical services UIOs provide to AI/ANs living in urban areas, UIOs remain critically underfunded and need greater access to grant programs through the IHS, this expansion should not impact funding available to IHS and Tribes. UIOs only receive direct funding for staffing, operations, and facilities through this single line item. Increased funding can improve the quality of care delivered to the growing AI/AN population in urban areas.

13 Health Education: $737.95 million (+$712.57 million)

Health Education programs are an integral component of cultivating culturally appropriate education and prevention efforts and bridging evidence-based research to materials accessible to community members. The goal of the Health Education program is to improve the health of AI/ANs by providing education and training. Health Educators provide services such as injury prevention, sexually transmitted infection prevention education, preventative cancer screenings, and educating the community on immunizations, in addition to many other campaigns. They also assist individuals navigate the health care system, improve adherence to health recommendations, and reduce the need for emergency and specialty services, resulting in an improved overall health status for Tribal citizens.

5 See 25 U.S.C. § 1601(1); Sen. Rpt. 100-508 (1988).

6 IHS National Budget Formulation Data Reports for Urban Indian Organizations Calendar Year 2021, INDIAN HEALTH SERVICE (2023), https://www.ihs.gov/sites/urban/themes/responsive2017/display_objects/documents/IHS_National_Budget_Formulation_Reports_Calendar_Year_2021.pdf.

14 Equipment: $643.26 million (+$609.58 million)

The state of medical equipment at IHS and Tribally operated facilities is unknown because of the lack of complete or reliable data.[7] Medical equipment is costly due to inflation and high installation and maintenance costs. The high maintenance of medical equipment includes the repair of components, training staff, and service contracts for operating the medical equipment. As the demand for medical equipment to interface with electronic health records increases, the need for compatible equipment to replace outdated, inefficient, and unsupported equipment will also significantly increase. Newer equipment can enhance the speed and accuracy of diagnoses, increase efficiency, and productivity, thereby reducing referrals to the private sector and saving on PRC costs.

15 Electronic Health Records / Health IT: $686.43 million (+$488.77 million)

IHS provides the technology infrastructure for a nationwide health care system, including a secure wide area network, electronic health record (EHR), enterprise e-mail services, and regional and national help desk support for approximately 20,000 network users. Tribally-operated and urban Indian health programs rely on comprehensive health information technology to maintain quality health care delivery and operational efficiency. Increases in funding for the replacement of the current EHR Resource and Patient Management System (RPMS) into the transition to a new enterprise EHR system, Patients at the Heart (PATH) EHR, to improve interoperability and functionality is critically important. Modernizing the EHR and Health IT is costly, but necessary. The move to PATH EHR will improve patient care and provider experience, improve data, and allow the Indian health care system interoperability with secondary and tertiary providers.

16 Facilities & Environmental Health Support: $795 million (+$478.04 million)

Facilities and Environmental Health Support (FEHS) programs provide and support an extensive array of real property, health care facilities, staff quarters construction, maintenance, operation services, community and institutional environmental health, injury prevention, and sanitation facilities construction services. The program has five focus areas: (1) Children's environment, (2) Safe drinking water, (3) Vector-born and communicable disease, (4) Food safety, and (5) Healthy homes. IHS works hard to identify community environmental health hazards and risk factors to propose control measures.

17 Special Diabetes Program for Indians: $530.44 million (+$374.96 million)

The Special Diabetes Program for Indians (SDPI) is proven to save lives and money. Yet, it remains under-resourced and in a constant state of funding uncertainty. Despite its successes, the SDPI program has only received one increase in 20 years. SDPI reduces the prevalence of diabetes among AI/AN adults and has also demonstrated an estimated net savings to Medicare of up to $520 million over 10 years due to averted cases of end-stage renal disease.[8] The NTBFW calls for ending the competitive grant nature of SDPI and instead promotes stability in access to and flexibility of funds.

18 Indian Health Professions: $380.73 million (+$299.90 million)

IHS and Tribal communities face persistent challenges in recruiting and retaining qualified medical personnel for their facilities. As an incentive, IHS provides loan repayments and forgiveness programs to support the Indian health system's workforce. IHS loan repayments and forgiveness programs should be expanded for medical professionals providing care in severely underserved areas or returning to serve in their Tribal communities, and should include public health professionals, certified doulas, and nutritionists. Funds should be made available as part of CHAP implementation in the lower 48

7 Ibid.

8 Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. (March 10, 2019). The Special Diabetes Program for Indians: Estimates of Medicare Savings. Retrieved from: https://aspe.hhs.gov/sites/default/files/migrated_legacy_files//189221/SDPI_Paper_Final.pdf.

states to provide scholarship funding for students seeking a career as a CHAP provider and expand the curriculum for Dental Therapists, Behavioral Health Aides, and Community Health Aides at Tribal colleges, universities, and partner institutions. The NTBFW also requests that the IHS Scholarship and loan repayment program be exempt from Federal Income Tax Withholding, aligning it with other federal programs.

19 Alaska Immunization: $48.80 million (+$46.60 million)

Alaskan rural residents travel an average of 147 miles one way to access the next level of health care, often by air and surface transportation.[9] Eighty percent of Alaska Native communities are located off the road system. Hunting and fishing for subsistence remain a way of life for remote villages, and they experience seasonal influxes of workforces for regional hunting and fishing grounds. This mix of remoteness, health care structure, and seasonal population increases place Alaska Native communities at unique risk of illness, which can take a devastating toll on life. The Alaska Immunization program works to eliminate disparities in vaccine-preventable diseases for Alaska Native people.

20 Direct Operations: $131.25 million (+24.94 million)

The Direct Operations budget supports a multitude of services, including the development of health policy formulation at IHS, policy development for self-determination contracting, administering Tribal grant programs to expand Tribal self-determination efforts, and maintaining the Direct Services Tribal Advisory Committee (DSTAC). Additionally, through this funding, the Office of Direct Services and Contracting Tribes (ODSCT) provides technical assistance to IHS Area Offices and Tribes with health service and program administration. 18 Tribes choose to receive IHS direct services,[10] and there are 123 IHS-operated facilities providing direct health care operations.[11]

21 Self-Governance: $7.86 million (+1.67 million)

Title V of the ISDEAA authorizes Tribes and Tribal Consortia to enter self-governance compacts, self-determination contracts, and related funding agreements to assume federal programs, functions, services, and activities (PFSA), and associated Tribal shares, placing the accountability of PFSA service provision with Tribal Nations.

This account supports the expansion and implementation of the IHS Tribal Self-Governance program; and provides funding for Planning and Negotiation Cooperative Agreements to assist Tribes as they prepare for and enter the IHS Tribal Self-Governance program. The account also funds Tribal shares needed in IHS Areas and Headquarters for Tribes that have decided to participate in the IHS Tribal Self-Governance program. The IHS Self-Governance program promotes self-sufficiency and reduces burden on the federal government by allowing Tribes to operate their clinics.

22 Tribal Management Grants: $3.45 million (+467 thousand)

Under the ISDEAA, the Tribal Management Grants were established to assist federally recognized Tribes and Tribal Organizations (T/TO) in planning, preparing, or deciding to assume all or part of existing IHS PFSAs through an ISDEAA Title I contract. The grant program also assists established ISDEAA contractors and compactors in further developing and improving their management capabilities. The Program consists of four project types: Feasibility study, Planning, Evaluation study, and Health Management Structure. Feasibility, Planning, and Evaluation projects are one-year grant programs, and the Health Management Structure program supports projects between one and three years.

9 Chhean, E., DelFavero, M., Thoumi, A., Tewarson, H., Haldar, S., Hockenberry, S. (2021, Aug.). A Case Study of Alaska's State and Tribal Nation Partnerships for COVID-19 Vaccination. Washington DC: National Academy of State Health Policy, DukeMargolis Center for Health Policy, National Governors Association Center for Best Practices.

10 Indian Health Service. (2025). Direct Service Tribes. Retrieved from: https://www.ihs.gov/odsct/dst/#:~:text=DST%20Areas,(As%20of%20July%202021).

11 Ibid.

Introduction

This budget book is a collection of recommendations and reminders of the federal trust and treaty obligations owed to Tribal Nations and their citizens. The United States' trust responsibility is well established in the U.S. Constitution, treaties, statutes, and federal laws in recognition of the United States' unique legal and political relationship with Tribes.

The U.S. Constitution recognizes three sovereigns: the Federal government, States, and Indian Tribes. The United States formed a judiciary relationship with Tribal Nations through its acquisition of land and resources whereby the United States is obligated to uphold a fiduciary relationship and responsibility to Tribes and AI/AN beneficiaries. As a result, the IHS is responsible for providing comprehensive health services to AI/ANs to raise the health status of Indian people.

Historic legislation like the ISDEAA and the IHCIA fulfills a special trust responsibility and legal obligation to Tribal Nations to improve health outcomes for AI/AN people and their communities. Congress has also legislated resources to provide Tribes with access to health programs like Medicaid while creating Indian-specific protections within these programs that uphold the government-to-government relationship between Tribes and the United States. Unfortunately, legislation without appropriation continues to exacerbate the health disparities faced by the AI/AN population, and appropriators continue to ignore their obligations to Tribes.

Federal systems and policies should not affect the legal trust relationship between our sovereign Tribal Nations and the federal government. This workbook outlines the fiduciary obligation to Tribal Nations and AI/AN beneficiaries to improve their health and well-being for future generations.

ANNIVERSARY OF THE INDIAN SELF-DETERMINATION AND EDUCATION ASSISTANCE ACT (ISDEAA)

The historic Indian Self-Determination and Education Assistance Act (ISDEAA) of 1975 gave way to an era in Federal Indian policy – Self-Determination. ISDEAA empowered Tribal Nations to contract and compact their own health care programs while preserving a Tribe's right to choose that services continue to be provided by IHS. Since its inception, Tribal governments have successfully implemented services, programs, and infrastructure that better meet the needs of their Tribal citizens. [12]

ISDEAA has restored a Tribe's ability to integrate practices and protocols that help them meet the unique cultural, political, and economic needs of AI/ANs. The emergence of culturally appropriate health care programs delivered by Tribal clinics has supported AI/ANs access to trusted providers, improved the continuum of care, and created health networks that supports whole-person care. When we build out our Tribal programming, we are not only developing services for the current generation but also planning for the next seven generations. Successes made during the first 50 years of ISDEAA can be expanded with sufficient obligated federal funding to enhance Tribal self-determination.

12 Today, many Tribal governments operate self-governance under the IHS, Department of Interior, Department of Transportation, Department of Justice, Department of Homeland Security, Department of Defense, Department of Agriculture, and the Environmental Protection Agency.

HEALTH STATUS OF INDIAN COUNTRY

There is a significant disparity between the life expectancy of AI/ANs and the general population. The combination of the effects of intergenerational epigenetics, COVID-19, lack of access to care, and limiting policies over Tribal Nations have contributed to the AI/AN life expectancy being only 65.2 years, which is 11.2 years less than the Non-Hispanic White (NHW) person's life expectancy of 76.4 years.[13] Despite the obligation of the United States to provide resources to improve the health status of AI/ANs, the IHS continues to be overburdened for the responsibility of the federal government.



In 2020, the COVID-19 cases among AI/AN people were 3.5 times higher than White populations, and the age-adjusted AI/AN COVID-19 mortality rate was 1.8 times that of White populations.[14] In response, Tribal Nations and Native organizations launched early vaccination campaigns resulting in AI/ANs being the most vaccinated of all racial and ethnic populations reducing mortality for our Elders and knowledge keepers. The undercount and misrepresentation of AI/AN in data contribute to our gaps in understanding the full effect of COVID-19 and long-term COVID-19 within our communities. Our resiliency and strength-based approaches to infection support our cultural values and keep our community safe.

However, chronic underfunding of our health and public health systems contributes to our declining health. AI/AN people are 2.3 times as likely to die from pregnancy-related causes compared to NHW people and experience a 1.3 higher rate of infant mortality than NHW.[15] AI/ANs also experience disproportionate rates of posttraumatic stress disorder, substance use disorders, and suicide risks due to intergenerational historic trauma.[16] In 2021, the five leading causes of death for non-Hispanic AI/ANs were COVID-19, heart disease, cancer, unintentional injury, and liver disease.[17] From birth to death, AI/ANs experience unique health-related challenges which are exacerbated by historical trauma, socio-economic disparities, and high disease burdens, these impacts can be mitigated through culturally-appropriate prevention, intervention, and response models delivered by the Indian health system and trusted community partners.

AI/AN health will improve with dedicated funding that supports the cultural values of Indian Country. The continuing underinvestment in our health care system leads to worsening health outcomes. We ask for the fulfillment of the federal trust and treaty responsibility by fully funding the Indian health care system to care for AI/AN citizens.

13 Centers for Disease Control, National Center for Health Statistics. (August 31, 2022). Life Expectancy in the U.S. Dropped for the Second Year in a Row in 2021. Accessed March 2025. Retrieved from: https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2022/20220831.htm.

14 Arrazola J, Masiello MM, Joshi S, et al. COVID-19 Mortality Among American Indian and Alaska Native Persons — 14 States, January–June 2020. MMWR Morb Mortal Wkly Rep 2020;69:1853–1856. DOI: http://dx.doi.org/10.15585/mmwr.mm6949a3.

15 Burns A, DeAtley T, Short SE. The maternal health of American Indian and Alaska Native people: A scoping review. Soc Sci Med. 2023 Jan;317:115584. doi: 10.1016/j.socscimed.2022.115584. Epub 2022 Nov 29. PMID: 36521232; PMCID: PMC9875554.

16 American Psychiatric Association. December 2017. Mental Health Disparities: American Indians and Alaska Natives. Retrieved from: https://www.psychiatry.org/getmedia/d008fb53-3566-4a0a-adac-ba1f3b88528c/Mental-Health-Facts-for-American-Indian-Alaska-Natives.pdf.

17 Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System – Mortality, 2018-2021, Single Race. Retrieved from: https://wonder.cdc.gov/single-race-population.html.

Successful Models to Fund the Indian Health Care System

ADVANCE APPROPRIATIONS FOR INDIAN HEALTH SERVICE

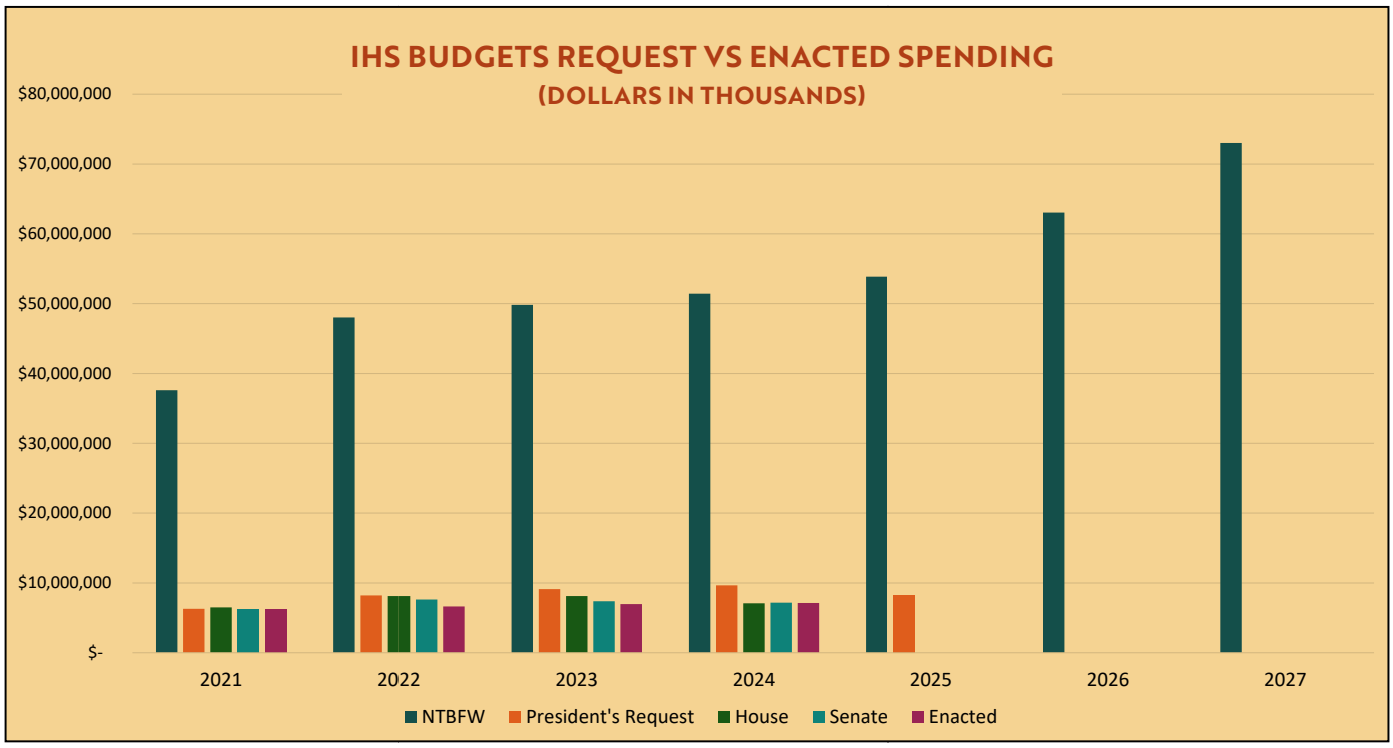
Sustainable federal funding streams like advanced appropriations achieved in FY 2024 and FY 2025, support planning and programming by IHS, Tribal, and Urban Indian Organization's clinics to enhance current services for AI/AN beneficiaries. Advance appropriations have reduced the financial burden on clinics, allowing them to sustain a culturally responsive workforce, operations, and continuum of care for AI/ANs.

MEDICAID'S FEDERAL MEDICAL ASSISTANCE PERCENTAGE

Other funding provisions, like Medicaid, provide foundational funding to the Indian health care system to preserve current services and ensure clinic resources support the health care needs of Indian Country. Since 1976, Congress has required the Centers for Medicare and Medicaid Services (CMS) to reimburse States at 100% federal medical assistance percentage for services provided by or through Indian health care providers. Outside of the Indian health system, more than one million AI/ANs are enrolled in coverage through Medicaid and CHIP, which allows AI/ANs to access care in urban, rural, and remote areas.

FUNDING METHODOLOGY

Early in 2003, the NTBFW, including IHS, Tribal leaders, technical advisors, and other policy advisors, worked with a team of economic actuarial experts to produce the first IHS Needs Based Budget (NBB) for FY 2005. Since then, the Workgroup has met annually to update the IHS NBB using the most current available population and per capita health care cost information. The IHS need-based cost estimate for FY 2027 is $73.0 billion.



The FY 2005 Workgroup recommended a 10-year strategy for fully funding obligations to AI/AN beneficiaries – an obligation that still goes unmet. The graph above compares the Workgroup's recommendation to the President's Budget, House and Senate budget proposals, and the enacted amount. The Workgroup continues to use a budget formulation based on models of the Office of Management and Budget (OMB) guidance to agencies for the development of the President's Budget Request to Congress. The Workgroup's recommendations continue to encourage full funding levels that align with trust and treaty obligations owed to Tribal Nations. Over time, the other funding proposals and enacted amounts failed to meet the needs of Indian Country, resulting in intergenerational health disparities.

Step 1

The FY 2027 NTBFW methodology begins with a guidance level on topline spending for IHS in FY 2027, based on the adjusted NBB using population data, per capita health care cost information, geographic considerations, and health needs assessment. The adjusted NBB for IHS is $73.0 billion for FY 2027.

Step 2

The FY 2027 NTBFW methodology begins with reviewing each funded account at the IHS with the latest enacted amounts necessary to maintain current services at the IHS. The FY 2024 enacted amount for IHS is $7.11 billion.

Step 3

Tribes and Tribal representatives from each of the twelve IHS Areas meet to formulate their budgets using the guidance parameters above and a worksheet that allows areas to calculate their budget scenario and discuss in real-time. Along with each Area's budget tables are narratives on budget priorities, hot issues, and success stories.

Step 4

Before the NTBFW convenes for its annual budget formulation, each of the IHS Areas, the TSGAC, DTSAC, and NCUIH present proposed budgets to Tribal and federal partners. This allows each area to hear, digest, and discuss national priorities before coming to the annual budget formulation meeting of the NTBFW.

Step 5

Each year, the NTBFW convenes to review the Area submissions and discuss pressing budget concerns for the IHS. During this meeting, budget policy recommendations are discussed to accompany the national budget submission, often referred to as the 'National Roll-Up,' and a theme and tonal direction are developed by the Tribal membership of the NTBFW.

Step 6

Once an agreement is reached on a NTBFW funding request, they are presented to the IHS Director for active discussion and engagement. The Workgroup confirmed the funding recommendation, and the adjusted NBB for IHS is $73.0 billion for FY 2027.

1ST REQUEST:

Honor Tribal Sovereignty by Protecting and Preserving the Trust Responsibility and Treaty Obligations to Tribal Nations and the Preservation of American Indian and Alaska Native Programs and Services

Tribal Nations have lived in their homelands from time immemorial and continue to develop programs and services for their communities' health and welfare. Tribal Nations have a unique legal and political relationship with the United States as defined by the U.S. Constitution, treaties, statutes, court decisions, regulations, including 25 C.F.R., and administrative law. In exchange for the surrender and reduction of Tribal lands and removal and resettlement, the United States signed nearly 400 treaties and agreements, passed laws, and instituted policies that shape and define the special government-to-government relationship between Tribal Nations and the federal government. Because of this unique relationship, the federal government has certain obligations and responsibilities to Tribal Nations – one of which is to provide for AI/AN health care, including goods and services. Congress reaffirmed this obligation in the IHCIA, which states that *"it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians . . . to ensure the highest possible health status for Indians and Urban Indians and to provide all resources necessary to effect that policy."*

The United States fulfills its trust and treaty obligations through the direct delivery of Tribal programs and services and with the provision of federal funding to Tribal Nations and Tribal organizations serving Tribal members and communities. Over time, the United States has created a web of different mechanisms, used to deploy federal funding to serve Tribal Nations and Tribal communities. Essential and legally mandated services provided by federal employees include health care services through the IHS; law enforcement and public safety through the Bureau of Indian Affairs; and educational services through the Bureau of Indian Education. Any Tribal program or funding delivered to Tribal Nations — including through UIOs and Tribal Organizations serving Tribal Nations — is to further the United States' trust and treaty obligations. The federal employees necessary for the functioning of those Tribal programs and the disbursement of those Tribal funds are also part of the trust and treaty obligations. The United States further has an obligation to conduct Tribal consultations through mutual and meaningful government-to-government consultations with Tribal Nations on all federal actions, including policy and regulatory changes, that may have Tribal implications, including effects on the delivery of trust and treaty obligations. These actions are not discretionary; they are legal obligations rooted in treaties, trust obligations, the U.S. Constitution, Executive Orders, and long-standing federal statutes.

In fulfillment of its trust and treaty obligations, HHS and all federal agencies and entities must ensure that Tribal Nations have the choice to receive any funding not required by law to be distributed through grants directly through the ISDEAA agreements. HHS must also ensure all programs and services that serve and support Tribal Nations, Tribal citizens, and Tribal communities remain protected and are not subject to reductions, limitations, or eliminations. Efforts to reduce the federal government's budget or size must ensure that AI/AN programs and services are held harmless and that the federal government's fulfillment of the trust and treaty obligations goes uninterrupted. Tribal Nations' exercise of Tribal sovereignty and Tribal Self-Governance and the United States' delivery on its trust and treaty obligations must be honored in the Administration's implementation of its priorities.

Current Services (Fixed Costs)

The Workgroup requests $251.76 million for Current Services in FY 2027. This requested increase accounts for costs associated with maintaining current services at IHS through 2026. The fixed costs used are calculated by IHS, accounting for service population growth, medical and non-medical inflation estimates, and compensation increases for IHS staff. The funding to maintain current services is spread throughout the appropriate IHS budget line items provided by IHS and included in the Detail of Changes table above.

In recent appropriation cycles, insufficient IHS funding decreased the agency's purchasing power and operations. Despite significant medical inflation and population growth over the last decade, Congressional funding has not kept pace, leaving IHS struggling to maintain levels of care. By including additional funding for fixed costs through FY 2026, the Workgroup seeks to maintain the variety of programs provided by IHS including clinical services to improve community health and wellness through immunizations, case management, health screenings, and patient education and counseling.

The NTBFW also requests increased funding to ensure the IHS, Tribal, and Urban Indian (I/T/U) health system can recruit health care providers and administrative support staff. IHS has long been understaffed and IHS data shows an average vacancy rate for physicians, nurses, and other care providers of between 32 and 37 percent.[18] The I/T/U system faces many competitive disadvantages. For example, the IHS has trouble matching local market salaries.[19] Additionally, although Tribally operated sites have more flexibility in compensation packages and processes, these programs are hindered in recruitment and retention efforts due to funding limitations. These vacancy rates disrupt a patient's care continuum and make running a quality health care program nearly impossible.

The I/T/U system also struggles to retain employees. One contributing factor to this is that other federal agencies can provide more generous benefit structures. The Department of Veterans Affairs (VA), for example, currently provides a more generous automatic 8 hours of leave per pay period for its Title 38 employees and has a standardized annual performance bonus for providers.

Future recruitment of health care workers, including clinical providers, is anticipated to become more competitive in the next 5-10 years, with anticipated shortages across many categories, including primary care physicians. Perpetual understaffing limits the abilities of the I/T/U system and impairs its ability to provide high quality health care services. Increased funding for fixed costs will allow the I/T/U system to maintain current services and better recruit health care professionals to ensure adequate service delivery for AI/AN people.

Binding Obligations

The workgroup requests an increase of $9.71 billion for binding obligations in 2027, including staffing at newly completed facilities, Health Care Facilities Construction, and an estimate of Contract Support Costs (CSC) and Payments for Tribal Leases, also known as 'Section 105(*l*) Lease Agreements.' These amounts are included in the Detail of Changes table above and described below.

Staffing for Newly Completed Facilities

The Workgroup requests $75 million for staffing at newly completed facilities. Construction of health care facilities is an ongoing process, with an annually published construction list of future projects and constantly completed projects previously funded for construction. Consistent with annual IHS Congressional Justifications, the Workgroup supports the inclusion of resources for the staffing of newly completed facilities that would otherwise not have the workforce and personnel to operate. These amounts are estimates provided by the IHS for use by the Workgroup and may be subject to revisions of cost estimates at completion.

18 U.S. Government Accountability Office, Indian Health Service: Agency Faces Ongoing Challenges Filling Provider Vacancies, GAO-18-580, published August 15, 2018, available at: https://www.gao.gov/products/gao-18-580, accessed on: February 26, 2025.

19 U.S. Government Accountability Office, Indian Health Service: Agency Faces Ongoing Challenges Filling Provider Vacancies, GAO-18-580, published August 15, 2018, available at: https://www.gao.gov/products/gao-18-580, accessed on: February 26, 2025.

Contract Support Costs (CSC)

The Workgroup requests such sums as necessary to fully fund statutory and legally obligated CSC and that Congress should appropriate CSC through mandatory spending. This must be done as an interim step until Congress moves the entire IHS budget to mandatory funding. The estimated cost of CSC for FY 2027 by the IHS is $8.95 billion. This estimate is provided to the Workgroup by the IHS. The Workgroup recognizes that this amount is subject to change based on the actual CSC obligations required by statute and reconciliation requirements of the IHS-CSC Manual.

Approximately 60 percent of the IHS budget is operated by Tribes under the authority of the ISDEAA. The ISDEAA allows Tribes to assume the administration of programs, services, functions, and activities previously carried out by the federal government. The IHS transfers operational costs for delivery of health programs to Tribes through the "Secretarial amount," which is the amount IHS would otherwise have spent to administer the health programs. In addition, Tribes are authorized to receive an amount for CSC that meets the statutory definition and criteria, which consists of actual administrative costs available to the IHS to support health programs but not available to Tribes within the "Secretarial amount."

The FY 2027 CSC estimate, as part of binding obligations, includes an estimate of the required amount to administer the full funding request for direct health programs. The Supreme Court has consistently ordered that CSC is a contractual obligation of the IHS. If Congress continues to allocate the IHS budget through annual discretionary appropriations, the Workgroup supports that the appropriation continues in such sums as may be necessary due to the mandatory nature of CSC legal obligations. However, the inclusion of mandatory accounts under discretionary spending caps has resulted in a net reduction in the amount of funding provided for Tribal programs and, by extension, the ability of the federal government to fulfill its promises to Tribal Nations. The Workgroup requests that Congress appropriate all the IHS funds as mandatory spending. CSC and payments for Section 105(*l*) Lease Agreements must be immediately moved to mandatory because of the impact these payments are having on funding for programs and services. The Workgroup urges this immediate action to ensure that spending for IHS under discretionary caps can prioritize addressing Tribal health disparities made worse by Termination Era budgets.

Health Care Facilities Construction

The Workgroup requests at least $100 million over the FY 2024 enacted amount for planned Health Care Facilities Construction. This amount for planned binding obligations is in addition to the Workgroup's request for additional program expansion. It is included in the FY 2027 total provided in the Detail of Changes table and described under the Workgroup's explanation of program expansions.

Section 105(l) Lease Agreements

Section 105(*l*) of the ISDEAA requires and authorizes IHS to enter into a lease for facility operations and maintenance upon request of a Tribe or Tribal Organization to administer or deliver programs, services, functions, or activities under the Act. The number of Tribes and Tribal Organizations utilizing this has grown significantly recently as the information and benefits spread throughout Indian Country. This has proven to be a very powerful tool to aid not only in the operations and maintenance of the existing facilities but also in the construction of new facilities.

As facilities appropriations continue to be under-funded, this creates additional barriers to patient care:

1. The condition of existing buildings continues to fall as the cost of upkeep increases faster than increases to facilities budgets to maintain the needed service level.
2. The replacement list for new facilities continues to grow at an accelerated rate due to increased construction costs of new facilities and longer time frames to fund these projects fully, which leads to fewer new facilities being constructed. This problem, combined with the rapid decay of existing buildings needing to be replaced sooner, only further accelerates the rate at which new facilities need to be replaced.
3. Patient services ultimately suffer due to a lack of adequate facilities to provide modern health care.

With the help of Section 105(*l*) Lease Agreements, federal entities can effectively partner with Tribes to bridge the gap between the need and the current level of funding. Tribes can bring in more flexibility with alternative funding and private financing structures. This opportunity not only accelerates the completion of new facilities that are due for replacement, but also provides the necessary funding to stop the rapid decay of existing facilities, decreasing the rate at which buildings need to be replaced. These new modern facilities allow for modern health care delivery methods to provide a higher level of whole person care.

The Workgroup continues to urge all the IHS budgets be provided as mandatory spending, and CSC and payments for Section 105(*l*) Lease Agreements are moved to mandatory. The Workgroup urges this immediate action to ensure that spending for IHS under discretionary caps can prioritize addressing Tribal health inequities made worse by inadequate budgets.

The Workgroup requests such sums as may be necessary to fully fund statutory and legally obligated payments for Section 105(*l*) Lease Agreements and that Section 105(*l*) Lease Agreements should be provided through mandatory spending. The estimated cost of Section 105(*l*) Lease Agreements for FY 2027 by the IHS is $581.65 million. This estimate is provided to the Workgroup by the IHS. The Workgroup recognizes this amount is subject to change based on the actual amount and description of leases with obligations in FY 2027.

Fully Funding the Indian Health Care Improvement Act (IHCIA)

The IHCIA provides foundational legislation for the IHS, Tribal, and urban Indian health programs to carry out legal obligations to AI/ANs by delivering quality and culturally appropriate health care services. IHCIA permanently reauthorized Indian health services in 2010, as part of the Patient Protection and Affordable Care Act (P.L. 110-148) (ACA). Although there are many successes under the implementation of IHCIA, it has never been fully funded.[24]

The reauthorization of the IHCIA in 2010 expanded programs augmenting the HHS health care workforce, increased the amount and type of services available at facilities funded by the IHS, and increased the number and type of programs that provide behavioral health and substance abuse treatment to AI/ANs.[25] Unfortunately, the promises of the IHCIA remain unrealized due to chronic underfunding by Congress. Securing necessary funding for unfunded programs, including long-term care for elders, chronic illness specialty care, behavioral health treatment centers, and many others, is a priority of the NTBFW.

Now is the time to fully fund IHS and achieve the highest level of health for AI/AN people. Mandatory IHS appropriations for the full obligation owed to Tribal Nations and their citizens under the IHCIA are consistent with the United States' treaty and trust obligations.

24 25 U.S.C. §1621d.

25 Congressional Research Service, IHCIA Reauthorization and Extension as Enacted by ACA, Updated January 3, 2014, R41630, available at: https://crsreports.congress.gov/product/pdf/R/R41630, accessed on: March 5, 2023.

Reclassify Contract Support Costs and Section 105(l) as Mandatory

Although legally required in every aspect, CSC and Section 105(l) Lease Agreements are currently paid for under discretionary spending caps instead of under mandatory appropriations. Misclassification of CSC and 105(l) Lease Agreements is not just a Tribal issue – it is dramatically impacting the entire Interior, Environment, and Related Agencies budget.

The Appropriations Committees recognized as far back as 2014 that the mandatory nature of CSC obligations places the appropriators in an "untenable position."[20] As they wrote in the Explanatory Statement that year, "[t]ypically obligations of this nature are addressed through mandatory spending, but in this case since they fall under discretionary spending, they have the potential to impact all other . . . equally important Tribal programs."[21] Similarly, appropriators stated in the FY 2021 Explanatory Statement for the Interior bill that 105(l) leases, as confirmed in the Maniilaq cases, "appear to create an entitlement to compensation . . . that is typically not funded through discretionary appropriations."[22]

Tribal participation in ISDEAA programs has increased rapidly over the past decade, and Congress continues to struggle to meet CSC and Section 105(l) funding obligations through discretionary appropriations. In their Explanatory Statements, the Committees called on the agencies and Congress to find a sustainable solution including mandatory reclassification.[23]

More recently, on June 6, 2024, the U.S. Supreme Court ruled that the IHS must pay CSC on revenue collected from third party payers like Medicare, Medicaid, and private insurance. This ruling is already pushing CSC even higher. In FY 2025, the draft appropriations bills in the Senate and the House marked the CSC and Section 105(l) Lease Agreements cost increases as 87 percent and 93 percent of the total agency increases, respectively. In today's funding model, it is unclear where this funding would come from.

Immediately moving these two accounts to mandatory is good governance and risk management for the United States because the amount is already mandatory in nature and there is a mechanism for controlling costs. If the goal or intent is better fiscal management or maintaining annual control over federal spending, then leaving accounts in the discretionary process with standing to sue that would also generate additional administrative or legal costs if any underpayment or delay were to occur is wasteful and misleading, at best, and intentionally reckless, at worst.

Both CSC and Section 105(l) Lease Agreement accounts are necessarily bound by the parameters of the authorizing law and amounts are determined through sophisticated negotiations and calculations between parties with administrative avenues for recourse prior to suit. This means that the amount is determinable each year and can be determined into the future with reliability, accuracy, and efficiency. Further, it means that costs are controlled and defined by the amount of resources provided for HHS and DOI programs, services, functions, or activities in the Interior bill, along with other quantifiable measures like employee pay costs.

There is a better way to manage and score this authority for the American people and that is by providing such sums as may be necessary for these accounts through mandatory spending. Reallocating base funding from discretionary to mandatory funding has a net zero impact on the Federal budget and would not undermine fiscal control measures. Moreover, as mandatory appropriations in the Interior bill, the Appropriations Committees would retain oversight of the programs.

The NTBFW continues its support for immediately reclassifying CSC and 105(l) Lease Agreements payments as mandatory spending and urges the Administration to include this request in its budget proposal. It is already mandatory in every single way, but it places a penalty on the Interior appropriations bill due to its current accounting. Transparency on the current status of the law is good for the American people.

20 Page H975 at https://www.govinfo.gov/content/pkg/CREC-2014-01-15/pdf/CREC-2014-01-15-bk2.pdf.
21 Id.
22 Page H11281 at https://www.govinfo.gov/content/pkg/CREC-2019-12-17/pdf/CREC-2019-12-17-house-bk3.pdf.
23 Id.

2ND REQUEST:

Protect and Preserve Advance Appropriations for the Indian Health Service

IHS and Tribes finally received appropriations parity with the other federal health systems in FY 2023 when Congress first provided advance appropriations. Advance appropriations for the IHS marked a paradigm shift in the nation-to-nation relationship between Tribal Nations and the United States by providing certainty and stability in the provision of the United States' trust and treaty obligations to provide for AI/AN health care.



Advance appropriations provide a full-year appropriation one year in advance, which provides much needed stability for IHS and Tribes to plan long-term for health care delivery and staffing. Advance appropriations allow IHS, Tribes, and UIOs to focus on the delivery of health care and improving health outcomes across Indian Country. It also creates efficiency at IHS by reducing the number of short-term payments and drawdowns. Finally, it reduces the need for emergency operating and contingency plans for the next unpredictable federal spending outcome.

Evaluation of the implementation is underway, but from the Tribal perspective, implementation went exceedingly well. There are still areas to improve advance appropriations for IHS. The current appropriation does not extend to all IHS accounts or line items, leaving some important programs uncertain. These include funding for the Indian Health Care Improvement Fund, modernization of EHRs, sanitation facilities and health care facilities construction–accounts and line items dependent on consistency and stability. The Workgroup recommends the continuation of advance appropriations and the inclusion of these important accounts and line items.

3RD REQUEST:

Provide Full and Mandatory Funding to the Indian Health Service ($73.0 billion in FY 2027)

IHS funding levels remain consistently lower compared to other federal health programs. Despite IHS, Tribal, and urban Indian clinics utilizing innovative tactics to extend resources, the lack of adequate funding levels has disrupted the operation of the Indian health system and limits the implementation of long-term solutions for improving the health status of AI/ANs. Providing full and mandatory funding to the IHS will ensure the federal government is upholding trust and treaty obligations to Tribal Nations.

IHS plays a crucial role in ensuring facilities are appropriately resourced. Appropriate funding levels can improve the management and operations of facilities, update outdated and aging facilities and equipment, improve retention and recruitment of health care professionals, improve equipment available at facilities, and ensure continuity of care to patients. It is essential for IHS to receive full and mandatory funding to effectively deliver health care services, programs, and activities that address the unique determinants of health for AI/ANs.

For over two decades, the Workgroup has requested full and mandatory funding for the IHS. Numerous federal government reports[26] have documented the need for the federal government to invest in the health-related resources offered by the IHS. AI/AN people rely on the services offered by the Indian health system. The livelihood of Indian Country is tied to the federal government's ability to provide full and mandatory funding to the IHS.

>>• CLINICAL SERVICES •<<

Hospital and Health Clinics: $18.49 billion (+15.73 billion)

The Hospitals and Health Clinics (H&HC) account provides funding for essential health services for approximately 2.8 million AI/AN people. IHS and Tribal health programs provide medical and surgical inpatient care, routine and emergency ambulatory care, and medical support services including laboratory, pharmacy, nutrition, diagnostic imaging, medical records, and physical therapy.

For FY 2027, the Workgroup recommends a program increase of $15.73 billion for the H&HC account. Providing sufficient program increases for the H&HC account has consistently ranked as the number one priority. This funding provides for 605 hospitals, clinics, and health programs throughout Indian Country. Many of these programs are predominantly located in rural and frontier settings. A number of these health programs also provide services to non-Tribal individuals. In remote, rural locations these programs are often the only health care providers in the area. H&HC funds provide the greatest flexibility to support the required range of services needed to target chronic health conditions affecting AI/AN people, many who live in remote areas that are not easily accessible by road.

26 Government Accountability Office. (December 2018). Indian Health Service: Spending Levels and Characteristics of IHS and Three Other Federal Health Care Programs. Retried from: https://www.gao.gov/products/gao-19-74r;l U.S. Commission on Civil Right. Broken Promises: Continuing Federal Funding Shortfall for Native Americans. (2018). Retrieved form: https://www.usccr.gov/files/pubs/2018/12-20-Broken-Promises.pdf.

The demands for direct care services are a continuous challenge in our facilities. We experience constant and increased demand for services due to population growth and increased rates of chronic diseases. Yet, the program increases provided in the IHS budget rarely fund the costs of rising medical inflation and population growth year to year. The IHS has received inflation, or population increases in the IHS budget only four times in the last ten years.[27] Over time, the IHS budget loses purchasing power because budgets must absorb the unavoidable costs of inflation and population growth. Medical inflation particularly impacts the H&HC line item as IHS and Tribal sites fail to keep up with rising medical costs. Underfunding of H&HC translates to rationed care that is less accessible and of lower quality, further limiting efforts towards making meaningful improvements in health outcomes.

IHS and Tribal health programs have been at the forefront of providing quality health care and face a crossroad with the pressure of increasing demand for higher acuity care and deepening financial instability. The IHS and Tribal health providers across the United States continue to confront persistent workforce shortages, severe fractures in the supply chain for drugs and supplies, and high levels of inflation, collectively increasing hospital costs to care for patients. At the same time, the health care system throughout the United States — including IHS and Tribes—have been met with inadequate increases in reimbursement by public payers, as well as increasing administrative burden due to inappropriate commercial health insurer practices. These issues have created an environment of financial uncertainty for many Tribal hospitals and health care providers operating with little to no margin.

Due to chronic challenges in recruiting and retaining providers in rural health care settings and the lack of adequate facilities and equipment, H&HC resources are stretched thin. As a result, any underfunding equates to limited health care access, especially for patients that are not eligible for, or who do not meet the medical criteria for, referrals through Purchased/Referred Care (PRC) to the private sector (please see the PRC section for further discussion). For many people in Indian Country, there are no alternatives other than the direct care provided at an IHS or Tribal facility.

Tribes are committed to working with IHS and HHS to make meaningful impacts in terms of improved health outcomes. AI/AN communities experience significantly higher mortality rates from cancer, diabetes, heart disease, suicide, injury, and substance abuse than other populations. Preventative and primary care programs reduce costly medical expenditures for specialty care and treatment.

A critical component to achieve the full potential of hospitals and health clinics is fully funding IHCIA. The provisions in this law represent a promise made by the federal government to significantly improve the health of our people, yet this law remains unfunded. Legislation without appropriation damages the health of our Tribal Nations. We renew our request to the federal government to keep its promise by funding IHCIA authorities. Tribes also request that funding these new authorities should be in addition to the base level H&HC funding.

Electronic Health Records / Health IT: $686.43 million (+$488.77 million)

The Workgroup requests $686.43 million to fully fund the modernization of the IHS Health Information Technology (HIT) system, PATH EHR in FY 2027. IHS provides the technology infrastructure for a nationwide health care system, including a secure wide area network, electronic health record (EHR), enterprise e-mail services, and regional and national help desk support for approximately 20,000 network users utilizing RPMS, which was implemented in Indian Country in 1985. Increased funding for the implementation of a new system, PATH EHR, is critically important. No other health system in the country operates on a 40-year-old EHR. Full funding is necessary for rolling out and implementing the EHR across Indian Country.

Just as IHS provides technological support for its health system, Tribally-operated and urban Indian health programs also provide support for mission critical health operations through the purchase of commercial-off-the-shelf (COTS) EHRs. Many Tribal health systems have purchased COTS and are many years ahead of

27 In FY 2024 inflation $109.1 million; FY 2018 inflation $93.9 million; FY 2017 inflation $50.3; and FY 2016 pay costs $19.5 million.

the IHS HIT modernization. These modernization initiatives have been completely funded by Tribal Nations and organizations through non-federal resources, meaning that many Tribal entities have sacrificed significant portions of their own funds to modernize health technology. This often results in less funding available for other priorities within the health system. HIT modernization funding at IHS has not flowed from the agency to the Tribes despite the fact that Tribal Nations operate over 51 percent of Indian hospitals and 86 percent of Indian health centers, clinics, and health stations.[28] As part of the initiative to modernize the federal system, Congress should appropriate additional funding to reimburse Tribal health systems that have invested in COTS and modernized on their own, as the decision to modernize ahead of the IHS initiative is rooted in patient care, and the federal government's failure to adequately fund the Indian health system. Tribal Nations should not be forced to subsidize the federal government's trust and treaty obligations.

Despite this unequal allocation of resources between IHS and Tribal HIT modernization efforts, Tribal leaders and the NTBFW continue to support full funding for HIT modernization for the whole Indian health system — not just the IHS initiative. Comprehensive and modernized health information solutions are critical to health care operations in Indian Country. Beyond being critically necessary for the provision of care, a fully modernized EHR is important for the recruitment and retention of health professionals that work within the Indian health system.

These requested resources will continue to support efforts to stabilize the aging IHS RPMS system while modernization is underway. Now that the IHS is working with the vendor to build out the program and implement it at a pilot site, increased funding for this initiative will be used to support the configuration of the new PATH EHR, as well as transition and implementation efforts. A properly resourced Indian health care delivery system is better able to care for patients, pay providers, provide essential care referral and care coordination services, recover costs, and recruit and retain health professionals.

RPMS is over 40 years old, and the GAO identifies it as one of the 10 most critical federal legacy systems in need of modernization.[29] Since FY 2020, the NTBFW has supported a new budget line specifically for HIT. The NTBFW also has recommended a meaningful investment to maintain and update the outdated IHS RPMS while replacement efforts are underway, as the delivery of health care cannot stop, and insufficient funding for the modernization program has resulted in further implementation delays. A significantly longer than expected timeline for this project will have lasting negative impacts on the Indian health system. Additionally, the NTBFW further requests funding to support the investments that Tribal Nations and organizations have already made in modernizing their own HIT systems.

An adequately resourced IHS HIT program is critical to ensure the provision of quality and safe care and will reduce inefficient and costly consequences associated with an outdated health technology system. We request the President's Budget for FY 2027 include substantial investments for both Tribal and IHS HIT modernization efforts to address the changing technology and resource environment of health care.

Dental Services: $3.78 billion (+$3.52 billion)

The Workgroup recommends a total of $3.83 billion for Dental Services. Many Native communities continue to struggle under the continued weight of oral health disparities. Oral Health is one of the 34 Leading Health Indicators 2030, which identifies public health priorities to help individuals, organizations, and communities across the United States improve health and wellbeing.[30]

Reasons for poor dental health in Tribal communities include geographic isolation that continues to limit available providers, economic and racial disparities, and the historical trauma of decades of inadequate health care. Limited access to oral health care can be life-threatening. Missing teeth can impact a person's quality

28 Indian Health Service. (2024). The Indian Health Care System – Fact Sheet. Retrieved from: https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/factsheets/IHSProfile.pdf

29 GAO-21-524T, INFORMATION TECHNOLOGY: Agencies Need to Develop and Implement Modernization Plans for Critical Legacy Systems https://www.gao.gov/assets/gao-21-524t.pdf

30 Leading Health Indicators, 2030, Advancing Health, Equity, and Well-Being. National Academies Press, 2020.

of life by lowering self-esteem and, for some, reducing employment opportunities. In addition, people with extensive or complete tooth loss are more likely to substitute easier-to-chew foods such as those rich in saturated fats and cholesterol. The three oral conditions most affecting overall health and quality of life are cavities, severe gum disease, and severe tooth loss.[31]

AI/AN children with dental caries, a common chronic bacterial infection leading to tooth decay, do not receive the necessary treatment. By age two, approximately 40% of AI/AN children already have tooth decay, with the number rising to 80% by age five, and peaking at 90% for AI/AN children between the ages of six to nine.[32] Untreated tooth decay causes pain and infections that may lead to problems with eating and speaking for all age groups and children growing and learning.

AI/AN adult dental patients also suffer disproportionately from untreated decay, with twice the prevalence of untreated caries as the general United States population and more than any other racial/ethnic group.[33] Of the AI/AN dental patients aged 40-64, 83 percent had teeth pulled because of tooth decay or gum disease compared to the national average of 66 percent.[34]

31 World Health Organization. (2020, March 20). Oral Health. Retrieved April 3, 2020 from https://www.who.int/news-room/fact-sheets/detail/oral-health

32 Indian Health Service Data Brief, August 2023. The Oral Health of American Indian and Alaska Native Children Aged 6-9 Years A Follow-Up Report to the 2017 Survey.

33 Phipps KR, Ricks TL, Mork NP, and Lozon TL. The oral health of American Indian and Alaska Native children aged 6-9 years – a follow-up report to the 2017 survey. Indian Health Service data brief. Rockville, MD: Indian Health Service. 2023.

34 Id.

Limited Access to Dental Care Can Be Life-Threatening



Limited access to dental care can be life-threatening. In one IHS Area, a 43-year-old presented at an IHS facility with a dental emergency: he had an abscess. Yet, the dental clinic was unable to work him in due to very limited service capacity. The patient was referred to a dentist outside of the IHS system; however, the dentist would not remove the abscessed tooth and required additional payment up front that the patient did not have during the emergency. The patient left with no treatment plan for the abscess, and he became very ill. He was later admitted to the Intensive Care Unit where he spent 3 weeks in the hospital because the infection spread throughout his body.

Because IHS was unable to care for him, immediately, the agency paid even more for surgeries, a ventilator, additional medications, and staff, which was billed to the very limited Purchased/ Referred Care (PRC) program. The patient suffered permanent disfiguration of his nose when skin was pulled off his nose due to the tubes that had to be taped for the ventilator. He could have lost his life because he did not have the means to afford proper treatment. He was left to worry about his job, bills, and caring for his family while facing a dental crisis.

If this patient had access to proper preventative and emergency dental services to begin with, he could have prevented this life-threatening illness and hospital stay, altogether. Dental funding is critical to the overall health of our Tribal members. This is just one of many examples throughout Indian Country where the cost of inaction is greater than action.

An IHS oral health survey was conducted in 2019 on 5,223 13–15-year-old AI/AN youth, the largest-ever sample size of this age group. Following the trends of the 2016-17 and the 2018 oral health surveys, this survey not only highlighted the oral health disparities between AI/ANs but also compared disease rates to previous surveys of this age group.[35] Subsequently, the survey showed a 10 percent reduction in caries experience from 1999 to 2019 (83.6 percent to 75.4 percent) and a 30 percent reduction in untreated decay from 1999 to 2019 (64.0 percent to 45.0 percent). Despite this success, AI/AN children and adults continue to suffer disproportionately from dental disease compared to the rest of the United States: three to five times as many cavities across all ages and twice as much gum disease in adults.[36]

IHS and Tribal Dental Programs have long been challenged to meet the high level of need for oral health care services. Many communities do not have on-site dental services to treat advanced caries. Lack of access to professional dental care significantly contributes to the disparities in oral health in the AI/AN population. Three major factors contribute to inadequate access to care: the lack of funding, the relative geographic isolation of Tribal populations, particularly in Alaska, and the inability to attract dentists to practice in IHS or Tribal health facilities in rural areas.[37] Another potential reason is that the dental hygienist-to-population ratio within the IHS is 1:9,300 while the general population is at 1:2,000. Additionally, IHS cannot fill all vacant positions for dentists, with vacancy rates ranging between 10 percent-32 percent.[38]

Overall, AI/ANs experience significantly more dental caries and periodontal disease in all age groups. Unfortunately, these numbers do not surprise anyone who grew up or lives in a Tribal community; nonetheless, they are staggering.

Mental Health: $5.41 billion (+5.27 billion)

Native American communities are facing a profound mental health crisis driven by historical trauma, systemic inequalities, and limited access to culturally appropriate health care. These challenges have resulted in alarmingly higher rates of mental health disorders, substance abuse, and suicide compared to the general U.S. population.[39] The disparities in mental health within Native American communities are a direct consequence of ongoing historical trauma and chronic underfunding of health services, despite the federal government's trust and treaty obligations to ensure the well-being of Native American peoples.

Addressing this issue requires a substantial, long-term investment in mental health services grounded in principles of self-determination and equality. Tribal leaders urgently request $5.41 billion for FY 2027 to fund quality mental health services in Indian Country. It is essential to support trauma-informed care, culturally responsive services, certified and trained mental health specialists, inpatient and outpatient treatment facilities, telehealth opportunities, crisis response and triage, case management services, community-based prevention programming, outreach, and health education activities.

This funding request is crucial for healing and empowering Native American communities. It is a call to action for justice, equity, and fulfilling promises. By addressing these mental health disparities, the resilience and strength of Native American peoples are honored and ensure a healthier, more equitable future for all.

Mental Health Crisis in Native American Communities

ESCALATING CRISIS OF MENTAL HEALTH DISORDERS

Native Americans experience mental health disorders at alarmingly higher rates than the general population. The suicide rate among Native youth is 2.5 times the national average, the highest among any ethnic group in

35 1999 & 2010-2020 IHS oral health surveys, IHS National Dental Data Mart, 2019 national GPRA results, and National Health and Nutrition Examination Survey data.

36 Id.

37 Nash, D. A., & Nagel, R. J. (2005). Confronting oral health disparities among American Indian/Alaska Native children: the pediatric oral health therapist. American journal of public health, 95(8), 1325–1329. https://doi.org/10.2105/AJPH.2005.061796

38 Give Kids a Smile Day: An IHS-ADA Collaboration, Special IHS CDE Webinar, presented on Nov. 20, 2019.

39 American Psychological Association. (October 2023). The healing power of Native American culture is inspiring psychologists to embrace cultural humility. Retrieved from: https://www.apa.org/monitor/2023/10/healing-Tribal-communities-native-americans.

the United States. As of 2020, AI/ANs have the highest suicide rate at 23.9 per 100,000, which has surged by 55.7 percent over the past decade.[40]

The situation is even more dire for AI/AN adolescents and young adults, with suicide rates reaching all-time highs. Among 15 to 24-year-olds, the rate is 24.6 per 100,000; among 25 to 34-year-olds, it is 29.8 per 100,000.[41] These adolescent rates are 1.9 times higher than the national average for others in the same age group and 2.1 times higher than the national average for other young adults.[42]

Suicide is the eighth leading cause of death among all AI/ANs across all ages.[43] This is not just a statistic; it is a heartbreaking reality that demands urgent action. We must address these disparities with compassion, commitment, and culturally competent care to support the mental health and well-being of Native American communities.

CONTRIBUTING FACTORS TO MENTAL HEALTH ISSUES

Historical trauma, systemic inequalities, and socio-economic challenges contribute to mental health disparities in AI/AN communities. Historical trauma stemming from centuries of colonization, forced relocation, and cultural suppression has left lasting scars on AI/AN communities. This trauma is passed down through generations, contributing to higher rates of mental health disorders, substance abuse, and suicide.[44]

These challenges are worsened by systemic inequalities such as poverty, unemployment, and restricted access to quality education. AI/AN communities often face significant barriers to accessing health care, including mental health services. These barriers include geographic isolation, high costs, and a shortage of culturally competent providers.[45]

Discrimination and racism also play a critical role in these disparities. AI/ANs frequently encounter prejudice and systemic barriers that affect their mental well-being. This ongoing discrimination contributes to chronic stress and mental health problems.[46]

Additionally, the high rates of substance abuse in AI/AN communities are both a coping mechanism for dealing with stress and trauma and a contributing factor to mental health disorders. Substance abuse is prevalent due to the lack of resources and support for addressing these issues effectively.[47]

Addressing these fundamental problems requires funding for mental health services, culturally tailored care, and policies that support economic stability and social justice in AI/AN communities. By tackling these underlying issues, we can work towards reducing mental health disparities and improving the overall well-being of AI/AN peoples.

EFFECTS ON PERSONAL AND COMMUNITY WELL-BEING

Historical trauma, current stressors, and systemic inequalities heavily influence the health of AI/AN individuals and communities. These factors have profound impacts on both individuals and communities. Psychological distress and mental health disorders are prevalent among AI/AN youth and adults who are descendants of those who experienced historical trauma. The unresolved grief and emotional pain from past generations can manifest in the mental health of current generations. Exposure to intergenerational trauma can lead to PTSD, characterized by symptoms such as flashbacks, nightmares, and severe anxiety.[48] Historical

40 American Psychological Association. (October 2023). The healing power of Native American culture is inspiring psychologists to embrace cultural humility. Retrieved from: https://www.apa.org/monitor/2023/10/healing-Tribal-communities-native-americans.

41 Ibid.

42 Ibid.

43 Ibid.

44 Mass General Brigham McLean. Native American Mental Health: What You Need to Know. Retrieved from: https://www.mcleanhospital.org/essential/native-american-mh.

45 Ibid.

46 Ibid.

47 Ibid.

48 PsychCentral. (May 2022). Mental Health in Native American and Indigenous Communities. Retrieved from: https://psychcentral.com/health/native-american-mental-health

trauma contributes to higher rates of mental health disorders such as depression, anxiety, PTSD, and substance abuse within the community.[49] This widespread psychological distress can lead to a community-wide sense of hopelessness and despair.

Substance abuse is another significant issue, with historical trauma contributing to higher rates of substance abuse among AI/AN youth and adults. The use of drugs and alcohol can be a coping mechanism for dealing with the emotional pain and stress associated with historical trauma.[50] Higher rates of substance abuse within the community can lead to increased instances of liver disease, respiratory issues, and other health complications.[51]

Suicidal behavior is alarmingly high among AI/AN youth and adults, who have significantly higher suicide rates compared to their peers. The loss of cultural identity, feelings of isolation, and the cumulative weight of personal and communal trauma can lead to hopelessness and suicidal thoughts. Studies show that 35% of AI/AN youth have seriously considered suicide in the past year, compared to 19% of all youth.[52]

Behavioral issues and academic challenges are also common among youth affected by historical trauma. These individuals may develop maladaptive coping mechanisms, such as aggression or risky behavior, in response to chronic stress and emotional pain. Historical trauma can also impact academic performance, leading to lower academic achievement and higher dropout rates. Adults may exhibit self-destructive behaviors, including substance abuse, hypervigilance, dissociation, and low self-esteem.[53]

Physical health issues are linked to historical trauma, with higher rates of lifestyle diseases among adults, including heart disease, cancer, stroke, diabetes, skeletal fractures, and liver disease. The chronic stress associated with historical trauma can weaken the immune system and contribute to these health problems.[54] Historical trauma is linked to higher rates of chronic diseases such as heart disease, diabetes, and cancer.[55]

Historical trauma's economic and social impact extends to various aspects of life. Adults may face challenges securing stable employment, leading to financial instability and perpetuating cycles of poverty within communities. Historical trauma can impact academic performance, leading to lower educational attainment and higher dropout rates. This can limit economic opportunities and contribute to socio-economic challenges.[56]

Increased violence and aggression within the community can also be a manifestation of historical trauma. This can lead to higher rates of domestic violence, child abuse, and community violence. The loss of cultural identity and community cohesion can lead to social disintegration, with individuals feeling disconnected from their cultural roots and community, exacerbating feelings of isolation and alienation.[57]

Reduced access to health care services is another consequence of historical trauma. Communities may face barriers such as lack of health care facilities, cultural insensitivity, and mistrust of health care providers. Despite these challenges, many Native American communities demonstrate remarkable resilience. Efforts to revitalize cultural practices, promote community support, and implement trauma-informed care can help mitigate the effects of historical trauma and improve community health.[58]

49 Mental Health America. Communities of Indigenous American descent. Retrieved from: https://mhanational.org/indigenous
50 Ibid.
51 Ibid.
52 Ibid.
53 Ibid.
54 Ibid.
55 Mental Health America. Communities of Indigenous American descent. Retrieved from: https://mhanational.org/indigenous
56 Ibid.
57 Ibid.
58 Ibid.

THE NEED FOR SPECIALIZED MENTAL HEALTH SERVICES

Current funding allocated for specialized mental health services, particularly those that cater to substance abuse treatment, youth services, and culturally sensitive care tailored to the unique needs of AI/AN communities, is woefully insufficient. This underfunding has dire consequences, and we must address this issue with the urgency it deserves.

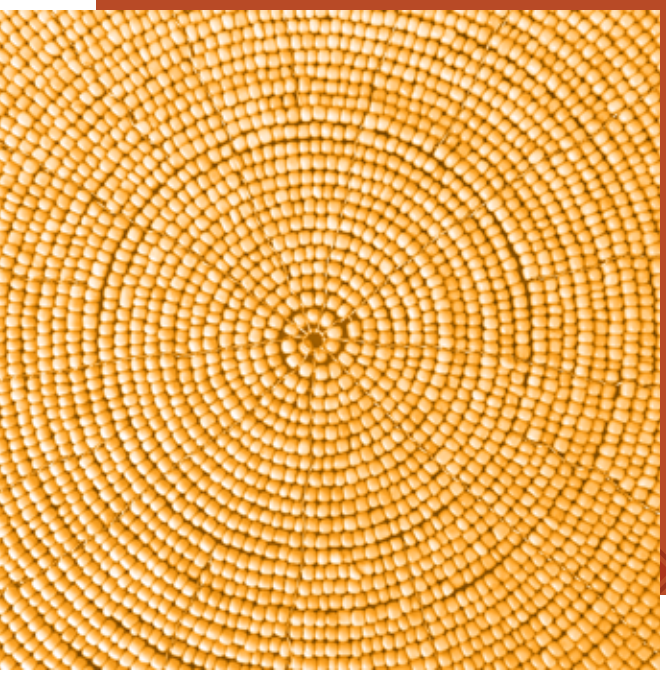
Inadequate Funding Levels: Despite the critical need, mental health services for AI/AN communities remain severely underfunded. In FY 2023, per capita expenditures for patient health services were only $4,078, compared to a national average of $13,498 per person in calendar year 2022.[59] This stark disparity highlights the urgent need for increased funding to bridge the gap and ensure that AI/AN communities receive the care they deserve.

Shortage of Mental Health Providers: There is a significant shortage of mental health providers in AI/AN communities. In 2022, the ratio of the national population to mental health providers was 350 persons per provider. In rural areas, such as South Dakota, there were approximately 500 people per single provider. This shortage severely limits access to essential mental health services, leaving many without the support they need.

Barriers to Access: Many AI/ANs face significant barriers to accessing mental health care, including cost, stigma, and a lack of culturally competent services. A 2022 survey found that 80% of respondents cited cost, and more than 60% cited shame and stigma as obstacles to accessing mental health services. These barriers prevent individuals from seeking the help they need, exacerbating mental health issues within the community.

High Demand for Services: The demand for mental health services is incredibly high, with one-third of respondents in a 2022 survey reporting that they could not get the mental health care they needed. This unmet demand underscores the need for increased funding to expand service capacity and reach, ensuring that everyone needing help can access it.

Infrastructure and Workforce Development



Investing in the development of mental health care infrastructure and expanding the mental health workforce, specifically within AI/AN communities, is not just essential — it's a moral imperative. We must ensure that the care provided is culturally competent, with training tailored to the unique needs of these communities.

This approach is not merely about numbers; it's about addressing the profound mental health disparities faced by AI/AN communities. It's about supporting sustainable, community-led solutions that honor and respect cultural values and practices. By investing in these areas, we can make a tangible difference in the lives of countless individuals, fostering resilience and well-being for generations to come.

59 https://www.ihs.gov/newsroom/factsheets/ihsprofile/

JUSTIFICATION FOR THE $5.41 BILLION FUNDING LEVEL FOR MENTAL HEALTH

Mental health is a critical aspect of overall well-being, and AI/AN communities deserve the best possible care. To achieve this, it is essential to allocate $5.41 billion toward enhancing mental health services across AI/AN communities. Through transparent and accountable funding distribution, this funding will provide better mental health care outcomes and help ensure that AI/AN communities receive efficient and effective delivery of mental health services.

The federal government has a trust responsibility towards providing mental health services to Tribal Nations. To fulfill this responsibility, allocating $5.41 billion in funding is necessary. This investment is a moral and practical imperative to improve health outcomes and enable self-determination among Tribal communities. Moreover, it will have far-reaching benefits for the health and prosperity of AI/AN communities and the nation. As such, the provision of mental health services to Tribal Nations is a crucial priority that should be pursued with commitment and diligence.

Alcohol and Substance Abuse: $4.24 billion (+$3.96 billion)

Alcohol, substance abuse, and addiction are among the most severe public health and safety problems facing AI/AN individuals, families, and communities. The Alcohol and Substance Abuse program (ASAP) supports an integrated behavioral health approach to collaboratively reduce the incidence of alcoholism and other drug dependencies in AI/AN communities. The purpose of ASAP is to raise the health status of AI/AN communities to the highest possible level through a comprehensive array of preventive, educational, and treatment services that are community-driven and culturally competent. These collaborative activities strive to integrate substance abuse treatment into primary care. For instance, the Substance Abuse and Suicide Prevention Program (SASP) provides prevention and intervention resources developed and delivered by local community partners to address the dual crises of substance abuse and suicide in AI/AN communities.

AI/AN populations suffer disproportionately from substance use disorders (SUD) compared with other U.S. populations. Research has consistently found that AI/AN experience higher rates of substance use compared with the U.S. general population.

Nationally, in 2023, the non-Hispanic-AI/AN and NHW populations reported a similar proportion of having an alcohol use disorder in the past 12 months (12.2% and 11.0%, respectively).[60] However, non-Hispanic-AI/AN had an age-adjusted alcohol-induced mortality rate of 61.5 per 100,000, which was 4.4 times that of NHW at 13.8 per 100,000. When asked about binge alcohol use in the past 30 days, 19.7% of Non-Hispanic-AI/AN respondents reported binge alcohol use and 22.5% of NHW respondents reported binge alcohol use.[61]

An estimated 10.4% of non-Hispanic-AI/AN had a drug use disorder (other than marijuana) in the past 12 months, which was nearly triple that of NHW respondents, at 3.7%.[62] In 2023, nationally, non-Hispanic-AI/AN had an age-adjusted drug overdose mortality rate of 63.6 per 100,000, which was almost double that of NHW, at 33.1 per 100,000.[63] Additionally, among those surveyed, 13.7% of non-Hispanic-AI/AN respondents reported using an illicit drug (other than marijuana) in the past year compared to 9.2% of NHW respondents. [64]

Findings from the 2019 National Survey on Drug Use and Health (NSDUH) reported the rate of AI/ANs aged 12 and over with an alcohol use disorder (6.4 percent) is higher than that of the total population (5.3 percent).[65]

60 Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System (BRFSS), 2022. https://nccd.cdc.gov/weat/#/crossTabulation. Accessed: 05 Mar 2025.

61 Ibid.

62 Substance Abuse and Mental Health Services Administration (SAMHSA)'s Data Analysis System (DAS). NSDUH: Public-use Data (2023), https://datatools.samhsa.gov/nsduh/2023/nsduh-2023-ds0001/crosstab. Accessed: 05 Mar 2025.

63 Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Provisional Mortality on CDC WONDER Online Database. Data are from the final Multiple Cause of Death Files, 2018-2023, and from provisional data for years 2024 and later, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/mcd-icd10-provisional.html on Mar 5, 2025.

64 Substance Abuse and Mental Health Services Administration (SAMHSA)'s Data Analysis System (DAS). NSDUH: Public-use Data (2023), https://datatools.samhsa.gov/nsduh/2023/nsduh-2023-ds0001/crosstab. Accessed: 05 Mar 2025.

65 https://www.samhsa.gov/data/sites/default/files/reports/rpt29394/NSDUHDetailedTabs2019/NSDUHDetTabsSect5pe2019.htm#tab5-4a

Consequences of heavy alcohol use contribute to increased risks of many negative health factors such as diabetes, heart disease, cancer, obesity, tuberculosis, hepatitis, depression, mental health disorders, sexually transmitted diseases, and liver disease. Cirrhosis, an alcoholic liver disease, is a major leading cause of death for AI/ANs. In conjunction with the unacceptable rates of Fetal Alcohol Syndrome, birth defects, and other direct negative health impacts, are the corresponding increases in unintentional injuries and violent crimes experienced by AI/AN who are under the influence of alcohol.[66]

Alcohol abuse is not the only factor where AI/AN use rates are higher compared to other U.S. populations. A 2009 study found that Native Americans have the highest rates of marijuana, cocaine, inhalant, and hallucinogen use disorders compared to other ethnic groups.[67] In 2017, the Centers for Disease Control and Prevention (CDC) reported that the AI/AN population had the second highest overdose rates from all opioids (15.7 deaths/ 100,000 population), and the highest rate from prescription opioids (7.2 deaths/100,000 population) during 2016-2017.[68] The overall rate of overdose deaths for AI/ANs increased by 13 percent between 2015-2017.[69] In 2017, the age-adjusted rate of drug overdose deaths was 9.6 percent higher than the rate for 2016. During that time, deaths rose more than 500 percent among AI/ANs. Due to misclassification of race and ethnicity on death certificates, the actual number of deaths for AI/ANs may be underestimated by up to 35 percent.[70]

Additionally, in a recent study by the National Institute on Drug Abuse (NIDA), deaths involving methamphetamines more than quadrupled among non-Hispanic AI/AN from 2011-2018 (from 4.5 to 20.9 per 100,000 people) overall.[71] The segue from opioid misuse to methamphetamine (meth) is common. Unlike opioids, there are currently no FDA-approved medications for treating methamphetamine use disorder or reversing overdoses. However, behavioral therapies such as contingency management therapy can be effective in reducing harms associated with use of the drug.

Substance use disorders are often associated with unresolved trauma that may contribute to related behavioral and mental health issues. AI/ANs experience some of the highest rates of psychological and behavioral health issues as compared to other racial and ethnic groups[72] which have been attributed, in part, to the ongoing impacts of historical trauma.[73]The COVID pandemic, and generations of cumulative emotional and psychological wounds from forced relocation, brutality, assimilation, genocide, racism, sexual abuse, and the blatant destruction of cultural practices resulted in unresolved grief, increased stress, and loss of traditions, land, identities, relationships, and families due to the traumatic experiences inflicted. Resulting negative coping factors include alcohol and drug use and abuse, compounding psychological distress, poor health, cycles of abuse, and poor health choices leading to a vicious cycle of negative outcomes.

These findings highlight the urgent need to develop culturally tailored, gender-specific prevention and treatment strategies for AI/AN with substance use disorders to meet the unique needs of those who are most vulnerable to the growing crises. The substance use disorder (OUD) crisis in the U.S. and our Tribal communities is dire. Integrated care and holistic approaches to wellness that respect AI/AN traditions and perspectives in Tribal communities are needed. Incorporating traditions offers a unique and culturally resonant way to promote resilience, help prevent drug use among young people and develop culturally appropriate and community-based prevention strategies and education.

66 Bureau of Justice Statistics. (December 2004). A BJS Statistical Profile, 1992-2002: American Indians and Crimes. Retrieved from: https://bjs.ojp.gov/content/pub/pdf/aic02.pdf

67 Young, R. S., & Joe, J. R. (2009). Some thoughts about the epidemiology of alcohol and drug use among American Indian/ Alaska Native populations. Journal of ethnicity in substance abuse, 8(3), 223–241. https://doi.org/10.1080/15332640903110443.

68 https://www.cdc.gov/drugoverdose/pdf/pubs/2019-cdc-drug-surveillance-report.pdf

69 Ibid.

70 https://www.cdc.gov/mmwr/volumes/66/ss/pdfs/ss6619.pdf

71 Indian Health Service, Fiscal Year 2023 Congressional Justification, CJ – 111, available at: https://www.ihs.gov/sites/budgetformulation/themes/responsive2017/display_objects/documents/FY2023BudgetJustificaton.pdf, accessed on: March 6, 2023.

72 Walls, et al., Mental Health and Substance Abuse Services Preferences among American Indian People of the Northern Midwest, COMMUNITY MENTAL HEALTH J., Vol. 42, No. 6 (2006) at 522, https://link.springer.com/content/pdf/10.1007%2Fs10597-006-9054-7.pdf, accessed on: November 20, 2022.

73 Kathleen Brown-Rice, Examining the Theory of Historical Trauma Among Native Americans, PROF'L COUNS, available at: http://tpcjournal.nbcc.org/examining-the-theory-of-historical-trauma-among-native-americans/, accessed on: November 22, 2022.

Local adaptations of culturally sensitive treatment protocols are needed to address the significant diversity among AI/ANs, as there are important differences in the language, culture, customs, and community identities between the 574 federally recognized AI/AN Tribes. Cultural identity and spirituality are important issues for AI/ANs seeking help for substance abuse, and these individuals may experience better outcomes when traditional healing is incorporated with other treatment approaches.

There is also a need for funding to provide new approaches that incorporate alternative treatment modes such as behavioral health, alternative holistic therapy, physical therapy, and alternative pain treatment therapy to curt the overused and abused pain medications and reduce alcohol and substance abuse related health disparities.

Breaking the cycle of addiction is paramount. Breaking the cycle means that we must prevent and offer early intervention with our at-risk youth and expand the scope of treatment in Youth Regional Treatment Centers. ASAP funds are needed to hire professionals and staff intermediate adolescent services such as group homes, sober housing, youth shelters, and psychiatric units. Our communities need increased adolescent care and family involvement services, primarily targeting Psychiatry Adolescent Care. Science is starting to catch up, but there is a need for a paradigm shift in thinking to break down the stigmas that are a barrier to addressing the disease of addiction.

In addition to funding needed to support detox and rehabilitation services, Tribes have also reported a critical need for aftercare services and transitional housing. Time and again, Tribal members are re-entering the community or reservation without access to professional support services to prevent them from falling into the same crowds and behaviors that led to past abuse. Additional funding should be directed to support groups, sober-living opportunities, job placement and other resources to encourage a clean and drug-free lifestyle.

Funding that aids prevention and education and promotes healthy choices that align with cultural traditions is vitally important for AI/AN communities. Individual Tribal communities must have the ability to respond to and address their specific emerging concerns. Commercial tobacco use, domestic violence rates, and sexual and domestic abuse join the rising concerns of many Tribal Nations.

Domestic violence rates are alarming, with 4 in 5 AI/AN women experiencing violence in their lifetime.[74] The need to address issues of violence and sexual and domestic abuse against AI/AN women is critical in breaking the cycle of violence and addiction. This is apparent in the alarming statistics among Alaska Native children regarding witness to violence and the serious implications from this exposure in relationship to children's cognitive development. Consideration must be given to The National American Indian/Alaska Native Behavioral Health Strategic Plan as it provides a comprehensive approach to address alcohol and substance abuse and its tragic consequences, including death, disabilities, families in crisis and multi-generational impacts. Paramount is the focus needed to integrate and align primary care and behavioral health services with each Tribal Nation's cultural traditions.

Despite Tribal objections, funds continue to be allocated at the discretion of the IHS Director and through competitive grants. For over a decade, Tribes have noted that IHS' reliance on funding distribution via grant programs undermines the federal trust responsibility and Tribal self-determination. Tribal Nations suffering more from alcohol addictions than from meth or opioids, have the inherent right to design their respective programs to meet the needs of their communities. However, due to grant restrictions, Tribes are required to follow the predetermined guidelines of the grants. Furthermore, because grant funding is never guaranteed, vulnerable communities with the greatest needs but least capacity often slip through the cracks. The needed funding increases must be applied to the IHS funding base and away from the inefficient use of grants to stabilize programs. This will ensure program continuity and stabilize the care our struggling Tribal members and their families need.

74 Rosay, André B., "Violence Against American Indian and Alaska Native Women and Men," NIJ Journal 277 (2016): 38-45, available at http://nij.gov/journals/277/Pages/violence-againstamerican-indians-alaska-natives.aspx.

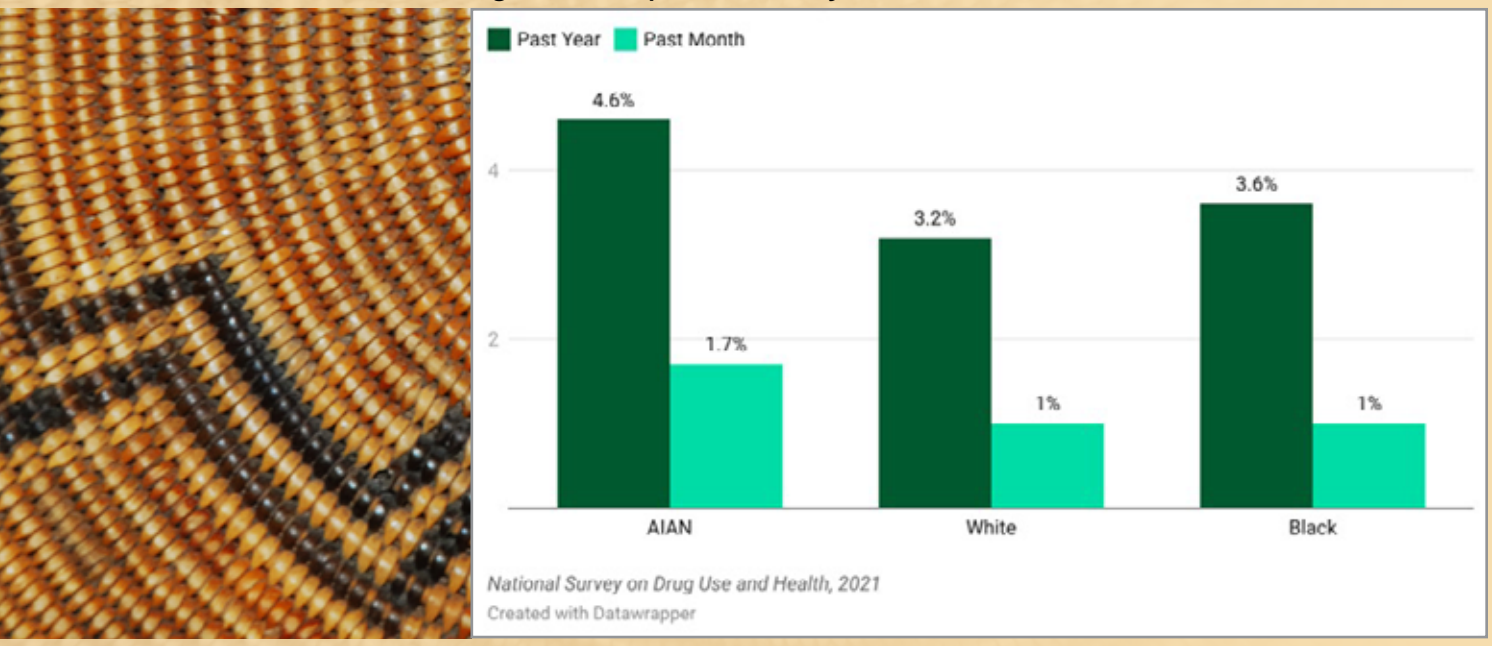
The Opioid/Fentanyl Crisis

Tribal communities are in crisis with increased opioid/fentanyl use and record overdoses of AI/AN people. While many of the Workgroup's recommendations are to address systemic inequities caused by chronic underfunding of the United States' treaty and trust obligations, certain emergent or accelerating issues are so dire that the Workgroup requests this Administration's immediate attention. The Workgroup recommends that the United States fully fund Tribes and Tribal and urban organizations to fight the opioid/fentanyl crisis in Indian Country.

Tribes across the country came together in August 2023 for the National Tribal Opioid Summit (NTOS) to consider the solutions, collaboration, and policy recommendations to directly address the devastating impacts of fentanyl and opioid drug abuse in Tribal communities nationwide. The Summit was widely attended by over 1,000 Tribal leaders, frontline workers, and federal and state policymakers, and the anchor of the evening was a panel of Tribal citizens who candidly and vulnerably shared their lived experiences with opioid misuse, either as former users now in recovery or as affected family members. The resulting NTOS Federal Policy Recommendations[75] include funding recommendations to address this crisis.

Nearly 28% of AI/AN's reported using illicit drugs within the past month compared to 15% of among NHW and 16.5% among African Americans. The rate of illicit drug use for AI/ANs is nearly twice as high compared to the rate for NHW in the United States. Additionally, the rates of misuse for opioids, prescription pain relievers, and other prescription misuse were highest among AI/ANs compared to other U.S. populations. Specifically, nearly 1.7% of AI/ANs reported opioid misuse within the past month compared to 1.0% for NHW and African Americans, respectively. In general, AI/ANs had higher in the past month and past year opioid misuse compared to other racial groups (Figure 2.0).

Figure 2.0 – Opioid Misuse by Race[76]



75 2023 National Tribal Opioid Summit Federal Policy Recommendations. Accessed at https://www.npaihb.org/wp-content/uploads/2023/12/NTOS-Report.pdf.

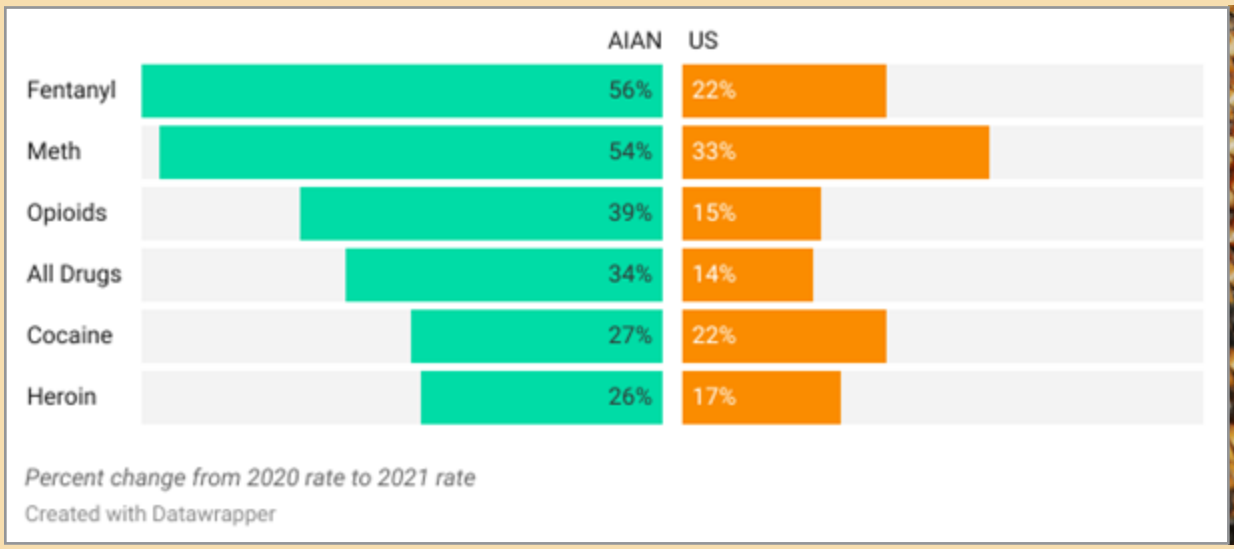
76 National Survey on Drug Use and Health, Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. NSDUH 2021 Detailed Tables. Accessed February 27, 2023.

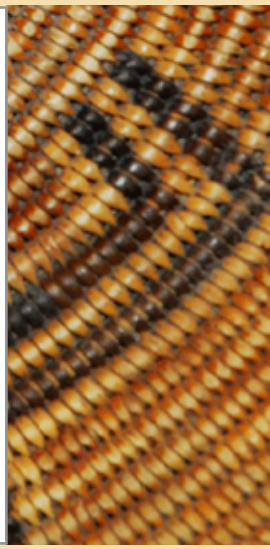
In 2023, nationally, the rate of age-adjusted drug overdose mortality for Non-Hispanic AI/ANs was nearly twice that of NHWs (63.6 deaths per 100,000 and 33.1 deaths per 100,000, respectively).[77]

In 2023, the age-adjusted opioid overdose and fentanyl overdose mortality rates among Non-Hispanic AI/AN were 49.4 per 100,000 and 46.5 per 100,000, respectively. The rates for Non-Hispanic AI/AN were double that of NHWs. Among NHWs, the opioid overdose and fentanyl overdose mortality rates were 25.5 per 100,000 and 23.2 per 100,000, respectively.[78]

The largest single-year change in drug overdose deaths for AI/ANs in the U.S. came from fentanyl-associated overdose deaths (i.e., synthetic). Fentanyl overdose deaths increased by 56% from 2020 to 2021 among AI/ANs followed by methamphetamine (54% increase) and opioid (39% increase) overdose deaths, respectively. For the U.S. general population fentanyl overdose deaths increased by 22% while opioid overdose deaths increased by 15% (Figure 2.1).

Figure 2.1 Overdose Deaths by Category of Drug





CURRENT FUNDING

The I/T/U health system is addressing the opioid/fentanyl crisis with IHS substance use and mental health funding. Annual IHS increases are not enough to address the need, and Tribal and State Opioid Response Funds are limited in how they can be used. In 2021, IHS launched a 3-year pilot opioid grant program called the "IHS Community Opioid Intervention Pilot Program and the Substance Abuse and Suicide Prevention Program" (COIPP).

Awards were issued in FY 2021 at $16 million and continued in FY 2022. Only 35 Tribal and UIOs were funded under this program. All I/T/Us must be fully funded to address this crisis in their community, with an option for Tribes to receive funds in their ISDEAA Contracts and Compacts.

The IHS Division of Behavioral Health administers this pilot project and other community-based grants and cooperative agreements to address mental health and substance use needs. Tribes were disappointed that IHS created the grant pilot project because they have been asking for IHS to support an option for Tribes to receive Behavioral Health Initiative funds through ISDEAA contracts and compacts.

77 Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Provisional Mortality on CDC WONDER Online Database. Data are from the final Multiple Cause of Death Files, 2018-2023, and from provisional data for years 2024 and later, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/mcd-icd10-provisional.html on Mar 5, 2025

78 Ibid.

The Opioid/Fentanyl Crisis, continued

IHS must create this option to streamline funding to Tribes.

TRIBAL RESPONSE

Tribes request a pandemic-type response to address the opioid/fentanyl crisis in their communities. Cross-agency collaboration and a significant influx of funding over several years would allow Tribes to address, respond, and eradicate opioid/fentanyl use among their people. Tribes also need funds distributed quickly and should not be burdened by grant administrative processes. Opioid funding from all HHS agencies must be transferred to IHS for distribution to Tribes through existing funding mechanisms, including an option for Tribes to receive funding in their ISDEAA compacts and contracts. This was a successful practice during the pandemic (e.g., Centers for Disease Control and Prevention Funding to IHS).

Siloed funding does not allow Tribes to comprehensively address the opioid crisis in their communities or allow the I/T/U health system the flexibility to develop culturally tailored and holistic programs that meet the needs of their communities. Cultural interventions and Tribal-based practices are critical to prevention, healing and recovery. In addition, other agencies must work with Tribes to address, for example, housing, law enforcement and judicial system issues, to ensure a comprehensive response.



Purchased/Referred Care: $12.63 billion (+11.59 billion)

For FY 2027, the Workgroup recommends a total of $12.63 billion (+$11.59) for the Purchased/Referred Care (PRC) program. PRC budget increases have historically been the highest prioritized recommendation since the inception of the IHS Budget Formulation process because of this program's importance.

PRC was established to allow IHS and Tribally-operated facilities to secure essential health care services from private sector providers when such services are unavailable within our systems. Much of the secondary care and nearly all the tertiary care provided in Indian Country is purchased from non-IHS facilities. PRC funds are used to purchase these essential health care services, including inpatient and outpatient care, emergency ambulatory care, transportation, and medical support services, such as diagnostic imaging, physical therapy, laboratory, nutrition, and pharmacy services.

There are a limited number of IHS-funded hospitals in existence, with several IHS Areas without a single IHS-funded hospital to provide inpatient, emergency, and specialty care services. When IHS or Tribally operated health facilities do not have the resources or capacity to provide needed care, they contract health services from private providers through the PRC program.

Despite PRC budget recommendations being one of the highest budget priorities, PRC funds are woefully inadequate to pay for the full scope of necessary care. PRC funds generally pay for only the highest priority levels of care, such as emergency care or services where life or limb tests apply and transportation costs to receive such care. IHS and Tribally operated facilities are often in isolated, rural areas where specialty care providers are not located, requiring patients to travel long distances to receive care. Tribal communities face systemic and long-standing health care challenges, with fewer specialty care physicians, mental health professionals, and acute care hospitals compared to urban and non-Tribal areas. Due to these issues, PRC programs in rural PRC delivery areas experience extraordinary medical costs associated with securing treatment for their patients.

Eligibility requirements for the PRC program are more restrictive than for services provided directly through an IHS or Tribally operated facility. All PRC services are prioritized according to a medical priority level system designed to ensure that the program provides resources only for the most serious medical conditions. In 2024, IHS moved to four priority levels, Preventive and Rehabilitative Services; Medical, Dental, Vision, and Surgical Services; Reproductive & Maternal/Child Health Services; and Behavioral Health Services, with Priority One services defined as "essential", Priority Two services as "necessary", Priority Three services as "justifiable", and Priority Four services as "excludable".[79,80] Funds permitting, PRC programs initially pay for the highest priority services, and then all or some of the lower priority services. Not all requests for PRC program funding are approved.[81] PRC requests may be denied because the patient did not meet PRC eligibility requirements, or because the services were not within the medical priority for which funding is still available. When this happens, patients may be denied approval for further care. In FY 2022, IHS reported denying or deferring an estimated $552 million for over 119,000 services for eligible AI/ANs, IHS considers PRC denials and deferrals as a measure of unmet need.[82] Given that Tribally managed PRC program data is not included, it is an understated measure of unmet need.[83] AI/ANs have higher incidence of cancer, with the type of cancer varying by PRC region.[84] AI/ANs also have "*the lowest survival rates for nearly all types of cancer of any subpopulation in the United States, with cancers often detected at later stages*".[85] Delays in early screening, specialty care, and local access to treatment lead to serious diseases not being identified while at a treatable stage.

79 Department of Health and Human Services, Fiscal Year 2025 Indian Health Service Justification of Estimates for Congressional Committees. CJ-95.

80 Indian Health Service. Purchased/Referred Care Fact Sheet. Dec 2024. Accessed Mar 3, 2025.

81 Ibid. CJ-95.

82 Ibid. CJ-97.

83 Ibid.

84 Melkonian SC, Weir HK, Jim MA, Preikschat B, Haverkamp D, White MC. Incidence of and Trends in the Leading Cancers With Elevated Incidence Among American Indian and Alaska Native Populations, 2012-2016. Am J Epidemiol. 2021 Apr 6;190(4):528-538. doi: 10.1093/aje/kwaa222. PMID: 33506248; PMCID: PMC8026484.

85 Cancer Control in American Indian and Alaska Native Populations: A Conversation with Dr. Shobha Srinivasan. National Cancer Institute. Apr 28, 2018. Accessed Mar 3, 2025.

Tribal health programs rely on third-party collections from payers like Medicare, Medicaid, and private insurance to pay for ongoing operations, including staff payroll and facility maintenance. For many Tribal Nations operating Tribal health programs under the self-governance authorities in Title V of the ISDEAA, third-party reimbursement can constitute up to 60 percent of their health care operating budgets.[86] While Medicaid Expansion has improved the ability for many facilities to approve PRC requests for higher medical priority levels by reducing the amount of funds the facility must spend on other health care priorities, this is not the case for all Tribes. The provision of health care services is a trust and treaty obligation of the federal government, Tribal Nations and their citizens should not be forced to ration care because of funding shortfalls.

With no annual program increases to PRC or additional funds for population growth and medical inflation, Tribal Nations are forced to cut health services to absorb these costs. For the IHS Areas with few or no IHS-funded hospitals, the health care delivery consequences are crippling. Through the IHS Director's Workgroup on Improving PRC, a PRC distribution formula was developed with a hospital access measure that would increase funding for those Tribal health programs without access to an IHS-funded hospital — often referred to as the "access to care factor." However, the access to care factor is only funded when there are funding increases (above inflation and population growth) to the PRC budget. The PRC program budget has been essentially flatlined in the appropriations process for the last six years. Increases in funding are also impacted by high PRC "unobligated balances" carried forward by IHS federally operated programs. Although unobligated PRC balances have been reduced in Q1 FY 2025 to 15%, if IHS continues to carry forward high unobligated balances in the PRC program Congress will be hesitant to provide increases in funding.[87] PRC programs, a consistently high-ranked value to the Tribes, remain severely underfunded, restricting access to comprehensive health care services, and health equity for AI/ANs remains out of reach. Substantial increases to PRC are needed to improve health outcomes, increase access to health care, and reduce health disparities among the AI/AN population. The federal government has a legal responsibility rooted in the U.S. trust and treaty obligations to Tribal Nations to address this crisis.

Indian Health Care Improvement Fund: $4.57 billion (+4.5 billion)

In FY 2027, the workgroup recommends a total of $4.57 billion for the Indian Health Care Improvement Fund (IHCIF) to address the Indian health system's significant funding disparities within IHS among Areas and Tribes within each Area. Historic allocations of resources appropriated to the IHS have created significant inconsistencies throughout the system. Over the years, allocation methodologies have created a disparity of available resources by line item when reflected in a per capita amount. Because of its limited funding, in FY 2023 IHS spent only $4,078 per user population compared to the average national health care spending in FY 2022 of $13,493.[88] However, some IHS areas and Tribes are not even funded at the IHS national average of $4,078 per user. This is because some Tribes had a small funding base from the start. Consequently, when increases are provided based on historical funding, the inequity is perpetuated, and the poor funding base minimizes the impact of such increases.

The IHCIA established the IHCIF to (1) eliminate the deficiencies in health status and health resources of all Indian Tribes; (2) eliminate backlogs in the provision of health care services to Indians; (3) meet the health needs of Indians in an efficient and equitable manner, including the use of telehealth and telemedicine when appropriate; (4) eliminate inequities in funding for both direct care and contract health service programs; and (5) augment the ability of the Service to meet health service responsibilities with respect to those Indian Tribes with the highest levels of health status deficiencies and resource deficiencies. Despite significant Indian health disparities and a legislative mechanism to address resource deficiencies and inequities via the IHCIF, 60% of all IHS sites in 2018 were funded at less than 50% of their "level of need" per user benchmark. The legislation also requires a Congressional report documenting the

86 Ibid. CJ-143.
87 Purchased Referred Care. https://www.ihs.gov/newsroom/factsheets/purchasedreferredcare/ accessed Mar 3, 2025.
88 Indian Health Service. (2022). IHS Profile. Retrieved from: https://www.ihs.gov/newsroom/factsheets/ihsprofile/.

funding level needed to address the current health status and resource deficiencies for each IHS Service Unit, Indian Tribe, or Tribal Organization.

As indicated in the IHS' Indian Health Care Improvement Fund Workgroup Final Report dated July 15, 2023, Congress has only provided $258.9 million for distribution to IHS Service Units, Indian Tribes, or Tribal organizations through the IHCIF since FY 2000. Unfortunately, gains in parity are negated by rescissions and sequestration. Since the user population is increasing year over year and health disparities continue to grow, consistent funding is necessary to achieve the goals of the IHCIF. To that end, in its FY 2025 Congressional Justification, the IHS proposed the use of the IHCIF 2018 "level of need" analysis in an attempt to close the funding gap over five years at $11.6 billion. The proposal includes distribution of the $11.6 billion using the current IHCIF formula methodology, which allocates funds to sites with the lowest Level of Need Funded (LNF) percentages. While very worthy, this would fund the IHCIF at an average of $2.32 billion per year, which is far short of the Workgroup's FY2027 IHCIF request.

Finally, the FY2025 advance appropriations for the IHS left the IHCIF out of the appropriation, even though all other base budget line items were funded through advance appropriations. The IHCIF is designated as base funding under the IHCIA. The consequence was that the IHCIF appropriation was made outside of the advance appropriations process through a series of continuing resolution appropriations until an exception apportionment was approved by OMB to fund the IHCIF. This is counter to what the IHCIA prescribes. The IHCIF should be included in the advance appropriations; moving the IHCIF budget line item into the Hospitals and Health Clinics funding line would prevent this from happening in the future.



>>• PREVENTATIVE HEALTH •<<

Public Health Nursing: $1.23 billion (+$1.15 billion)

The Workgroup recommends $1.23 billion for the IHS Public Health Nursing (PHN) program. The PHN is a community health nursing program that focuses on promoting health and quality of life and preventing disease and disability through quality, culturally sensitive primary, secondary, and tertiary health promotion and disease prevention nursing services to individuals, families, and community groups in throughout Indian country.

Unfortunately, the funding levels for the program, like many others, hold back this successful program from its full potential. Home-based services, where available, 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.

Some PHN programs can use funds to supplement traditional food programs that focus on food choices that are not only culturally appropriate but considered healthy changes for AI/ANs. Others might support health system patient navigator assistance programs, tobacco cessation programs, cancer screening programs, onsite emergency care assistance, and community mental health support, and education programs. Fully funding the PHN program would provide a more reasonable level of PHN services within all Indian communities and would provide the funds necessary for Tribes to develop the foundation for a stronger infrastructure to implement Tribal public health authorities.

Health Education: $737.95 million (+$712.57 million)

The Workgroup recommends $737.95 million for the Health Education program. Health Education programs are an integral component of culturally appropriate primary, secondary, and tertiary prevention, as well as bridging the primary care gap with community health outreach and preventive education. The goal of the Health Education program is to help AI/AN people live well and stay well. Cross-cutting prevention approaches aimed at education-driven voluntary behavior change activities offer the best hope of improving disease-related AI/AN mortality and morbidity.

Health Educators provide a myriad of services such as injury prevention, sexual transmitted infection prevention education, promote preventative cancer screenings, and educating the community on immunizations. Health Educators help people navigate the health care system, improve adherence to health recommendations, and reduce the need for emergency and specialty services resulting in improved overall health status. Unfortunately, Health Educators are limited in the scope of services due to chronic underfunding.

Tribal communities are facing the morbidity and mortality of cancer, heart disease, diabetes, chronic liver disease and cirrhosis, suicide, and both unintended and intentional injuries resulting in death and/or disability. These health disparities can be addressed through primary prevention and care to Tribal communities. Preventive services provided by Health Educators who are trained to provide communities with education and awareness relating to preventive health, emergency response, and communicable diseases, has shown that health education and prevention works – such as HIV screening and colorectal screening.

Health Educators often serve a vital role in interpreting health education messages from English to a Native language, bridging the communication gap that can hold back Tribal public health. Health Educators are extremely valuable in Native communities by raising awareness of lifestyle choices and decisions, helping to prevent countless sick days for workers and students. Health Educators assist individuals to restore or maintain

optimal health and guide individuals to practice sanitary and hygienic habits that prevent crippling and deadly diseases from being transmitted.

Community Health Representatives: $1.22 billion (+$1.15 billion)

The Workgroup recommends $1.22 billion for the Community Health Representatives (CHR) program to expand CHRs and the services they provide. CHRs during the COVID pandemic have shown tremendous strength for their connection to communities and a bridge to health facilities. Due to their large contribution to the COVID pandemic many found them valuable and have reignited efforts to expand similar professionals such as community health workers nationally. As highly trusted members in the community for the last 50 years, CHRs deliver preventive health education and case management to Tribal members in home and community settings.

CHRs are the trusted messengers for public health, including addressing vaccine hesitancy, misinformation, and mistrust in medicine. Many continue to provide health information in our Native languages that is culturally relevant and appropriate with a focus on the holistic wellness that encourages Tribal members to receive health and public health services clinically and at home. CHRs are also considered a valued team member of the medical or patient-centered medical home teams whose role is to follow-up on patients discharged from health facilities.

CHRs are part of the direct provision of health services to AI/ANs and are authorized in IHCIA. Without the services provided by the estimated 1,600 CHRs employed across Indian Country, thousands of patients will not receive their necessary follow-up services, and many will have difficulty accessing health services only for health conditions to worsen. In FY 2018, IHS reported that more than half of the visits performed by CHRs were made to patients with chronic diseases. In short, CHRs help to bridge the gap between AI/AN patients and health care resources through outreach by specially trained Tribal community members. Therefore, the Tribal CHR programs must remain present in Tribal communities.

Inadequate funding for the CHR Program will result in insufficient staff to address the chronic health and infectious diseases that require constant follow-up, as well as affect high-risk clients who receive preventive health screening education, monitoring, patient assessments and home visits. Reductions for the CHR program will result in a serious public health threat wherein high risk, elderly and disabled clients with chronic diseases will be left without case management and home health care services such as bathing, personal care, feeding and medication adherence.

On the Ground Support

The CHR program is unique to each Tribal community's needs. Some Tribes use CHR resources for public health activities that coordinate complex eclectic services by CHR programs including health promotion, preventing tuberculosis, Rocky Mountain Spotted Fever (RMSF) public health prevention measures, animal control, and Narcan administration information to prevent death due to an opioid overdose. Without an adequate increase to maintain these efforts, Tribes who rely on CHR programs to coordinate and conduct preventive education efforts will have difficulty maintaining adequate health services to support to high-risk clients in need of screening, education, and monitoring visits.

Alaska Immunization: $48.88 million (+$46.60 million)

The Alaska Immunization program works to eliminate disparities in vaccine preventable disease by making sure that AI/AN people living in the state have access to vaccines. Alaska's immunization program includes coordination across Tribal health partners to coordinate and advocate for the needs of Tribal immunization programs, educate Tribal staff on immunization recommendations and vaccine preventable disease. Key immunization programs include the Hepatitis B and Haemophilus immunization (Hib) programs.

The Hepatitis B program was initiated in 1983 to prevent infections among a large population of Alaska Natives with or susceptible to the disease. It continues to provide this service in addition to evaluation of vaccine effectiveness and the medical management of persons with hepatitis and liver disease. The Hib Program started in 1989 with a targeted Haemophilus Influenzae type b prevention project in the Yukon Kuskokwim Delta and now focuses on maintaining high vaccine coverage in a continued effort to prevent communicable disease by providing resources, training, and coordination to Tribal facilities throughout Alaska. Alaska's geography necessitates innovation in program delivery and use of technology as many Tribal facilities are located in remote areas off any continuous road system. The Program maintains immunization practice procedures in partnership with Alaska's statewide CHAP to ensure Health Aides working in both urban and remote Tribal facilities have the resources needed to provide high quality vaccination services for Alaska Native families.

To support this extremely important program, the Workgroup requests $48.88 million to fund the Alaska Immunization program. Eighty percent of Alaskan Native communities are located off the road system. Rural residents travel an average of 147 miles one way to access the next level of health care, often by a combination of air and surface transportation. Supplies are limited and subsistence hunting is often relied on for food. The remoteness of many villages means they lack regular access to law enforcement, courts, or related services, including internet and broadband access.

The 1918 influenza (flu) pandemic was devastating for Alaska Native communities. Some historians estimate that 8 percent of the Alaska Native population died from the flu, resulting in some villages being reduced to a single household. Villages were abandoned and surviving members moved to join other villages. History, language, and culture were lost for many Native communities. The Alaska Immunization program works to ensure that this atrocity will never happen again.

The Hepatitis B Program

Viral hepatitis, including hepatitis B, and other liver diseases continue to be a health disparity for AI/ANs in Alaska. The Alaska Native Tribal Health Consortium (ANTHC) Hepatitis B Program continues to prevent and monitor Hepatitis-B infection, as well as Hepatitis-A, immunizations maintained high vaccine coverage rates; health curricula, workforce policy and educational materials for patients as emerging health risks effect the populations.

The Alaska Immunization Program works to eliminate disparities in vaccine-preventable disease in Alaska Native people. Through strong collaboration with local Tribal health partners and regional immunization coordinators, the State of Alaska Immunization Program and the IHS Area Immunization Program, the Alaska Immunization program offers clinical expertise in advancing immunizations, vaccine reporting and data management capacity in an environment of evolving and expanding electronic health record systems. The immunization program works with statewide Tribal health partners to coordinate and advocate for the needs of Tribal immunization programs, educate Tribal staff on immunization recommendations, and administer vaccine for preventable disease in Alaska Native communities. Especially in a time when measles, a highly communicable disease that was eradicated in the United States by the year 2000 is showing an increased number of outbreaks across the nation in recent years, it's extremely important that the Alaska Immunization program receives adequate funding.

National Governor's Association State-Tribal Case Study

Building on the Alaska Immunization program, state and Tribal leaders co-led the COVID-19 vaccination effort including allocation, distribution, funding, and communication. As a result, many Alaska Native people received COVID-19 vaccinations at significantly higher rates than the general population despite Alaska's geographic and transportation challenges. Alaska's state public health and Tribal health partnership for COVID-19 was built on a framework of collaboration and co-leadership that leveraged existing resources of the Alaska Immunization program. The National Governor's Association (NGA) featured this collaboration as an NGA state-Tribal case study that provides best practices for the states to replicate in their relationships with IHS and Tribal health programs.[89]

89 National Governor's Association. (August 2021). Partnering with Tribal Nations for COVID-19 Vaccinations: A Case Study of Alaska. Retrieved from: https://www.nga.org/publications/partnering-with-Tribal-nations-for-covid-19-vaccinations-a-case-study-of-alaska/

>>• OTHER SERVICES •<<

Urban Indian Health: $1.09 billion (+$998.11 million)

The United States has a trust responsibility to maintain and improve the health of AI/ANs no matter where they live.[90] To meet this obligation in urban areas, the federal government contracts with 41 UIOs, which operate over 80 facilities in 38 urban areas nationwide. UIOs were created in the 1950s by AI/ANs living in urban areas, with the support of Tribal leaders, to address severe problems with health, education, employment, and housing caused by the federal government's Termination[91] and Relocation[92] policies.

In 1976, UIOs were formally incorporated into the I/T/U system through the passage of the IHCIA. Today, the 41 UIOs are a fundamental and inseverable component of the I/T/U system, providing a wide range of health care and social services to our people in urban areas, including primary care, oral care, HIV treatment, substance use disorder treatment, behavioral health, elder services, diet and nutrition classes, and traditional medicine. Collectively, the 41 UIOs serve patients from over 500 federally recognized Tribes.[93]

The Workgroup recommends $1.09 billion for the IHS Urban Indian Health line item. UIOs only receive direct funding through a single line item – Urban Indian Health – an increase to this line item will ensure increased federal funding for services at UIOs as well as facilities costs and other expenses. UIOs generally do not receive direct funds from other distinct IHS line items, including the Hospital and Health Clinics, Mental Health, Alcohol & Substance Abuse, Indian Health Care Improvement Fund, Health Education, or any of the line items under the IHS Facilities account. Like the rest of the I/T/U system, UIOs are chronically underfunded, and the Urban Indian Health line item historically is just one percent of IHS' annual appropriation. Only a significant increase to the Urban Indian Health line item will allow UIOs to increase and expand services to address the needs of their AI/AN patients, support the hiring and retention of staff, and open new facilities to address the growing demand for UIO services.

Even with recent increases to the Urban Indian Health line item, the United States has failed to keep pace with medical inflation. Despite the Urban Indian Health line item nominally doubling between FY 2000 and FY

90 *See* 25 U.S.C. § 1601(1); Sen. Rpt. 100-508 (1988).
91 *See* 25 U.S.C. § 1601(1); Sen. Rpt. 100-508 (1988).
92 Act of August 3, 1956, Public L.aw 84–959, 70 Stat. 986.
93 Indian Health Service, *IHS National Budget Formulation Data Reports for Urban Indian Organizations: Calendar Year 2021*, https://www.ihs.gov/sites/urban/themes/responsive2017/display_objects/documents/IHS_National_Budget_Formulation_Reports_Calendar_Year_2021.pdf.

2020, in real dollars, the line item only increased by 3.7%[94] According to the United States Commission on Civil Rights, "the low funding federally appropriated for urban Indian health care is concerning, and likely fails to meet the obligations of the federal government under the trust relationship."[95] Funding for urban Indian health must be significantly increased if the federal government is to finally, and faithfully, fulfill its trust responsibility. It is imperative that any increase not be paid for by diminishing funding for the other branches of the I/T/U system, which is contrary to the trust responsibility the United States owes to all our people, no matter where they live.

Retain and expand eligibility for IHS UIOs to participate in grant programs

Because UIOs have long suffered from significant underfunding, they often must seek additional funding opportunities through grants to expand services and adjust to growing patient needs. Such additional funding includes programs such as the SDPI. As UIOs work to provide for the growing needs of urban AI/AN populations, their continued eligibility for grant or funding initiative opportunities is essential. The preservation of grant funds for UIOs should not impact the ability of grants distribution to transfer to direct funding for IHS and Tribal facilities.

Ensure UIOs are Included in Exemptions for Medicaid Reform including Work Requirements

Medicaid plays a critical role in fulfilling the trust responsibility to AI/AN people and affecting the national policy set forth in IHCIA. In 2023, over 2.7 million AI/AN people were enrolled in Medicaid, including 47% of AI/AN adults under the age of 65.2.[96] Establishing mandatory work requirements as a condition of Medicaid eligibility will have an outsized effect on AI/AN beneficiaries, as they do not consider specific economic conditions and unique challenges faced by AI/AN beneficiaries in fulfilling these requirements. Therefore, it is critically important to ensure all AI/AN beneficiaries are exempt from Medicaid work requirements. This must include AI/AN beneficiaries who receive care at all I/T/U facilities, including those beneficiaries who live off reservation and may receive services at UIOs. Notably, in 2022, 59% of the AI/AN population served at UIOs were Medicaid beneficiaries.[97] Ensuring UIO Native beneficiaries are included in this exemption is crucial to protecting the health care access of AI/AN people who rely on UIOs to provide critical health care services. Exempting all AI/AN beneficiaries from Medicaid work requirements is consistent with the trust responsibility and the national policy set forth in the IHCIA.

96 Analysis of 2023 American Community Survey (ACS) data (1-year estimates). Includes data on AI/ANs identified as "Alone" or "In Combination."

97 Indian Health Service. National Uniform Data System Summary Report 2022, Urban Indian Organization. https://www.ihs.gov/sites/urban/themes/responsive2017/display_objects/documents/2022_UIO_UDS_Summary_Report_Final.pdf.

94 National Council of Urban Indian Health, Is Funding to Urban Indian Organizations (UIOs) Actually Increasing?, available at: https://ncuih.org/wp-content/uploads/Is-Funding-to-UIOs-Actually-Increasing_D045_V3.pdf (last accessed May 2, 2022).

95 U.S. Comm'n on Civil Rights, Broken Promises: Continuing Federal Funding Shortfall for Native Americans (Dec. 2018), available at: https://www.usccr.gov/files/pubs/2018/12-20-Broken-Promises.pdf.

Indian Health Professions: $380.73 million (+$299.90 million)

The Workgroup requests $380.73 million for the Indian Health Professions program. Within Indian Country, both the IHS and Tribal communities face persistent challenges in recruiting and retaining qualified medical personnel for their facilities. Rurality and geographic isolation of IHS and Tribal facilities compound this issue, as does chronic underfunding. This issue underscores the critical need to cultivate AI/AN health professionals from Tribal communities. To address this, broader initiatives to encourage and facilitate the entry of AI/AN individuals into health careers must be implemented. Such efforts encompass facilitating access to federal and state-funded scholarships, increasing loan repayment programs, and fostering partnerships with educational institutions to provide necessary support and resources.

IHS and Tribal providers have long contended with provider shortages, significantly complicating the delivery of care to patients. The federal trust responsibility, upheld by the Eighth Circuit Court of Appeals in *Rosebud Sioux Tribe v. United States*, emphasizes the provision of health care as a fundamental obligation. In that case, the Court discussed the duty of the government to provide "competent physician-led health care," affirming its existence and reinforcement through the Snyder Act and the IHCIA. Appropriations must be made to fulfill this commitment and ensure the availability of "competent physician-led health care" across Indian Country. IHS and Tribal health providers and Tribal public health programs continue to struggle to find qualified medical and public health professionals to work in facilities due to being rural and programs serving Indian Country. Nearly half of the public workforce nationwide is considering leaving their positions within the next five years. According to the GAO, IHS and Tribes have an "average vacancy rate for physicians, nurses and other care providers of 25%." Current vacancy rates make it nearly impossible to run a quality health care program. With competition for primary care physicians and other practitioners at an all-time high, the situation is unlikely to improve without a substantial investment in staffing.

The federal government must leverage its existing resources towards fighting this problem. We encourage the continued support for National Health Service Corps (NHSC) placements throughout Indian Country. This support is made possible because of the automatic designation of outpatient IHS, Tribal facilities and UIOs that receive funds through Title V of the IHCIA as Health Professional Shortage Areas (HPSAs). Tribes are automatically designated as 'population' HPSAs. Automatic HPSA designations do not expire, but the Health Resources Services Administration (HRSA) advises that the designations need to be updated periodically to ensure that the score is accurate. We support the continued use of the auto HPSA to ensure that IHS and Tribal providers have continued access to providers.

The Indian Health Professions program should be fully funded to increase scholarships and loan repayments to be commensurate with other federal programs such as the VA and HRSA.

Additionally, loan repayments and forgiveness programs should be expanded for medical professionals providing care in severely underserved areas or returning to serve in their respective Tribal communities. These scholarships should include public health professionals, certified doulas, and nutritionists. The Workgroup also requests that the IHS Scholarship and Loan Repayment program be exempt from federal income tax withholding aligning it with other federal programs such as NHSC Program, the VA, and HRSA. These federal income tax laws and policies negatively affect students receiving IHS scholarships and loan repayments and discourage them from pursuing careers in IHS and Tribal communities.

Creating Opportunities for Native Scholars

Efforts to encourage AI/ANs into health careers include targeted scholarships, mentorship programs and community-based outreach. Recently, the Pascua Yaqui Tribe, collaborated with the University of Arizona, and Learning Undefeated to develop Rising Stars, with the vision to create a future of health care professionals of practitioners, researchers, dentists, pharmacists, nurses, psychiatrists and other professionals that represent the population they are serving. In 2020, Cherokee Nation opened the first Tribally-affiliated medical school through partnership with Oklahoma State University. This program includes residency positions for both AI/AN and non-Tribal individuals. These positions are designed to train graduates in the Cherokee Nation Reservation and encourage medical professionals to remain and provide care in Indian County. The Workgroup recommends including funding to create additional Tribally-affiliated medical school programs and funding for graduate medical education that will keep providers in Indian Country.

A portion of the recommended amount should be made available as part of the CHAP implementation in the lower 48 states. This would provide scholarship funding for students seeking a career as a CHAP provider. Additionally, a portion of the funding should be made available for grants to establish course work for Dental Therapists, Behavioral Health Aides and Community Health Aides at Tribal colleges, universities, and partner institutions. Expanding the use of these funds in this manner remedies

CHAP was initially developed in Alaska in the 1960s as a response to the shortage of health care professionals and issues with accessing health care by AI/AN in remote and rural areas.

The success of the program paved the way for its expansion to the lower 48 states. In 2016, the IHS consulted with Tribes and established the CHAP Tribal Advisory Group (TAG) in 2018. Since this time, the CHAP TAG has worked to adapt the program to meet the unique needs and diversity of Tribes across the nation. IHS has provided funding opportunities through grants for Tribes to plan, assess, and implement CHAP in their health programs. However, official CHAP activities remain unfunded. Despite the efforts of the CHAP TAG and Tribes, there has been limited support from IHS to progress CHAP development and expansion. In November 2024 the CHAP TAG was dissolved by IHS and Circular 24-16 was published without Tribal Consultation. IHS has seated the National CHAP Board with 10 of the 12 IHS areas represented. Their initial tasks are to draft National Standards and Procedures and oversee Area Certification Boards. Due to an undisclosed rationale, these are closed meetings, which is concerning for CHAP programs because decisions are being made without Tribal input, without communication, in a process lacking in consistency and transparency.

The Portland Area has been instrumental in expanding CHAP nationally. As of 2024 there are 65 CHAP providers in training in the Portland Area for all disciplines. The first CHAP Providers in the area were certified in 2023 by the Alaska CHAP Certification Board. On November 26, 2024, Portland Area IHS was officially notified by IHS Director Tso that the Portland

a major need for training in or near Tribal communities. Paid Internships that would start from an associate degree level all the way to a Doctorate or professional programs could be offered for Natives and non-Natives seeking employment to serve Tribal Health Care programs. These measures elevate our ability to train, recruit and retain AI/AN professionals and mid-level providers seeking to enter health professions through comprehensive efforts.

In conjunction with these efforts to develop and expand the Indian Health Professions workforce, the Workgroup recommends additional recurring resources for provider housing and development, maintenance and improvement for both IHS and Tribal sites for all provider types and interns/residents.

Area CHAP Certification Board was officially recognized and approved to certify Primary Dental Health Aide I's, Behavioral Health Aide's I-III, and Dental Health Aide Therapists. The Portland Area has five CHAP education programs. One Dental Health Aide Therapy Education Program, two Behavioral Health Aide Education Programs, one pilot Dental Health Aide Program and one pilot Community Health Aide/Practitioner Program. Those programs are accepting students from other Areas including Bemidji, Billings, Navajo, and Oklahoma. The Northwest Portland Area Indian Health Board (NPAIHB) hosted the first annual CHAP Symposium in 2023 and collaborated with Oklahoma to host the second annual CHAP Symposium in March 2025. NPAIHB also provides technical assistance to Tribes in other areas including California, Billings, Oklahoma, and more. The NPAIHB is working to develop an electronic Community Health Aide Manual for Practice (eCHAMP) and CHA/P curriculum, the first CHA/P educational materials developed outside of Alaska that are specific to a different region and Tribal health system. All Areas still struggle with provider shortages and retention challenges and CHAP expansion is more important now than ever.

Increased funding for CHAP expansion with the recognition that some Areas need seed funding to scope out and implement CHAP and other Areas need funding to support foundational education programs and continued operations is necessary to help maintain the Alaska program and for a successful CHAP expansion that will address health equity and social determinants of health. Federal CHAP infrastructure should be protective of CHAP, not directive. Therefore, funds should be readily available to the IHS Area Offices to support the development of area certification boards and other Tribally-driven activities for those areas that are actively working on CHAP. The CHAP budget should be increased to $60 million per year with an additional $200K for IHS Area Offices and an additional $2-4 million allocated per education program to the Tribe or Tribal organization operating a CHAP education program for Areas with education programs (including Alaska); for operation of those education programs CHAP funding to Tribes must be made available through ISDEAA contracting and compacting. Area Indian Health Boards and Tribal Epidemiology Centers should be funded through a separate funding structure to provide technical assistance and support to Area Tribes so they do not compete with specific Tribal needs for CHAP planning and integration. Increased and consistent funding would provide Tribes/Tribal organizations with the resources needed to train health aides, establish certification processes, and build administrative and clinical support systems. Such measures would strengthen the foundation of CHAP, enhancing its ability to address health care disparities, improve access to care in underserved communities, and support Tribal self-determination in health care delivery. By securing stable funding and fostering locally tailored solutions, CHAP can grow into a sustainable, culturally relevant program that improves health outcomes for Tribal communities nationwide.

Tribal Management Grants: $3.45 million (+$467 thousand)

The Workgroup requests $3.45 million for the Tribal Management Grant (TMG) program. Authorized through the ISDEAA, this program supports federally recognized Tribes and Tribal organizations (T/TO) in planning, preparing, or deciding to assume all or part of existing IHS programs, services, functions, and activities (PSFAs) through an ISDEAA Title I or Title V agreements. Additionally, the grant program helps existing ISDEAA contractors and compactors in further developing and improving their management capabilities.

The Tribal Management Grant Program includes four project categories:
- Feasibility study
- Planning
- Evaluation study, and
- Health Management Structure.

Feasibility, Planning and Evaluation projects are one-year grant programs, and the Health Management Structure program supports projects between one and three years.

- Planning grants are awarded up to $50,000. Awardees collect data to establish goals and performance measures for current PSFAs that a T/TO anticipates taking on under a Title I contract.
- Evaluation funds are awarded up to $50,000 and determine the effectiveness and efficiency of a program, or if new components are needed to assist T/TOs in making improvements to its health care delivery system.
- Feasibility funds are awarded up to $70,000 to analyze programs to determine if T/TO management is practicable.
- Health management structure (HMS) grants are awarded up to $300,000. HMS projects include the design and implementation of systems to manage PSFAs, such as EHR systems, billing, and accounting systems management, along with health accreditation review and recommendations for correction of audit material weaknesses.

While IHS prioritizes direct health services over this discretionary competitive grant program, Tribal Nations and Tribal organizations remain highly interested in exercising their sovereign right to assume all or part of their health care delivery systems. This aligns with the broader initiative to expand self-governance contracting and compacts across the federal system. The TMG program plays a crucial role in equipping Tribal Nations and Tribal organizations with the resources necessary to prepare for the assumption of any program.

Direct Operations: $131.25 million (+$24.94 million)

The Workgroup recommends $131.25 million for Direct Operations. The Direct Operations budget supports a multitude of services, including the development of health policy formulation at IHS, policy development for self-determination contracting, administering Tribal grant programs to expand Tribal self-determination efforts, and maintaining the Direct Service Tribes Advisory Committee (DSTAC).

As Tribes continue to assume greater self-governance and self-determination by choosing to contract or compact their health programs, the funding amount for Direct Operations has decreased on average by 2 percent per year.[98] IHS still owes a duty to those Tribes who continue to exercise their inherent sovereignty by electing to receive services directly from IHS.

Today, 18 Tribes choose to solely receive IHS direct services,[99] and there are 123 IHS-operated facilities providing direct health care operations,[100] in addition to the central oversight and management of personnel required

98 Indian Health Service, *FY 2024 Congressional Justification*, CJ – 185, available at: https://www.ihs.gov/sites/budgetformulation/themes/responsive2017/display_objects/documents/FY2024-IHS-CJ32223.pdf.

99 Indian Health Service. (2025). Direct Service Tribes. Retrieved from: https://www.ihs.gov/odsct/dst/#:~:text=DST%20Areas,(As%20of%20July%202021).

100 *Id.*

to operate IHS' facilities and administrative functions. Current resources provide for the direct operations of IHS' system-wide administrative, management, and oversight priorities at the discretion of the IHS Director that include:

- Continuing vital investments to enhance the IHS' capacity for providing comprehensive oversight and accountability in key administrative areas such as: human resources, property, acquisition, financial management, information technology, and program and personnel performance management.
- Improving responsiveness to external authorities such as Congress, the GAO, and the Office of Inspector General (OIG); and addressing Congressional oversight and reports issued by the GAO and the OIG to make improvements in management of IHS programs, such as the PRC program, quality oversight, and workforce.
- Addressing requirements for national initiatives associated with privacy requirements, facilities, and personnel security.
- Continuing to provide analysis and timely disbursement of binding obligations for CSC and Section 105(*l*) Lease Agreements to maintain internal controls and improve the accuracy of annual cost estimates.

Direct Operations and services remain a key function IHS' role in providing direct health care services. The President and Congress must consider Tribally driven, long-term solutions for the improved delivery of IHS direct services to Tribal citizens and the effective and efficient management of IHS inherently federal functions.

Self-Governance: $7.86 million (+$1.67 million)

The Workgroup requests $7.86 million to support and expand self-governance training and technical support through the Office of Indian Self-Determination and Self-Governance (OISDSG). This request supports an expansion of the IHS Tribal Self-Governance program and funding for Planning and Negotiation Cooperative Agreements to assist Tribes preparing to enter the IHS Tribal Self-Governance program. This line funds Tribal needs across IHS Areas and at Headquarters for any Tribe that has elected to participate in the IHS Tribal Self-Governance program. Additionally, this funding supports the IHS Director's Tribal Self-Governance Advisory Committee, which advises the IHS Director on Self-Governance policy decisions.

The OISDSG is responsible for a wide range of critical agency functions to honor the IHS relationship with Tribes and their citizens under the authorization of Title V of the ISDEAA. Title V authorizes Tribes and Tribal Consortia to enter Self-Governance compacts, self-determination contracts, and related funding agreements to assume federal PSFAs and associated Tribal Shares, placing the accountability of PSFA service provision with Tribal Nations. Today, Tribes administer over one-half of IHS resources through ISDEAA self-determination contracts and self-governance compacts.

Self-Governance Planning and Negotiation Cooperative Agreements

Title V of the ISDEAA provides the IHS statutory authority to enter Planning and Negotiation Cooperative Agreements. These agreements assist Tribes in planning and negotiation activities, technical assistance, analysis, and systems review are all part of those negotiation activities. IHS agency lead negotiators, Tribal technical advisors, and financial experts are required to help Tribes implement self-governance planning successfully. Two types of cooperative agreements are meant to assist Tribal expansions of self-governance programs. The first is the Planning Cooperative Agreement, which provides resources to Tribes entering or expanding Title V compacts. Costs supported by the planning cooperative agreements include legal and budgetary research, internal Tribal government planning, and organization preparation relating to the administration of health care programs. The second is the Negotiation Cooperative Agreement. This agreement provides resources to Tribes to help defray the costs of preparing for and conducting Self-Governance program negotiations. The design of the negotiation process enables a Tribe to set its priorities when assuming responsibility for IHS PSFAs, observes the government-to-government relationship between the United States and each Tribe, and involves the active participation of both Tribal and IHS representatives, including the OISDSG.

>>> FACILITIES <<<

Maintenance and Improvement: $1.90 billion (+$1.72 billion)

The Budget Formulation Workgroup recommends $1.90 billion to fully fund facility Maintenance and Improvement (M&I) in FY 2027. M&I funding is consistently ranked as a top priority of the Areas due to its essential and required purpose to ensure that patients receive services in well-functioning health care facilities that meet building and life safety codes, conform to laws and regulations, and satisfy accreditation standards and Medicare conditions of participation. Without sufficient M&I funding the continued deterioration of critical health facilities is the reality that AI/AN people experience across the nation whether they are served at an IHS facility or Tribally-owned or leased building.

Facility aging has increased costs and risks associated with maintenance and repairs, which is accelerated by funding deficiencies that allow backlogs to persist. This trend is accelerating as maintenance and repair funding deficiencies could not be fully corrected because the M&I budget was insufficient. The IHS' October 2023 Backlog of Essential Maintenance, Alteration and Repair (BEMAR) report for maintenance and repair is $792.2 million. The IHS Facilities Appropriations Advisory Board (FAAB) reported that this number is an under report by facility managers due to the limited amount of funding available for such projects.

Risks for Deferring Maintenance

When a facility is unable to keep up with its maintenance needs, the risk of failure increases. For example, to balance the budget, the informed decision is made to defer maintenance on an aging elevator system to save money. When the elevator suddenly stops working, the consequent financial damage and lost productivity is often many times greater than the cost the hospital would have incurred had it not deferred maintenance on the elevator. In fact, one report has calculated that waiting to replace a part or system until it fails will end up costing an organization the expense of the replacement squared. For example, if a hospital decides to defer maintenance on an aging water heater to save $500, it may end up costing $250,000 when the water heater leaks through the floor and damages adjacent floors and walls.

According to the 2021 Indian Health Service and Tribal Health Care Facilities' Needs Assessment Report to Congress, annual appropriations for M&I are approximately 1/3 of the industry standard practice, virtually guaranteeing sub-standard facilities condition by intentional Congressional design. Adequate funding is essential to ensure functional health care facilities that meet building/life safety codes, conform to laws and regulations, and satisfy accreditation standards. Investments that improve the quality of patient care improve our health outcomes, increase access, reduce operating costs and are, therefore, proven to be cost-effective.

Sanitation Facilities Construction: $1.15 billion (+$1.02 billion)

The IHS Sanitation Facilities Construction (SFC) Program – an integral component of IHS disease prevention and public health activities – has brought potable water and constructed or rehabilitated waste disposal facilities for AI/ANs and Tribal communities since 1960. As a result, the rates for infant mortality, the mortality rate for gastroenteritis and other environmentally related diseases have been dramatically reduced by about 80 percent since 1973. However, the need for adequate sanitation infrastructure remains critical as many Tribal communities still rely on aging community-based water and sanitation infrastructure (e.g. un-piped water or sanitation). The Workgroup recommends $1.15 billion for the Sanitation Facilities Construction program in FY

2027. The Workgroup also recommends that IHS create and fund an Operation and Maintenance account to support sanitation and water infrastructure that has already been constructed.

Water, solid waste, and sewage utility service delivery has not yet reached 100 percent across every AI/AN residential household. The provision of Indian sanitation facilities is a very important component of the overall effort required to achieve a reduction in waterborne disease outbreaks, a goal highlighted in Healthy People 2020 "Topics and Objectives" for Environmental Health. Safe drinking water supplies and adequate waste disposal facilities are essential preconditions for most health promotion and disease prevention efforts, as well as being a major factor in improving the quality of life for Indigenous people.

Lack of Sufficient Sanitation Facilities in Indian Country

All AI/AN communities and homes should have adequate access to running water and sanitation services, like most other homes in the United States. Yet, many rural Indian communities only have fractions of residential subdivisions connected to fully operating water and sanitation for both kitchens and bathrooms. These communities typically have a washeteria building (a combination of a water treatment plant, laundromat, with toilets and showers) that the entire community uses. Most of these communities haul their water from the washeteria to their home in a five-gallon bucket and haul their sewage from their home in a different five-gallon bucket. These communities rely on water hauled from rivers, streams, ponds or livestock water wells and stored in drums, with honey buckets or outhouses in place of toilets. This condition is no longer acceptable in the twenty-first century to have entire communities without in-home water and sanitation, living with third world sanitation conditions in the United States. Federal trust and treaty obligations need to be adhered to address health issues that are also livelihood issues for Tribal communities.



The Bipartisan Infrastructure Law (BIL) provided $3.5 billion over five years for the SFC Program to address the 2021 estimate for all reported sanitation deficiencies in the Indian health system. Despite the historic level of funding in the BIL for sanitation projects, current need and inflation now exceed the amount of funding that Congress provided. As with other infrastructure issues in Tribal communities, the need to complete sanitation projects remain great. The magnitude of the sanitation facility needs increase is due to the underlying challenges of construction cost inflation, construction material availability, material supply chain challenges, and failing of existing sanitation infrastructure. The IHS spend plan for the FY 2025 BIL allocation estimates that as of November 19, 2024 there were 1,241 SDS projects, totaling $5.9 billion in eligible costs and $1 billion in ineligible costs.[101] Clearly we can see that the $3.5 billion provided in the BIL will not be sufficient to meet the initial projected costs for SDS projects when the BIL was passed, not to mention the growing need of new projects. This is why it is imperative that Congress create a mechanism to protect the federal investment that has been made in those BIL projects that have been completed and those that will be built under the annual recurring SFC appropriation.

Under the IHCIA, IHS is authorized to provide operation and maintenance (O&M) assistance for, and emergency repairs to, Tribal sanitation facilities, when necessary to avoid a public health hazard or to protect the federal investment in sanitation facilities. However, resources have not been appropriated by Congress specifically for this purpose. The consequence of no resources for O&M support is that it leads to system failures which disrupt access and erodes success of the SFC program.

101 See IHS Dear Tribal Leader Letter, "The IHS Director writes to announce the Indian Health Service Fiscal Year 2025 allocation decisions for the $700 million appropriated to the IHS in the Infrastructure Investment and Jobs Act,:" January 7, 2025.



Without adequate funding and flexibility, Tribal citizens are living with no water and sanitation in their homes due to aging and failed infrastructure, which is too costly to repair. It makes no sense that funds can be used to initially provide water and sanitation to homes but cannot be used for ongoing maintenance and repair. Yet, many water and sanitation systems installed in homes just 10 years ago are failing, leaving members without access to water and sanitation services because of the astronomical cost to repair such systems, which were never adequately maintained. Therefore, investment to establish an O&M program is needed to provide for adequate maintenance and repairs for water and sanitation systems up to current industry standards.

Tribes are often forced to utilize their limited funds to support water and sanitation systems. In many instances support may not be available at all because the Tribes may not have the resources to carry out these functions that require engineering and/or technical support to maintain and repair. Continued dependence on this practice will not ensure proper operation and maintenance of sanitation projects and continue to shorten the useful life of existing sanitation projects or expedite the need for total replacement – driving up costs overtime. The unprecedented amount of funding for construction and repair of these facilities through the BIL underscores the need to protect the federal investment in these projects. This will help ensure sustainable lifecycle operation of water and sanitation systems. In order to accomplish this mission, the Workgroup requests the following:

- IHS should immediately establish an Operation and Maintenance program funded through the SFC account at $200 million annually.
- Direct as much funding as possible directly to projects. All regulatory and non-regulatory barriers preventing funds from directly reaching our unserved communities must be addressed. Any approach to supporting sustainable efforts on water and sanitation systems must be wholistic and include self-determination, address high construction costs and limited construction season for rural communities, workforce needs and climate change impacts on these systems. Many communities have remained unserved due to these barriers.
- IHS should fund all projects that are determined to be "unfeasible" in the Sanitation Deficiency System and weigh these funds toward projects that address higher level deficiencies or consider them for emergency project funding.
- Remove IHS SDS Cost Caps.
- Remove IHS SDS ineligible cost match requirements. IHS must work with those communities to address the required contributions. Tier one or Tier Two projects should not be passed over in any fiscal year because they do not have contributions for ineligible costs.
- Fund alternative energy systems to be designed and installed as part of sanitation infrastructure projects to reduce the operational cost.

Health Care Facilities Construction and Other Authorities: $2.54 billion (+$2.26 billion)

At an average age of approximately 37 years,[102] the current facilities infrastructure available for the IHS are outdated and grossly undersized for the identified user population, which has created crowded conditions for staff, patients, and visitors. In many cases, existing services have been relocated outside the main health

102 Indian Health Service, *Health Care Facilities Construction Facts Sheet*, 2016, available at: https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/factsheets/HealthFacilitiesConstruction.pdf, accessed on: March 8, 2023.

facility; often times to modular units, in order to provide additional space for primary health care services. These conditions cause challenges for staff and patients, lead to longer wait times, and result in inefficiencies within the health care system.

As the existing health care facilities age, associated building equipment and components are also deteriorating to a point of failure and the decreasing availability of replacement parts on aged equipment disrupt health care service delivery. The construction of new health care facilities alleviates many of the problems associated with the failing infrastructure and exorbitant costs on maintenance and repairs.

In some regions, there are no IHS facilities, and Tribes and Tribal organizations depend on specific parts of the IHS budget, while not being able to access others. Although the solution will not develop immediately, outdated and insufficient health care facilities increase costs throughout the system.

In 1989, Congress directed IHS to develop the current Health Care Facilities Construction (HCFC) priority system. Originally, there were 27 projects on the priority list, with six remaining today. Once those projects are funded, IHS is required to implement a new priority system which is outlined in the IHCIA. The Act encourages the establishment of Indian health care delivery demonstration projects and development of innovative approaches to address all or part of the total unmet need for construction of health facilities.

One Area demonstration project that may be effective is for essential specialty health care. Essential specialty care, which is taken for granted by everyday Americans, is lacking for IHS beneficiaries. IHS beneficiaries are forced into the grossly underfunded and overburdened Purchased/Referred Care (PRC) Program, are frequently left holding the bill, or too often, forego care because of the broken system. As previously mentioned in the Dental Services section above, sometimes specialty services go untreated until they become life-threatening and are financially and emotionally devastating for the family. Because IHS was unable to care for this beneficiary immediately, the agency paid even more for surgeries, a ventilator, additional medications, and staff, which was billed to the PRC program.

An important provision of the IHCIA allows the new priority system to establish an Area Distribution Fund in which a portion of health facility construction funding could be devoted to all Service Areas. It requires that the Secretary shall consult and cooperate with Indian Tribes and Tribal organizations, and confer with Urban Indian Organizations, in developing innovative approaches to address all or part of the total unmet need for construction of health facilities. It also requires each IHS Area to generate an updated priority list every three years for a combined submission of top Area priorities to the U.S. Congress. A robust consultation and conferring process will help to identify the most pressing facility and infrastructure needs in each Area and ensure that these needs are addressed more expeditiously.

Lastly, Tribal Leaders commend the IHS policy that all new HCFC funded projects include an additional 4% of the necessary resources dedicated to the incorporation of sustainability features into construction projects. Tribal values align with promoting human health and energy efficiency which lessens any negative environmental impact on our lands in the construction process.



Facilities & Environmental Health Support: $795.00 million (+$478.04 million)

Facilities and Environmental Health Support (FEHS) programs provide and support an extensive array of real property, health care facilities and staff quarters construction, maintenance and operation services, as well as community and institutional environmental health, injury prevention, and sanitation facilities construction services. The programs directly and indirectly support all IHS facilities performance measures and improved access to quality health services. The Workgroup requests $795 million for FEHS programs to staff and support its headquarters, regional, area, district, and service unit activities.



FEHS program activities include Facilities Support, Environmental Support and Office of Environmental Health & Engineering (OEHE) Support. Facilities support includes operations and management staff for facilities and staff quarter and construction management support. Environmental Health Support provides staff and operating costs for environmental health service, injury prevention, institutional environmental health, and sanitation facilities construction staffing. OEHE support includes IHS headquarters staff, engineering services staff and direct support and management of overall facilities appropriation services and activities.

The IHS delivers a comprehensive, national, community-based, and evidence-based Environmental Health program which has 5 focus areas: (1) Children's environment, (2) Safe drinking water, (3) Vector-born and communicable disease, (4) Food safety, and (5) Healthy homes. IHS works hard to identify environmental health hazards and risk factors in communities and propose control measures. Additionally, they conduct investigations of disease and injury incidents, and provide training to federal, Tribal, and community members.

Equipment: $643.26 million (+$609.58 million)

The Workgroup requests $643.26 million for the IHS Equipment program. Tribal Leaders and IHS are committed to providing the highest quality and level of care to the AI/AN people we serve. This program is needed to maintain quality bio-medical equipment, ensure the 1,500 Tribally and federally managed health care facilities are timely replaced, and perform preventive maintenance and repair of the over 90,000 biomedical devices.

Medical equipment has a significant level of complexity, typically having high installation and maintenance costs associated with it. Repair of components, training and service contracts are also high costs associated with highly technical medical equipment. As the demand for medical equipment to interface with EHR increases, the need for compatible equipment to replace outdated, inefficient, and unsupported equipment will greatly increase. The newer equipment will enhance speed, accuracy of diagnosis, heighten quality decision making, increase efficiency, quality, and productivity, thereby reducing referrals to the private sector and saving on PRC costs.

>>• SDPI •<<

Special Diabetes Program for Indians: $530.44 million (+$374.96 million)

The Workgroup recommends the permanent authorization of the Special Diabetes Program for Indians (SDPI), along with authorities providing Tribes flexibility in choosing how to receive SDPI funds: through ISDEAA contracts or compacts or through current grants.

Although Tribes appreciate the current SDPI funding which was established by Congress in 1997 to combat the disease that has ravaged our Tribal Nations, the funding amount between 2004 and 2024 remained stagnant at $150 million. After receiving its first increase in 20 years in 2024, the program is still only funded at $160 million. Today there are over 300 SDPI programs that serve approximately 780,000 AI/ANs. Tribes have lost over a third of their buying power due to medical inflation and population growth. Our major concern is that SDPI does not provide permanent funding, and the uncertainty creates barriers to continuity of care that is essential to optimal health. Many Tribal health services have experienced disruption of delivery of care related to sequestration which has resulted in a reduction of $3 million annually for FY 2022 and FY 2023. Tribes request grantees to be held harmless regardless of sequestration as any reduction in funding further harms grantees who are working diligently to extend the resources they receive through the grant cycles.

Many of our programs have experienced budgetary cuts, reductions in ability to purchase necessary diagnostic equipment, staff burnout, recruitment, and retention for health care providers in many areas are severely understaffed. Permanent funding would ensure the implementation and delivery of quality diabetes outreach, education, and prevention for the Tribal citizens we serve.

The recent short-term extensions of SDPI funding have continued to allow Tribal grantees in providing the necessary programming our patients desire and deserve, but Tribal Health Centers commitment to a plan of care that is strategically planned is hindered due to the lack of guaranteed funding if the SDPI is not permanently reauthorized. If the SDPI funding from FY 2024 onward is not renewed and increased or worse, is reduced, this will negatively impact resources and Tribal members' clinical outcomes will be adversely affected.

No public health program compares to the achievements of SDPI. SDPI is the only public health program in the nation to demonstrate a reduction in diabetes and pre-diabetes diagnoses, and the program's prevention of comorbidities has saved Medicare over $520 million in End State Renal Disease (ESRD) treatment costs The continued resources provided by SDPI funding would allow us to carry on life-saving diabetes prevention and management programming. Reduction in diabetes equals a reduction of comorbidity disease rates including ESRD, heart disease, and hypertension across Indian Country.

Secured permanent funding is the keystone toward prevention, health promotion, and diabetes awareness. Without permanent SDPI grant funding, preventative care, direct services, and community outreach will be difficult to sustain. Permanent reauthorization of SDPI is a common-sense approach that will support a highly successful program. The best path to success for the SDPI is to increase funding, discontinue the practice of competitive grants, allow for greater flexibility in how Tribes receive these funds through contracts or compacts, and to eliminate the practice of mandatory sequestration which reduces overall federal funds for that Fiscal Year that negatively impacts all Tribes who receive the SDPI resource. This also has a direct impact on program planning and implementation if funds are "piece-mealed" out to Tribes.

Food is Medicine

Tribal communities are frequently located in rural areas, presenting unique challenges, including economic hardship and limited access to adequate food resources. The Pascua Yaqui Tribe and the Tohono O'odham Nation reservations are located in a food desert, which exacerbates the scarcity of food within the community. A food desert is typically characterized by limited access to affordable and nutritious food options. For these communities, this geographic challenge impacts the ability of community members to obtain fresh produce, make healthy food choices, and have essential ingredients for balanced diets. Food affordability represents a significant concern within the community. To ensure communities have access to healthy, affordable food, it is imperative to reconnect these communities to the value of traditional foods that are critical to long-term disease prevention and improve health outcomes in a culturally responsive way. Additionally, it is imperative to emphasize the notion that food is medicine.



To improve access and affordability to these foods, the Pascua Yaqui Tribe and Tohono O'odham Nation — Healthy O'odham Promotion Program (HOPP) have created initiatives to reduce the impact of living in a food desert and reduce the burden of chronic disease. The Sonoran Desert plant life includes the saguaro cactus fruit, cholla cactus, prickly pear cactus, mesquite beans and wild spinach. These plants are used to make food that are rich in vitamins, fiber, protein and other micronutrients, that have been a traditional diet staple for the O'odham. The HOPP has a strong history of focusing on gardening and has taken various actions to prioritize gardening as a part of a broader effort to promote health, food sovereignty, and cultural revitalization through traditional agriculture. HOPP's mission is to empower Tohono O'odham to live healthy lives by providing diabetes and nutrition education, physical activity,

Recommendation: IHS must expand funds and recommend advanced appropriations for programs such as the Prescription Produce Pilot Program (P4) and the Special Diabetes Program for Indians (SDPI). This will support food sovereignty initiatives

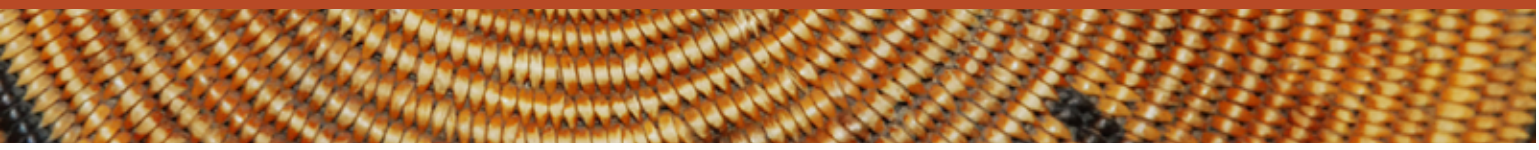
community outreach, and cultivating a healthy environment by providing opportunities, such as the gardening initiative to community members.

This HOPP initiative leverages its partnership with other programs such as the San Xavier Co-op Farm, Ramona Farms, Native Seeds, Tohono O'odham Community College, and the Tohono O'odham Recreation Centers to bring community members together in a healthy environment, while they learn how traditional foods grow and positively impact their health. The garden and harvest programs focus on:

- Traditional Practices: Utilizes dryland farming techniques and desert-adapted crops that thrive in an arid environment. Traditional harvesting for foods that grow naturally in the environment and have traditionally been used to sustain the O'odham.
- Health and Nutrition: Promotes the consumption of traditional, healthy foods as a way to combat health issues such as diabetes and other chronic diseases.
- Education and Community Engagement: Teaching gardening skills, traditional ecological knowledge, and incorporating community members of all ages.

The Pascua Yaqui Tribe has taken several steps to combat the challenges of providing healthy, affordable food to its members by leveraging different resources. To ensure access to healthy foods was addressed, the Pascua Yaqui Tribe created a micro-market initiative that aligns with disease prevention and health promotion. The micro-market initiative aims to reduce the incidence and impact of diseases, improving overall public health by providing programs that promote healthy lifestyles, balanced diets, and regular exercise. The micro-market initiative will provide and promote the consumption of wholesome foods, such as fruits and vegetables rich in essential nutrients, and minimize the intake of unhealthy processed foods, which can significantly reduce the risk of developing chronic conditions such as hypertension, high cholesterol, and diabetes. Additionally, the micro-market initiative activities will foster social, economic, environmental, and personal factors conducive to health by providing a space for promoting health education around food as medicine. A learning kitchen, registered dietitians, and food preparation will be pivotal to the initiative and will focus on offering locally grown vegetables and fruits to enhance access to fresh and nutritious produce but also support local farmers and promote community engagement.

The Pascua Yaqui Tribe was one of the five Tribes selected for the Prescription Produce Pilot Program (P4). The focus is to prevent diabetes and other chronic diseases. The aim of P4 is to demonstrate and evaluate the impact of produce prescription programs on AI/AN people and their families. More specifically, the overall goal is to improve health care outcomes by reducing food insecurity and improving overall dietary health by increasing consumption of fruits, vegetables, and traditional foods. This micro-market will allow members to utilize P4 vouchers locally.



and improve access to local and traditional foods, food education and preparation, and enhance local economic development to reduce food insecurity and prevent diabetes and other chronic diseases impacting our communities.

Conclusion

IHS funding is roughly 10 times less than the Workgroup's recommendation. It is time for the United States to uphold trust and treaty obligations to Tribal Nations through the full funding of IHS. Our communities and future generations' health outcomes rely on the sufficient funding levels of IHS, and we cannot afford to decrease the life span of AI/AN citizens again.

IHS, Tribal, and urban Indian clinics have celebrated the achievement of advance appropriations in FY 2024 and FY 2025 that created sustainability in our operations and services. Indian clinics were able to develop unique services and activities that contributed to strengthening cultural practices and utilizing best practices suited for our people. However, IHS advance appropriations should be expanded to include all IHS accounts and must be sustained until Congress fulfills its duty the way it was intended – as a mandatory obligation in the performance of a bargained-for exchange. Until Congress enacts this solution, the administration and Congress must prioritize advance appropriations for IHS through the discretionary appropriations process to ensure funding for health care services and critical facilities activities are not disrupted.

Many IHS programs, such as SDPI, have proven successful and resulted in cost savings for the federal government, yet remain under-resourced and uncertain. This program has proven to be effective at reducing the prevalence of diabetes among AI/AN adults[103] and has also demonstrated an estimated net savings to Medicare of up to $520 million over 10 years due to averted cases of end-stage renal disease.[104] Indian Country continues to stretch our limited resources. Still, the effects of inflation and the growing population require full and mandatory funding.

The United States can address AI/AN health disparities through the Workbook's funding recommendations. Tribal Nations seek no more than the duties affirmed and reaffirmed by the U.S. Constitution, treaties, statutes, court decisions, and federal administrative law. The United States' unique obligation to Tribal Nations requires increased investments and full funding for the IHS. The health, safety, and well-being of Indian Country is dependent on the United States' ability to adequately fund the Indian health care system so that we can enhance the quality of life for AI/AN people.

103 British Medical Journal: Prevalence of diagnosed diabetes in American Indian and Alaska Native adults, 2006-2017, available at: https://drc.bmj.com/content/8/1/e001218, accessed on: March 11, 2023.

104 HHS Assistant Secretary for Planning and Evaluation, Issue Brief: The Special Diabetes Program for Indians Estimates of Medicare Savings, available at: https://aspe.hhs.gov/sites/default/files/private/pdf/261741/SDPI_Paper_Final.pdf, access on: March 11, 2023.

4TH REQUEST:

Permanently Exempt Appropriations for or to all IHS, Tribes, Tribal organizations, and Urban Indian Organizations from Budget Cuts, Sequestration and Rescissions

As outlined by Tribal leaders throughout the IHS NTBFW's request and supported by numerous federal reports and findings, the IHS is chronically underfunded, with current estimates for full funding being roughly seven times greater than the amounts enacted by Congress. The IHS budget remains so small in comparison to the national budget that spending cuts or budget control measures would not result in any meaningful savings in the national debt, but would devastate Tribal Nations and their citizens and create the potential for life-or-death consequences in Indian Country. Further, any cuts or elimination of funding and services to Tribal Nations, our citizens, and communities is a violation of the federal government's trust and treaty obligations to provide for AI/AN health care.

Under the Budget Control Act of 2011, the IHS was not exempt from the automatic across the board cuts unlike other federal programs that serve the health of our nation's populations, such as Social Security, Medicare, Medicaid, the CHIP, and Veterans Affairs. Although the American Taxpayer Relief Act reduced the level of the sequester reduction for the IHS from 8.2% to 5.1% for FY 2013, even at that revised level, the IHS budget suffered a devastating cut of $225 million. The IHS has been chronically underfunded for decades, and the Indian health system has still not fully recovered from the effects of sequestration, which contributed heavily to the ineffective and insufficient delivery of health services in Indian Country. Now more than a decade later, given high rates of inflation and rising costs on top of those lasting effects from sequestration, further cuts to the IHS budget have the potential to create dire consequences in the Indian health system.

Several members of Congress publicly stated that the 2011 sequestration was clearly an oversight, and that IHS should not have been held to the full sequester. Nevertheless, the I/T/U programs were left with an impossible choice – either deny/reduce services or subsidize the federal trust obligation. In fact, many facilities did close their doors for several days per month due to lack of funding, and others were forced to only deliver PRC for Priority I, essential services. The IHS is one of only four federally funded services providing direct patient care; however, it was the only one of the four not exempted from the full amount of sequestration. This oversight, which created an unsafe hardship for Indian patients seeking care, must be permanently corrected. Tribal Nations are requesting Congress and the administration to amend prior statute or implement further legislation that will permanently and completely protect the IHS from sequestration. Any attempts to reduce the national budget or deficit must hold IHS programs and services harmless. All federal funding for I/T/U programs and services – especially funding for IHS which is charged with carrying out the trust obligation – is part of the US's trust and treaty obligations, and thus this funding is legally mandated.

Lost dollars result in the loss of health care practitioners and services through staff reductions and reduced access to basic health care. Many AI/ANs, 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. For some Tribal Nations, loss of a provider can result in life-or-death consequences for those communities. The trust obligations, which impact the lives and future survival of Indians, must be a priority for funding within HHS, this administration, and Congress. Until the IHS is fully funded, the promised health care that American Indians and Alaska Natives deserve will not become a reality.

As Congress considers funding reductions in FY 2027 or beyond, IHS must be held harmless. As we saw in FY 2013, poor legislative drafting subjected our tiny, life-sustaining, IHS budget to a significant loss of base resources, resulting in lasting effects that can still be felt within the Indian health system. Congress must ensure that any budget cuts, sequesters, or recissions – whether automatic or explicit – hold IHS and our people harmless. We cannot balance the budget on the backs of the First Americans.



5TH REQUEST:

Safeguard Special Provisions Within Medicaid, Medicare, and the State Children's Health Insurance Program

Medicaid

More than 48 years ago, Congress authorized the IHS and Tribal facilities to bill Medicaid for services provided to Medicaid-eligible AI/ANs to supplement inadequate IHS funding. The House Report stated, "[t]hese Medicaid payments are viewed as a much-needed supplement to a health care program which has for too long been insufficient to provide quality health care to the American Indian."[105]

Medicaid plays an integral role in ensuring access to health services for AI/ANs and provides critical funding support for the Indian health system overall through third party revenue. In fact, in many places across Indian Country, reimbursements from Medicaid have enabled Indian health facilities to provide medical services that were previously unfunded by the annual appropriations from Congress.

The Medicaid system is a critical lifeline in Tribal communities. Efforts that decrease already scarce Medicaid resources also jeopardize the ability to cover the cost of care and further restrict the eligible patient population. This puts an unequal burden on the IHS budget, which is dependent upon these resources to make up for funding shortfalls. The unique relationship between Medicaid and the Indian health system means that the administration has the tools it needs to allow states to design Medicaid programs that best fit non-Indian populations while simultaneously respecting Tribal sovereignty and maintaining Medicaid as a critical source of funds for the Indian health system. Like states, Tribal governments are in the best position to address the unique needs of their citizens and the Indian health system that serves them.

We urge the administration to work with Tribes and to strengthen its Tribal consultation practices on Tribal priorities so that fiscal strain does not unintentionally fall back to the IHS and Tribal health programs.

Also, important existing Tribal protections in the Medicaid program must be preserved. These include:

- An AI/AN who is eligible to receive or has received an item or service from an Indian health care provider (IHCP) or through referral under PRC is exempt from Medicaid premiums or cost sharing (such as deductibles and copayments) if the items or services are furnished by an I/T/U or through referral under PRC.
- If an AI/AN elects to enroll in a Managed Care Organization (MCO), they are permitted to designate an IHCP as their primary care provider.
- A state is prohibited from classifying trust land and items of cultural, religious, or traditional significance as "resources" for purposes of determining Medicaid eligibility for AI/ANs. Certain income and resources (including interests in or income from trust land or other resources) are also exempt from Medicaid estate recovery.
- An IHCP must be promptly paid at a rate negotiated between the MCO and provider, or at a rate not less than the amount an MCO would pay to a non-Indian health care provider.

105 Tribal Self-Governance "Maintaining Federal Funding for Medicaid Provided Through the Indian Health Service System". Accessed on April 3, 2025, available at https://www.tribalselfgov.org/wp-content/uploads/2017/01/One-pager-Medicaid-Reform-and-the-Indian-Health-System-No-branding.docx

Other Tribal protections and measures must be implemented. These include:

- Encourage states to maintain telehealth flexibilities adopted during the Public Health Emergency and to increase Medicaid telehealth reimbursement for IHCPs to the OMB encounter rate.
- Shield IHCPs from state benefit cuts and enrollment limitations using 1115 waivers to protect AI/AN beneficiaries.
- Establish standardized oral health care benefits for AI/ANs under state Medicaid programs.
- Extend 100% Federal Medical Assistance Percentage (FMAP) for Urban Indian Organizations.
- Work with states to help them file Section 1115 waivers to obtain Medicaid reimbursement for traditional practices.
- Authorize IHCPs to bill for all Medicaid optional services and services authorized under the IHCIA regardless of whether the State authorizes those services for other providers.

Medicare

Medicare plays an essential role in the Indian health system by providing additional coverage for AI/ANs who are elderly or have certain disabilities. Reimbursements from Medicare serve as a critical funding source for IHCPs and have enabled the expansion of services in many areas. Because of this, strengthening and expanding Medicare reimbursements for services can protect the financial health of the Indian health system.

However, many Medicare policies do not align with the trust responsibility or fit the Indian health system, and the program itself lacks the kinds of protections the Medicaid program offers. This must change to provide equitable health care services to AI/ANs, who are owed health care by the federal government.

Tribal protections in the Medicare program must be enacted. These include:

- Ensure that the IHS Outpatient Encounter Rate is available to all Indian outpatient programs that request it.
- Exempt AI/AN beneficiaries from Medicare premiums and deductibles, just as Medicaid cost sharing is waived.
- Permanently cover all telehealth services it permitted during the public health emergency, expand the types of services it permits to be conducted via telehealth, and expand the definition of permitted telehealth to include audio-only telephonic and two-way communication methods.
- Improve Medicare Part D by requiring plans to pay IHCPs without unlawfully imposing discounts as a result of an IHCP exercising its right to discounted pharmaceuticals under Section 340B or federal supply schedule.
- Require all Medicare Advantage (MA) plans to automatically deem IHCPs as in-network even if they do not enroll in a provider agreement and reimburse IHCPs at the OMB encounter rate. This automatic deeming and rate-setting should not supersede rates that an IHCP has negotiated and prefers over the OMB encounter rate.
- Require Medicare to reimburse IHCPs for 100% of the calculated cost of their services.
- Authorize reimbursement for traditional healing services through Medicare.
- Include Pharmacists, Certified CHAPs, Behavioral Health Aides/Practitioners, Dental Health Aide Therapists (DHATs), and other providers as eligible provider types under Medicare for reimbursement for all Medicare-covered services that are within the scope of their licensed or certified practice under applicable state, federal, or Tribal laws.
- Create a dental benefit under Medicare that does not require enrollment in managed care.
- Exempt I/T/U Durable Medical Equipment suppliers from the competitive bidding process.

Due to the chronic underfunding of the IHS, changes in Medicare, Medicaid, and the state CHIP have substantial effects on the quality of provision of care through the IHS. As a champion within the HHS, the Workgroup requests that IHS join Tribal leaders in calling on the administration and Congress to preserve and expand these critical programs.

6TH REQUEST:

End the Practice of Competitive Grant Making Where Not Required by Statute, and Distribute Funds to Tribes Through Indian Self Determination and Education Assistance Act Contracts and Compacts

Tribal Nations are not merely grant recipients; they are sovereign Nations that have a unique legal and political relationship with the United States as defined by the U.S. Constitution, treaties, statutes, court decisions and regulations. Therefore, funding to Tribal Nations must flow directly, consistently, and predictably. To meet its trust and treaty obligations IHS funding must be mandatory rather than discretionary, and Tribal Nations must have the option to accept all federal funding directly via streamlined channels, such as ISDEAA agreements. Health care funding should be consistent and arrive predictably to support long term changes that address the complex and chronic needs of AI/ANs. In stark contrast, grant programs are temporary, unreliable, non-recurring, and lack the flexibility necessary to address the ongoing, critical needs of Tribal communities.

Utilizing grant mechanisms to deliver on the United States' trust and treaty obligations undermines the unique priorities and individual responsibility of each Tribal Nation. It also forces Tribal Nations to compete for limited resources. This creates categories of Tribal Nations — those that have the staffing, technical experience, and financial resources to secure and manage competitive awards, and those that do not. Often, those that do not are the ones that would benefit the most from additional funding. Frustratingly, grant funding typically comes with excessive reporting requirements, means testing, and overall administrative burdens which fail to honor Tribal sovereignty and the unique nature of the federal trust and treaty obligation.

ISDEAA agreements would reduce and streamline administrative burden for Tribal Nations and the IHS, because awards can be made quickly, and federal oversight requirements are minimal. Tribes with ISDEAA agreements are subject to the Single Audit Act; the single audit is generally considered the most comprehensive type of audit for organizations receiving federal funds. Tribal Nations are ultimately responsible for those awards and are audited by external firms annually to ensure appropriate protocols are in place. These agreements also provide the opportunity for Tribal Nations to recover costs for oversight and management without reducing direct care through contract support cost (CSC) funds. Today, grants only allow for indirect costs, which can reduce direct care and services supported by granting mechanisms.

Further, despite Congressional directives, agencies like IHS continue to distribute some appropriations increases through grants to track the outcomes and performance of these funds to demonstrate the effectiveness of critical investments. The agency has also continued to distribute decades old increases through grant mechanisms even though Tribal Nations overwhelmingly support streamlined and formula-based distributions in Tribal consultation and public comments. Each grant program creates and supports federal administrative positions that, should distributions be made through ISDEAA agreements, would

reduce federal bureaucracy and allow essential programs and services to be more efficient and effective using less resources when administered via ISDEAA agreements.

In the previous administration, the IHS issued six grant announcements, some of which were new. Tribal Nations competed against each other for each of these separate grants, even though all experienced critical behavioral health and alcohol and substance abuse crises. In total, 135 awards were made for about $43 million across all six programs. None of the six programs awarded grants in all 12 IHS Areas, leaving many populations out. For example, the newly branded "Domestic Violence Prevention" program awarded 37 grants, 27 of which were provided to Tribal Nations across only eight of 12 IHS Areas and 10 Urban Indian health centers. IHS proposes that competitive grants reach the communities of most need, but this is not true. Instead, many Tribal Nations lack the capacity to apply for such programs.

The federal trust and treaty obligations to fund health care and public health in Indian Country cannot, and must not, be achieved through the competitive grant mechanism. By their very design, competitive grants create an inequitable system of winners and losers. The federal obligation to fully fund health services in Indian Country was never meant to be contingent upon the quality of a grant application – yet that is the construct that the federal government has forced Tribal Nations to operate under. Tribal Nations are sovereign governments, and funding for Tribal Nations, our citizens, and communities, is provided in fulfillment of legal and historical obligations. As a result, those federal dollars should not be subject to an inappropriate, grant-based mentality that does not properly reflect the diplomatic relationship between Tribal Nations and the federal government.



The NTBFW recommends that the United States uphold its trust and treaty responsibilities and distribute funding for all ongoing health services in FY 2027 directly through ISDEAA agreements using a fair and equitable formula. This will ensure sufficient, recurring, and sustainable funding for Tribal Nations, reduce federal administrative costs and better meet the federal government's trust and treaty obligations to Tribal Nations.

7TH REQUEST:

Authorize Federally Operated Health Facilities and IHS Headquarters to Use Federal Dollars Efficiently and Adjust Programmatic Fund Flexibility Across Accounts at the Local Level in Consultation with Tribes

The IHS funding through federal appropriations from Congress for the provision of health services. Funds are received by the agency and then distributed through several different mechanisms, including through IHS Area Offices, Tribal self-determination contracts and self-governance compacts under the ISDEAA, Urban Indian Organizations, and to federal service unit facilities. At issue is the ability of the federally operated health care facilities and IHS headquarters to use federal dollars efficiently and adjust programmatic funds across IHS accounts, especially at the local service unit level.

Current appropriations law often creates a barrier for the IHS to fully utilize authorized annual funding. For FY 2019 and FY 2020, the IHS was granted two-year authority to obligate/re-obligate funding, which has provided some needed flexibility to utilize its appropriation fully and efficiently. However, additional flexibility is still needed to allow IHS ability to reprogram funding if savings are achieved in one fund. For example, programs such as PRC severely lack funds to meet critical health needs, and services are often deferred or denied due to lack of funding. Such programs can benefit from reallocation of savings or reprogramming or transfer of appropriations to provide continued health services.

Fundamentally, the ability to direct resources is one of Tribal sovereignty and self-determination. Just because a Tribe chooses to receive direct services from IHS does not mean it forfeits these rights. The workgroup requests that IHS be granted greater budget flexibility, especially at the local service unit level, to reprogram or transfer appropriations to meet health service delivery priorities, in consultation with the Tribes who receive services from that share of the IHS funding.

8TH REQUEST:

Provide Recurring Funding and Flexible Authority to Build Tribal Public Health Infrastructure

AI/AN health advancement is limited by the aging public health infrastructure available to Tribal Nations. The Workgroup requests recurring funding and flexible authority to build Tribal public health infrastructure. IHS, Tribes, and urban Indian facilities currently do not receive dedicated public health funding from many HHS agencies. IHS can only provide limited public health and emergency preparedness infrastructure funding that is only available to IHS and Tribal clinics.

During COVID-19, the Indian health system received flexible supplemental funding to develop and expand public health infrastructure. The flexible spending extended the timeline for utilizing funds and allowed the Indian health system to spend dollars where they best saw fit. This flexibility allowed individual clinics to develop unique public health solutions for their local communities, including investing in the prevention, tracking, and monitoring of COVID-19, vaccinating Tribal citizens, purchasing updated diagnostic equipment, and developing local outbreak reports, among many others. Indian Country's unique model was so successful that it was replicated by local and state health jurisdictions to improve prevention and treatment efforts across the nation.

As sovereign governments, Tribal Nations have inherent authority and responsibility to meet their citizens' health care and public health needs. Other federal agencies like CDC, the Substance Abuse and Mental Health Services Administration (SAMHSA), the Administration for Children and Families, and HRSA must recognize this. Too often, we see funding and partnership structures from grant notices that focus on states and local governments but exclude Tribes. For jurisdictional comparison:

- Tribal Nations represent the 15th most populous state in the United States with the 8th largest landmass.[106]
- Collectively, Tribes are the 13th largest employer in the United States, employing both Native and non-Native citizens, contributing to economic growth in surrounding areas.[107]
- Approximately 260 miles of Tribal lands have an international border, or about 100 miles longer than California's border with Mexico,[108] and some Tribal citizens have treaty rights that permit them to cross international borders and possess specific rights within each country.[109]
- Shipping and travel logistics are multi-modal for Tribes, with some operating as airport authorities, others operating ferries and other transportation on U.S. waterways, and a growing number of Tribes conducting international business.

In 2024, the CDC awarded $4.3 billion through the Public Health Infrastructure Grants, which is one of the largest investments in the country's infrastructure. Yet, Tribes were left out, with the CDC noting to Tribal leaders that it transferred funding to IHS for this purpose. However, the Tribes did not see that funding. In June 2023, Congress rescinded $419 million of unspent funds from IHS under the Fiscal Responsibility Act. More recently, the FY 2024 IHS appropriation rescinded $350 million in unspent COVID-19 monies, much

106 As of 2021, there are 574 federally recognized Tribes with a Census-estimated population of approximately 7.2 million in 2021. In 2019, the Bureau of Indian Affairs stated that 70.2 million acres are recognized as Tribal lands.

107 Written Testimony of Patrice H. Kunesh, Director, Center for Indian Country Development, Federal Reserve Bank of Minneapolis, before the United Stats Senate Committee on Indian Affairs, Lending Opportunities: opening the Door to Homeownership in Indian Country, October 16, 2019, accessed on: February 6, 2024, available at: https://www.indian.senate.gov/wp-content/uploads/10.16.2019%20%20Kunesh,%20Patrice,%20Testimony%20CICD,%20MPLS%20Fed,%20SCIA%20%20-%20Final.pdf.

108 National Congress of American Indians, Tribal Nations and the United States: An Introduction, updated February 2019, accessed on: February 6, 2024, available at: https://archive.ncai.org/Tribalnations/introduction/Indian_Country_101_Updated_February_2019.pdf.

109 For example, the Jay Treaty of 1794 grants certain Tribal citizens on the U.S.-Canada border the right to pass and repass the border.

of which were earmarked for public health infrastructure. This process continues to reinforce an unequal system where states and localities receive support for public health infrastructure, but Tribes are left out. Congress and HHS must entirely rethink these structures to appropriately build in Tribal Nations as they work to improve the public health of the whole country.

The United States treaty and trust obligations are not singularly contained within one federal government agency, and the IHS cannot carry that burden exclusively. HHS can advance the health status of AI/ANs by ensuring dedicated resources, Tribal public health capacity, and infrastructure development are available to Tribes; flexibility and Tribal control in public health programs for Indian Country; conducting meaningful Tribal Consultation; and upholding trust and treaty obligations by directly investing in Tribal public health infrastructure.

EXPANSION OF TRIBAL SELF-GOVERNANCE AT HHS:
The Department should be working with Tribal leaders and the Secretary's Tribal Advisory Committee (STAC) to move forward with expanding Tribal Self-Governance in Indian Country. For decades, Tribes have requested that HHS work with us to craft a strong plan to support and implement this expansion.

TRIBAL FUNDING SET-ASIDES AND DIRECT FUNDING:
While full self-governance expansion remains the ultimate goal, the process may take time. In the meantime, we implore the Department to include Tribal set-asides for all federal programs that serve Indian Country and allow funding to be directly accessed by Tribes and not states. HHS must include broad Tribal access and eligibility to all programs serving Tribal communities. This also includes key block grants going to states like the Community Mental Health Services Block Grant, the Substance Use Prevention, Treatment, and Recovery Services Block Grant, the Preventive Health and Health Services (PHHS) Block Grant Program, and the Title V Maternal and Child Block Grant. Where statutory authority may not exist, we ask that HHS include adding direct Tribal funding to these programs through the A-19 budget recommendation process.



9TH REQUEST:

Ensure the Office of Management and Budget is Engaged in Tribal Budget Formulation for Meaningful Engagement

It is necessary for the OMB to honor the government-to-government relationship by engaging directly with Tribal Nations during the Tribal Budget Formulation. Direct and meaningful engagement between the OMB and Tribal Nations can improve transparency and efficiency when developing the Tribal Budget Formulation and ultimately strengthen our partnership.

OMB should reaffirm the unique treatment, programs, and services to Tribal Nations by working directing with Tribes during the implementation of Tribal Budget Formulation, based on their political and legal status as sovereign nations. The Indian health system experiences dire consequences when federal funding is frozen, paused, or eliminated. Improved relationships between OMB and Tribes can help to avoid confusion and disruption in the future.



To improve transparency with Tribal Nations, the Workgroup recommends the OMB maintain the operation of the Tribal Advisor to uplift the funding priorities of Tribal Nations directly to the OMB Director. Both emerging governance issues and ongoing government efficiency underscore the need for permanency in the position of Tribal Advisor to the OMB Director. The Workgroup also recommends that OMB create a Tribal Advisory Committee (TAC) to ensure consistency for Indian policy in all government matters. The TAC would be able to provide a wide-ranging perspective to OMB as they uphold presidential policies that have countless impacts on Tribal Nations and AI/AN people.

The treaty and trust obligations to the Tribes are not, and should not, be compartmentalized. Instead, having OMB expertise present and participating in meaningful national budget formulation is a step toward honoring those obligations.

Appendix:

TRIBAL BUDGET RECOMMENDATIONS, HOT ISSUES, AND SUCCESS STORIES BY IHS AREA



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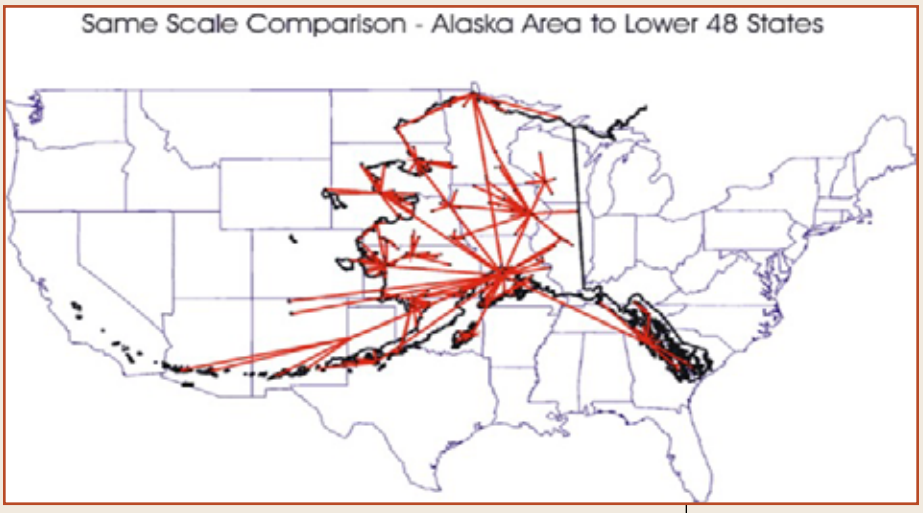
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Alaska Area



The Alaska Area offers the following budget recommendations for Fiscal Year 2027.

Profile of the Alaska Area

In the Alaska Area, Tribes and Tribal Health Organizations (T/THOs) collectively serve 241 communities. The Alaska Tribal Health System (ATHS) is a dynamic system that has risen to many challenges and has made great strides through both ingenuity and necessity. The ATHS consists of several levels of service, including Village Health Clinics, Sub-Regional Services, Regional-Hub Services, Statewide Services, and Tribal Care Coordination. In many rural areas of Alaska, T/THOs are the only healthcare providers available. As a statewide referral center, the Alaska Native Medical Center (ANMC) operates both the Quyana House and ANMC Patient Housing facility, which combined, provide 258 rooms for our out-of-town patients and their escorts. The furthest a patient has had to travel is 1,193 miles, from Attu Station to ANMC in Anchorage.

Budget Recommendations

1. Current Services & Binding Obligations:

The Alaska Area recommends $8.8 billion for current services and binding obligations. The IHS current services and binding obligations must include increases to ensure no loss of current services, to protect important programs and existing infrastructure. Severe and chronic underfunding of the Indian Health Service (IHS) has resulted in the loss of purchasing power and diminution of infrastructure, programs, and services over the years. This has resulted in a reduction of services and deferred maintenance of facilities and technological infrastructure. The Current Services request includes funding for non-medical inflation and medical inflation. The actual inflation rate for different components of the IHS are much greater, especially in rural Tribal areas including very remote locations in Alaska. Additionally, the cost of pharmaceuticals and other supplies has increased significantly, and these costs are driven by inflation.

The Alaska Native and American Indian (AN/AI) population suffers some of the highest rates of health disparities in the United States. In Alaska, the age-adjusted death rate for AN/AI adults exceeds that of the general population by 36% with deaths due to diabetes, chronic liver disease and cirrhosis, and accidents occurring at least three times the national rate, and deaths due to tuberculosis, pneumonia and influenza, suicide, homicide, and heart disease also exceeding those of the general population.

Medical supplies and construction materials have to be mailed/shipped to very remote and isolated Alaska Native communities. These shipping costs have a significant impact on remote and very rural communities. Approximately, 80% percent of Alaskan Native communities are located off the road system. It is not uncommon for residents to travel an average of 147 miles one way to access the next level of health care, often by a combination of air and ground transportation. Food and medical supplies are limited, and subsistence hunting is an essential source of food.

Significant increases in labor costs with high turnover require higher funding levels to operate facilities and maintain current services. Tribal health program areas are limited in the services they can provide every year due to budgets that do not increase with inflation and cost of living in frontier/ remote areas. Recruitment of health care staff for remote areas in Alaska has never been easy, Tribal health organizations incur significantly higher labor costs due to the necessity of having to use Locums Tenen health providers and extremely high salaries for many clinical functions just to be able to recruit and retain workforce.

2. Hospitals & Health Clinics:

The Alaska Area recommends a $30.7 billion program increase for the Hospital & Health Clinics (H&HC) account to support hospital and health clinic services. The H&HC funds ensure that comprehensive, culturally appropriate medical services are available. This is the core budget line item that makes available medical care services for AN/AI people, which also supports public health services in Tribal communities. IHS and tribally managed facilities continue to grapple with inadequate funding, which is slowly eroding the ability to deliver adequate services.

Increasing H&HC funding is necessary as it supports the following subline items: all primary medical care services, including inpatient care, routine ambulatory care; and medical support services, such as laboratory, pharmacy, medical records, information technology, and other ancillary services. In addition, H&HC funds provide the greatest flexibility to support community health initiatives targeting health conditions disproportionately affecting AN/AI people such as diabetes, maternal and child health, and communicable diseases.

The demands on the H&C budget remains an ongoing challenge for providers. In our facilities, we experience constant and increased demand for services due to the increased rate of chronic diseases that result in overwhelming patient workloads and significant costs of travel in a large vast state with many rural and frontier communities. This is exacerbated by rising medical inflation, difficulty in recruiting and retaining providers in rural health care settings, and the lack of adequate facilities and equipment, these resources are stretched. Increased H&HC funding is necessary to address both urgent health crises as well as basic primary and specialty high-cost health care needs.

3. Dental Services:

The Alaska Area recommends a program increase of $13.9 billion for Dental Services. 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 AN/AI children. Funds are used for staff salaries and benefits, contracts to support dental services, dental lab services, training, supplies, and equipment. More complex rehabilitative care (such as root canals, crowns and bridges, dentures, and surgical extractions) is extremely limited but may be provided where resources allow.

Oral health is a leading health indicator going beyond the mouth, gums, and teeth. Poor oral health is correlated to several chronic diseases including diabetes, heart disease, stroke, and is even associated with premature births and low birth weight. Frontier and rural communities in Alaska have had limited options and capacity to provide dental services. This challenge has forced innovation and has provided an evidence-based model in remote villages. Supporting Dental Services and oral health is essential in protecting overall health.

4. Immunization Alaska:

The Alaska Area recommends an additional $559 million for the Alaska Immunization Program. The Alaska Immunization Program works to eliminate disparities in vaccine-preventable diseases. The immunization program works with statewide Tribal health partners to coordinate Tribal immunization programs, educate Tribal staff on immunization recommendations, and administer vaccines for preventable diseases. Influenza, RSV, and COVID variants show that funding and support of immunization programs are more important than

ever to fight sickness and preventable disease in children and adults. The Alaska Immunization Program is a critical resource in ensuring that our rural and remote communities have access to immunizations that are hard to procure, the program provides access and health equity to vaccines.

The 1918 influenza pandemic was devastating for Alaska Native communities. Some historians estimate that 80% percent of the Alaska Native population died from the flu, resulting in some villages being reduced to a single household. History, language, and culture were lost for many Native communities as a result of the 1918 pandemic. The Alaska Immunization Program works to ensure that this atrocity will never happen again.

The Alaska Immunization program offers clinical expertise in advancing immunizations, vaccine reporting, and data management capacity in an environment of evolving and expanding electronic health record systems. The immunization program works to educate Tribal staff on immunization recommendations and administer vaccines for preventable diseases in Alaska Native communities with geographic and transportation challenges.

5. Maintenance & Improvement:

The Alaska Area recommends a $5.59 billion program increase for the Maintenance and Improvement (M&I) line item. M&I funds are the primary source for maintenance, repair, and improvements for IHS and tribal health facilities. Many facilities and clinics are in dire need of maintenance and improvement. With the average age of many Tribal facilities well beyond initial recommendations or design, the need to adequately fund the upkeep is essential to prolonging the usability of such facilities. When patients and providers lack access to well-functioning infrastructure, the delivery of care and patient health is compromised. To provide the level of care necessary to ensure a minimum standard of patient care, more resources need to be provided at the facility and clinic levels.

6. Sanitation Facilities Construction:

The Alaska Area recommends a $5 billion program increase for the Sanitation Facilities Construction program. While the Infrastructure Investment and Jobs Act (IIJA) provided needed resources to address water and sanitation facilities needs in Tribal communities but, it will not meet all the needs with the recent trend of supply chain issues, rising labor costs and shortages, and inflation. Additional funding is needed to meet these growing costs. In FY 23 and FY 24, IIJA funding was provided for 15 piped water and sewer systems. All comprehensive water and sewer projects that were "Ready to Fund" received funding. As we work through the FY 25 IIJA funding cycle, we anticipate having more Ready to Fund piped water and sewer projects than available funding. Some communities will be pushed to FY 26 for funding consideration, but a few will likely still not be funded.

At a FAAB meeting, IHS presented a concept of a funding ceiling for Economically Infeasible Legacy List Projects by Area. Three Areas have already exceeded their ceiling for legacy list economically infeasible projects. Alaska is still under the ceiling, but it is likely we will reach the Alaska Area ceiling projects when IHS allocates the FY 25 IIJA funding. This would leave the Alaska Area IHS with no funding to provide piped water and sewer to the communities that exceed the economically infeasible costs caps in the final year of the IIJA, since all the first service water and sanitation projects are economically infeasible. We are estimating a shortfall of over $900 million for these first-service projects.

We agree with IHS that the intent of Congress was to provide IIJA funding for projects on the legacy list. Congress also included language to use up to $2.2B of these funds for economically infeasible projects. The $2.2B amount represented the amount of economically infeasible projects in the 2020 SDS snapshot. The overall costs of projects have increased, and Areas have adjusted project estimates prior to marking the projects as Ready to Fund. We believe the amount of funding provided for economically infeasible projects ($2.2B in the 2020 snapshot) should also be adjusted to reflect today's costs so these very important first-service projects will have a chance to be funded.

Through the authorizing statute for the IHS, the Indian Health Care Improvement Act (IHCIA) (25 U.S.C. § 1601, et seq.), Congress affirmed the IHS as the agency with "primary responsibility and authority to provide necessary sanitation facilities" and "it is in the interest of the United States and it is the policy of the United States, that all Indian communities and Indian homes, new and existing, be provided with safe and adequate water supply systems and sanitary sewage waste disposal systems as soon as possible" (25 U.S.C. § 1632).

The Alaska Area continues to recommend that IHS establish an Operation and Maintenance (O&M) program within the Sanitation program to maintain the federal investment that has been made for sanitation infrastructure. As part of the FY 2025 President request, the IHS requested $10 million in 2026 to support a nationwide analysis of cost implications of funding O&M activities. We do not believe that a study is needed to analyze O&M costs in the IHS system. Even if a study was conducted, the findings would be dependent on the funding methodology that would be used to support O&M. An Alaska pilot project could be evaluated and refined as needed and also create a funding methodology for a national model that could be replicated by the IHS. O&M costs should be used for existing systems to keep projects that are already complete off the SDS list in the future.

We appreciate the Indian Health Service's acknowledgment and need for O&M in the FY 2024 and FY 2024 Congressional Justifications, estimating a $250 million need in FY 2027, after the 5-year IIJA funding is allocated. However, the need for O&M funding does not begin in FY 2027. It is needed now to support current systems and protect the federal investments already made. We recommend the IHS take steps to make needed O&M funding available immediately to Tribes to support systems already in operation. Providing the funding now will provide needed support to our community systems and assist in informing Congress and the IHS of future O&M needs as additional systems are constructed and come online.

Tribes are often forced to use their limited funds to support operation and maintenance. In many instances support may not be available at all because Tribes may not have the resources to carry out these functions. Continued dependence on this practice will not ensure proper operation and maintenance of sanitation projects, and most likely will continue to shorten the useful life of existing sanitation projects or cause their breakdown. Under the IHCIA, IHS is authorized to provide operation and maintenance assistance for, and emergency repairs to, Tribal sanitation facilities, when necessary to avoid a health hazard or to protect the federal investment in sanitation facilities.

The lack of piped water creates significant health risks for our communities. Safe drinking water supplies and adequate waste disposal facilities are essential preconditions for most health promotion and disease prevention efforts, as well as major factors in the quality of life for AN/AI people. Alaska has clinics (where temperatures can drop to -30 degrees Fahrenheit or colder) that have instructions posted in outhouses on how to capture a urine sample. It is unfathomable in this day and age, with the vast wealth of this nation, that we have communities enduring developing world conditions.

Rising prices, labor costs, and seasonal challenges continue to drive up the cost of delivering water and sanitation. As systems have aged, there is a growing number of deficiencies that will require ongoing funding by the IHS. Many of the existing water and wastewater systems in Alaska and across the country are failing or out of regulatory compliance due to lack of resources. New methods and technology are being developed to address this problem, however, many tribal communities in the United States do not have a taxable land base to raise funds for the much-needed infrastructure necessary to promote public health, leading to increased risk of skin and respiratory infection and costly community outbreaks of communicable disease.

Funding is needed to address sanitation emergencies and climate change impacts. Climate threats (fall storms, rising ocean levels, and eroding shorelines) continue to damage essential public infrastructure (water storage tanks, distribution lines, sanitation roads), and aging public infrastructure impacts water quality.

Essential maintenance of public facilities, such as water storage tank cleaning was delayed due to the pandemic. Heavy equipment and adequate arctic storage facilities are needed in every community for snow removal during winter, and year-round for ongoing maintenance to water, sewer, and honey bucket services. To protect the health of our people, the IHS must provide the necessary resources to address sanitation crises for villages that still depend on single water tanks or standalone washeterias. We must address the impacts on our water and sanitation systems, which cause further climate-related deficiencies, such as settled mainlines, damage to pipes feeding homes, and wildfires, which damage facilities.

Alaska Area Hot Topics

Full and Mandatory Funding for Indian Health Service

ADVANCE APPROPRIATIONS AND MANDATORY FUNDING

The Alaska Areas recommends full mandatory funding as the best long-term solution for stable and adequate funding for the entire Indian Health Service (IHS) budget. Moving the IHS budget to mandatory funding is in line with the United States Trust and Treaty obligations to Tribes and will provide an additional measure of stability and support for IHS. Mandatory funding would mean that the government would no longer debate IHS funding annually, and it would be funded like other programs such as Medicaid or Social Security.

Tribal health programs are on the front lines in providing critical health and are the only providers in many rural and frontier communities in Alaska. A lack of sufficient federal funding plays a significant role in these continuing devastating health disparities, and more must be done to fully fund IHS to improve health outcomes. The IHS is the only major federal healthcare program that is not exempt from sequestration, and the possibility of these cuts undermines the stability and certainty that is needed for planning and operating our programs. The move towards full mandatory funding would help to demonstrate the federal government's commitment to the health and well-being of Alaska Native and American Indian peoples across the United States. In addition, to alleviate additional pressures on the IHS budget, and the budgets of Tribal entities that contract and compact with the IHS.

The Alaska Area expresses its continued appreciation for providing advance appropriations for the IHS. The Alaska Area supports advance appropriations until full, mandatory appropriations are achieved. We support expanding IHS advance appropriations to all areas of the IHS budget and including increases from year to year that adjust for inflation, population growth, and necessary program increases. The IHS was the only federally funded direct health care provider that was not protected when Congress failed to enact required appropriations bills. The FY 2020 government shutdown underscored the need for this change. The delays in funding had dire impacts in AN/AI communities across the country.

Advance appropriations for the IHS marks a historic step however, the inclusion of advance appropriations each year is not guaranteed and does not cover the full IHS budget. It is critical to point out that the advance appropriations funding levels do not account for the cost of medical inflation and population growth in Tribal communities. In the current environment, flat funding, or nominal increases result in a reduction in access to health care.

CONTRACT SUPPORT COSTS AND 105(L) LEASE PAYMENTS

The Alaska Area strongly supports reclassifying Contract Support Costs and Section 105(*l*) Lease Payments as mandatory appropriations. These accounts are already mandatory in nature, and their inclusion in the discretionary budget makes it difficult for other programs to expand under discretionary funding caps.

In FY24, appropriations for CSC and 105(l) Lease Payments increased by $168 million (12%). However, these increases were offset by cuts to other Tribal programs in the budget. In all, the agencies received a combined $23 million topline cut and were denied the $421 million requested for fixed costs, inflation, and population growth to simply maintain current levels of service. FY25 is shaping up to be an even bigger challenge, with CSC and 105(l) payments estimated to increase by another $268 million (17%).

On June 6, 2024, the U.S. Supreme Court ruled that the IHS must pay contract support costs on revenue collected from 3rd party payers like Medicare, Medicaid, and private insurance. This will undoubtedly have major budget implications for the IHS CSC budget on top of the annual increases impacting the budget. The government argued that this decision could cost up to $2 billion annually, which would more than double the current CSC obligation. With the Fiscal Responsibility Act in place, domestic discretionary spending will increase by just 1%. This is not nearly enough to absorb these costs without further cuts to other essential services and programs. Now is the time to reclassify these costs appropriately, as mandatory funding.

Simply put, both programs will continue to grow as they continue to be utilized by Tribal nations throughout the United States, and the Interior bill will continue to fail to meet its trust and treaty obligations to Tribes under the budget structure and process currently in place. Reclassifying CSC and 105(l) payments as mandatory would be a positive

step and would be consistent with budgeting for most other Federal legal obligations.

TRIBAL SELF-GOVERNANCE FUNDING MODEL OF SUCCESS

The Alaska Area supports the introduction of legislation establishing a demonstration project to implement Title VI of *Indian Self-Determination and Education Assistance Act* (ISDEAA) across the Department of Health and Human Services (HHS). The Alaska area continues to provide technical assistance to implement self-governance beyond IHS. The Tribal self-governance program model promotes efficiency, accountability, and best practices in managing Tribal programs and administering federal funds at the Tribal level. When Tribes can tailor programs according to their needs, self-governance results in more responsive and effective programs.

Tribal self-governance has been the most successful Indian Policy the Federal Government has ever pursued. We have seen with the investment in the Alaska Tribal Health Compact the wisdom of supporting Tribal self-governance because Tribes know best how to solve local challenges. Tribal programs, when given the resources, can be innovative and have remarkable health outcomes. Tribal governments have repeatedly advocated for government-wide expansion of Tribal self-governance. Many of the programs founded by Tribal self-governance are some of the most innovative and modern health systems in the country. Tribal health programs are creating systems that are culturally appropriate and efficient, are able to provide a continuum of care unparalleled in mainstream America.

Contracting and compacting under ISDEAA dramatically transformed the Indian health care delivery system, empowering Tribal Nations to exercise their governmental authority and make key decisions about program design and administration for the benefit of their citizens. Tribal Nations carry out these services in the exercise of their inherent sovereign authority and pursuant to various federal programs and authorities, including the Indian Self-Determination and Education Assistance Act, which provides the cornerstone for modern statutory self-determination policy.

TRAVEL, MEDIVAC, AND LODGING

The Alaska Area recommends the IHS address the rising costs of travel and expand travel-related funding. This can be done by creating a special initiative to address the rising costs of travel for high-cost frontier states. The IHS has created other special initiatives to address such issues as accreditation emergencies, quality oversight, recruitment and retention, and other special program needs. Alaska stands ready to explore innovative uses of funding, such as the Catastrophic Health Emergency Fund, to address increased emergency medivac costs.

Tribal Nations inhabit some of the most rural and remote areas of the United States. Often, Tribal health programs are the only primary providers of essential services, including health care, to both Tribal citizens and non-Indians alike. Alaska is a frontier and remote state with a large geography, rugged terrain, and extreme weather conditions, which present significant challenges for patients who must travel for health care services, not to mention the lack of broadband infrastructure essential for telehealth capability. Travel issues persist with rising costs and loss of air carriers associated with inflation and the pandemic have exacerbated these challenges

Transportation is a necessary step to access health care and address on-going health conditions. Both primary health care and chronic disease care require clinician visits, medication access, and changes to treatment plans to provide the best quality of care. However, without transportation, clinical interventions are delayed, and patients are more likely to have incomplete preventive cancer screenings, worse chronic disease control, and increased rates of acute care utilization for hospitalization and emergency department visits. Rising travel costs put non-emergency travel out of reach for many patients. Lodging costs during Alaska's summer tourist season have become cost-prohibitive, and many times hotel rooms are unavailable. Multiple factors have driven lodging rates to as much as $300-$400 per night. Patients who travel for care from rural Alaska are at risk of homelessness under such conditions. When emergency medivacs are required, it can be difficult for providers to secure services due to decreased medivac providers and exorbitant costs of emergent transportation

Alaska Tribal health programs deliver medical care across a geography which, if superimposed on the contiguous United States, would span distances from Phoenix, Arizona to Jacksonville, Florida, and from Little Rock, Louisiana to Minneapolis, Minnesota. Throughout this vast State, only about

20% of the communities have road access to the tertiary care center in Anchorage. This has necessitated the development of novel care delivery models that are heavily dependent on connectivity for both specialty and primary care services and travel related resources when higher level of care is needed.

Tribal health organizations manage regional critical access hospitals and their own networks of community clinics. The hospitals provide a full array of medical services and programs, including dental, pharmacy, audiology, optometry, physical therapy, behavioral health, inpatient and emergency services, among others. As with all modern hospitals, routine operations are dependent on information technology systems and network-connected equipment for medical imaging, medical record access, pharmacy and lab management, and patient communications.

In Alaska, a patient must typically fly in a small plane to access the next level of care due to the lack of road access within and between regions. Routine, 15-minute follow-up appointments can require days of travel to a specialty care facility, which is why videoconferencing and digital imaging systems have become so ubiquitous in the delivery of healthcare in the Tribal system. Medical evacuations, particularly in rural parts of Alaska that frequently experience extreme weather conditions, can be dangerous not only for patients but also for responders. Not to mention, they are costly.

The Alaska Area stands ready to help IHS to improve the administration of Purchased and Referred Care (PRC), including creating solutions to better facilitate reimbursement of authorized travel. There must be flexibility on the use of PRC funds based on actual patient need to ensure a safe, quality continuum of care for all Alaska Natives and American Indians. The PRC manual must be updated to remove some of the existing barriers to eligibility for PRC funded services. Additionally, efforts must be made to ensure the new authorities under the IHCIA for long-term care, preventative, and other services are incorporated into the updated PRC manual.

SPECIAL DIABETES PROGRAM FOR INDIANS

The Alaska Area recommends the renewal of the Special Diabetes Program for Indians (SDPI) at a minimum of $250 million and support permanent authorization of SDPI with an exemption from sequestration. Congress established the SDPI in 1997 to address the disproportionate impact of type 2 diabetes in Tribal communities. This program has grown and become our nation's most strategic and effective federal initiative to combat diabetes in Indian Country. Permanent reauthorization of SDPI at a minimum of $250 million annually, with automatic annual funding increases matched to the rate of medical inflation, exempt from sequestration. Additionally, we recommend amending SDPI's authorizing statute, the Public Health Service Act, to permit Tribes and Tribal organizations to receive SDPI funds through self-determination and self-governance contracts and compacts, and advocating for IHS programs, including SDPI, to be protected from mandatory sequestration. The continued uncertainty of reauthorization leaves Tribes unable to adequately plan and implement a quality program. Tribes demand the SDPI to be a sustained, high-quality treatment and intervention program.
SDPI is improving the diabetes landscape in Indian Country. Today, the program supports 310 diabetes treatment and prevention programs in 35 states. Community-driven, culturally appropriate programs have led to significant advances in diabetes education, treatment, and prevention. In short, SDPI is the gold standard when it comes to lifestyle change and prevention of chronic disease.

BEHAVIORAL HEALTH AND OPIOID FUNDING

The Alaska Area continues to recommend that all behavioral health funding distribution use the self-governance contracts and compacts funding mechanism. Alaska Tribes have assumed IHS responsibilities, all behavioral health funds must be made available to Tribal health programs on the same basis they are made available within the IHS. Many barriers impact access, quality, and availability of behavioral health and related services for AN/AI people including provider and personnel shortages, limited resources, and obtaining services without traveling great distances.

When making funding decisions, IHS must assess the availability of critical services, gaps in services, and opportunities for improvement to meet community needs. Without appropriate treatments early, behavioral health concerns can become compounding comorbidities putting further strain on both the behavioral and medical health resources on which our communities depend. Appropriate funding for culturally centered and tribally-driven behavioral health policies and programs that protect identity and promote holistic mental wellness are needed. Current grants silo

funding and prevent its use in treating mental health and substance use disorders conditions together, limit integrated care with medical teams, and prevent polysubstance treatment or culturally informed approaches.

OPIOID FUNDING

In March 2024, opioid grant awards were placed on hold while IHS explored the possibility of implementing a different funding mechanism to align with Executive Order 14112, "Reforming Federal Funding and Support for Tribal Nations to Better Embrace Our Trust Responsibilities and Promote the Next Era of Tribal Self-Determination." Since that time, the IHS reviewed potential options to change the funding mechanism to a Tribal shares distribution method. Unfortunately, IHS made the decision to continue funding the opioid funds through the current competitive grants process and not pursue a Tribal shares allocation distribution method.

The IHS receives $11 million annually for the opioid program. IHS designates $9.5 million for grants, which includes funds for Tribes and a set-aside for Urban Indian Organizations. The remaining $1.5 million is allocated for IHS headquarters national management. We do not agree that IHS needs to reserve funds for national management of these limited resources when we continue to recommend utilizing excising funding mechanism through Tribal compacts and contracts for all behavioral health funds including opioid funds.

Tribal programs need the resources and flexibility for implementation of behavioral health services without having to jump through so many burdensome processes. The IHS should use the success of the Tribal self-governance model and allow for Tribal self-determination to tailor services to address the current needs.

Health Facilities

WATER AND SANITATION

The Alaska Area recommends increases in funding for the Sanitation Facilities Construction program. Ongoing financial support for adequate sanitation infrastructure has never been more critical than it is now. It is imperative that all sanitation needs be captured to ensure proper reporting to Congress and an equitable distribution of funding to the Alaska Area. Even with the historic Infrastructure Investment and Jobs Act for the IHS Sanitation Facilities Construction Program more needs to be done to address the known sanitation deficiencies and ineligible costs in Tribal communities. There are $47 million in ineligible costs associated with these Tier 1 projects. More funding for first-time water and sanitation services for communities that have never been served. The first-time water and sanitation projects represent deficiency level 5, the highest deficiency level. It is well-documented that residents of communities whose homes lack access to piped water and sewer experience increased incidences of illness, lower respiratory tract infections, and skin infections.

OPERATION AND MAINTENANCE (O&M)

The Alaska Area recommends a demonstration project in the Alaska Area where O&M resources are provided to ensure affordable and equitable access to reliable water and wastewater services. Tribal communities experience the highest levels of water insecurity in the U.S. Reasons for this include absence or deterioration of infrastructure, lack of O&M funding, and high utility operating costs. This problem is particularly acute but not unique to Alaska. Communities must sustainably operate and maintain existing and newly constructed water and sanitation services for the life of the systems to ensure ongoing health benefits. Communities with water and sanitation services would greatly benefit from O&M funding as inflation, high operating costs and small populations result in many rural communities experiencing a high utility expenditure burden.

MAINTENANCE AND IMPROVEMENT

The Alaska Area recommends providing adequate funding for M&I as the primary source of resources for maintenance, repair, and improvements for facilities that house IHS-funded programs. With the average age of many Tribal facilities well beyond initial recommendations or design life, the need to adequately fund the maintenance is essential to prolonging the usability and lifespan of such facilities. Many facilities and clinics are in dire need of M&I. With the average age of many Tribal facilities well beyond initial recommendations or design, the need to adequately fund the upkeep is essential to prolonging the usability of such facilities.
When patients and providers lack access to well-functioning infrastructure, the delivery of care and patient health is compromised. To provide the level of care necessary to ensure a minimum standard of patient care, more resources need to be provided at the facility and clinic levels.
The resources are needed to provide the level of care necessary to ensure a minimum standard of

patient care, more resources are needed at the facility and clinic level. Proper M&I funding for facilities protects investments by extending the usability of the facilities. Based on the current resources provided to build new facilities, our projections estimate that many of our facilities will need to last for more than 250 years. Increased M&I funding is the only way to ensure facilities can continue to operate until they are able to be replaced.

JOINT VENTURE CONSTRUCTION PROGRAM AND STAFFING PACKAGES

Alaska Tribes recommend that IHS routinely and regularly offer a new cycle for the IHS JVCP applications and allow JVCP to expand and renovate existing IHS and Tribal facilities. Including allowing applications for construction projects already started, that are being developed in accordance with the IHS design/construction criteria. This recommendation is especially relevant in Alaska where the construction season is extremely short, materials are particularly expensive and must be shipped via barge, which might only arrive 1 or 2 times per year. For these reasons, Alaska Tribes must plan years in advance. At each competitive cycle, non-selected applications should be eligible to reapply during the next competitive cycle. The JVCP is a cost-effective investment, and a true partnership; most importantly, it will increase access to care.

Alaska Area also recommends the inclusion of dedicated behavioral health facilities in the JVCP solicitations given the high priority of substance abuse issues and the need for residential treatment centers.

In addition, we recommend removing the No-Cost Lease Requirement for Joint Venture Projects. Support amending the IHCIA to allow for 105(l) leases to be permissible under the JVCP. The IHCIA requires that the Tribe lease a facility to IHS for 20 years at no cost under the JVCP. The joint venture facility is eligible to receive a share of the IHS's perennially insufficient M&I funding but is not eligible for a lease under section 105(*l*) under the ISDEAA.

VILLAGE BUILT CLINIC LEASE (VBC) PROGRAM

The Alaska Area recommends providing mandatory appropriations for VBC leases to sustain the program and to fully fund VBC leases, by including VBC leases under the Payments for Tribal Leases account of the IHS budget. The VBC program provides the only local source of health facility in many rural areas of Alaska. VBC Leases are essential for Community Health Aides/Practitioners, Behavioral Health Aides/Practitioners, and Dental Health Aides to provide services; the program provides the foundation for the health care system in Alaska.

Current VBC lease funding for the Alaska Area Native Health Service covers less than half of the operating costs for rural health clinics where primary health care is provided. Costs continue to increase sharply as energy and other operating costs skyrocket in rural Alaska. The VBC Lease Program is intended to provide a full-service lease for utilities, insurance, janitorial, and maintenance costs of health care facilities in rural Alaska communities. The number and size of clinics throughout Alaska has increased to provide the facilities necessary to serve Alaska Native people and rural residents, yet the funding to support these clinics has not increased proportionally. Village clinics incur more costs due to the rapidly increasing costs of heating fuel, electricity, and other energy costs. Including increases in the scope and level of medical services provided and expanded access to local health care programs and preventative services.

SMALL AMBULATORY GRANTS PROGRAM

The Alaska Area recommends continued appropriations for the Small Ambulatory Grants Program and to award funding to construct, expand, or modernize small ambulatory health care facilities.

In many of the very rural communities in Alaska, and indeed in many rural communities throughout the United States, the only access to health care is a Tribal health program. In Alaska, where 80% of our communities are off the road system and spread across more than 660,000 square miles, these communities are, in effect, islands. Therefore, Alaska Tribes recommend that the eligibility for Tribal government offices that are located on an island be extended to include, "or that are not on the road system." These facilities support lower-cost care in home locations that allow for early interventions and preventative care. Congress recognized this fact when it authorized Section 306 of the IHCIA. This section allows IHS to award grants to Tribes and/or Tribal Organizations to construct, expand, or modernize small ambulatory health care facilities.

Public Health and Workforce Needs

RETENTION AND RECRUITMENT RESOURCES

Projections indicate Alaska is expected to have the most significant healthcare workforce shortages moving forward than any other state. With the pressures on the healthcare industry due to the rise in illnesses, the aging population, and a greater portion of people needing healthcare, more healthcare workers are needed than at any other point in history. There are too few Alaska healthcare workers to fill the current demand for services in Alaska, and job vacancies in the industry are significant. Alaska is competing with the rest of the country for a limited number of healthcare workers. In 2023, Alaska programs graduated fewer than 800 healthcare workers in key positions, while the number of healthcare workers needed for those positions was 3,471.

The pandemic highlighted the drastic shortage of health care workers in America. The need is at every clinical level from doctors, nurses, dentists, mental health specialists, to medical assistants, and other medical technicians. Further, the pandemic has resulted in widespread professional burnout among health care workers.

Solving this workforce crisis is a mission-critical priority and Tribal health programs are exploring all avenues for recruiting talent and developing their own employees through self-governance and innovative staff development to try to meet the need. T/THOs have worked to build systems that recruit, train, and develop clinical and executive staff. But additional support from the federal government is needed. While we appreciate that the funding for Indian Health Professions, it has minimally increased the past few years, more must be done to be able to continue to recruit and retain health care professionals to serve in Tribal communities. This includes increases in scholarships and increases in hiring and retention bonuses for individuals serving in Tribal communities. In this regard, the IHS should work with Tribal organizations to establish training sites, this could include programs like the DHAT program, and additional training funding for the Community Health Aide Program.

INDIAN HEALTH PROFESSIONS SCHOLARSHIP & LOAN REPAYMENT

The Alaska Area recommends the IHS Indian Health Professions Scholarship alignment and parity with the National Health Service Corps (NHSC) Loan Repayment Program. This is aa key tool in the recruitment and retention of essential IHS and Tribal health care providers. This recommendation includes allowing the IHS loan repayment program awards to be tax exempt, similar to the NHSC Loan Repayment and Scholarship Programs, to support competitive compensation for recruitment and retention of qualified providers and to allow for half-time (½) employment eligibility for the scholarship program.

The IHS Scholarship and Loan Repayment programs are crucial for recruiting and retaining qualified health care professionals to meet the staffing needs of Tribal health programs. Tribal providers have long faced chronic staffing shortages, which contribute to provider burnout and limit patient access to care. One solution that invests in Tribal individuals and health programs is to "grow our own," by making health care education accessible and affordable for local community members. This has the added benefits of building capacity, reducing turnover, and supporting culturally appropriate approaches to health care.

We continue to recommend expansion of providers and including the Community Health Aides/ Practitioners (CHA/Ps) provider types be added as an eligible health profession for the scholarship program, in addition to an eligible category for loan repayment. CHA/P providers are frontline workers in many Tribal communities and will only become more important across the IHS system as the CHA/P program is being expanded nationally. As the healthcare industry faces nationwide shortages across health professions, these alternative provider-extender models provide an effective way to ensure access to care in remote communities.

CHAP TRAINING & STAFFING SHORTAGE

The shortage of essential CHA/Ps available in villages and other rural areas presents a significant risk to the health of Alaska Native people and the strength of the ATHS. The CHA/Ps are the "backbone" of the Tribal health system in Alaska, in many cases, CHA/Ps are the only providers of care in their respective communities. When this care is not available, beneficiaries who need even the most routine care are forced to travel, at great personal and system expense, to regional hubs. Often, the shortage of primary care results in symptoms going unaddressed, and even minor maladies escalate to medical situations requiring far costlier treatments and procedures. As the CHAP program is being implemented nationally, additional funds

are necessary for building training capacity and increasing the number of essential CHAP providers

It is imperative to adequately fund the CHA/P training as an essential step toward ensuring that communities have local health care providers. The IHS should plan for and request the true need and ensure that Alaska programs are not adversely impacted if new training programs are established. The IHS must meaningfully include the Alaska Area in CHAP expansion nationally, and per Congressional direction, hold the Alaska Area program harmless during this process.

LONG-TERM CARE, ELDERCARE, AND DEMENTIA

The authority provided in the reauthorization of IHCIA which allows IHS to offer and fund long-term care services, presents great promise for meeting the needs of our elders and those with disabilities. Alaska Native elders and people living with disabilities must have access to the long-term care services and support necessary to remain healthy and safe while retaining as much independence as possible in their communities.

Alaska has the fewest options in the United States for assisted living and long-term care, this is particularly true in rural Alaska. More Alaska Native elders and those needing higher levels of assistance are finding themselves in nursing and assisted living homes in urban areas, far from the land, family, and friends where and with whom they were raised. AN/AI people reportedly live with more disabilities than other ethnic groups. Higher rates of disability and functional limitations along with the increasing numbers of elders, exacerbate the need for long-term care planning.

Through the *Addressing Dementia in Indian Country: Models of Care* grant opportunity, the IHS provides limited grant funding to support the development of models of comprehensive and sustainable dementia care and services in Tribal and Urban Indian communities. The Alaska Area recommends the IHS continue to provide these resources at increased funding levels and to work to make this funding recurring through contracts and compacts funding mechanisms.

HOUSING FOR RURAL HEALTH PROFESSIONALS

The Alaska Area recommends addressing the shortage of staff housing and provide funds separate from the IHS Health Care Facilities Construction Priority System. Including providing funding to maintain and replace the few existing houses, this has not been made available for more than 20 years. Not all health clinics can offer permanent housing for providers or even temporary housing for visiting specialists or locum staff. We recommend adding rural health professional housing buildings to the eligibility list for 105(*l*) participation.
Recruitment of health professionals is significantly impeded by the lack of housing. In many rural Alaska communities, there is no unoccupied housing availability for staff. Some multigenerational families live together in overcrowded homes because of limited housing options, and there are even fewer options for professional staff who are moving to a small community. Building new homes is expensive, resources are scarce, and the building season is short. Itinerant staff working in rural clinics are often required to sleep on cots or on the floor, in sleeping bags, or in some areas (if available) are placed in costly lodging options. This disrupts their ability to be well-rested and alert when providing routine and 24/7 on-call emergency patient care.

Health professional vacancy rates across the state of Alaska are high. In 2016, the IHS reported a 12% overall health professional vacancy rate for the Alaska Service Area. Difficulties in the recruitment of health professionals are compounded by the lack of housing options in many communities. In primary care, for example, housing availability was ranked fourth out of ten important issues in primary care physician retention. Funding to maintain and replace the few existing houses, in communities fortunate to have them, has not been available for the past 20-plus years.

The ability to provide safe housing for health professionals willing to work in isolated rural communities has become even more of a critical issue. Federal funding through the IHS has a long backlog waiting list of Tribes across the country wanting to build or renovate health professional housing. Many communities lack any permanent housing options for health care providers or even temporary housing for visiting specialists or locum tenens staff. We must support provider housing to solve the provider shortage crisis.

DENTAL HEALTH SERVICES

The Alaska Area recommends increasing the Dental Health budget line item to improve preventive services and expand basic dental services and to provide emergency dental care. 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 AN/AI 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 expand basic dental care services, as a large part of dental services are used to provide basic and emergency care services. More complex rehabilitative care (such as root canals, crowns and bridges, dentures, and surgical extractions) is extremely limited but may be provided only when resources allow.

Oral health is a leading health indicator beyond the mouth, gums and teeth. Poor oral health is correlated with several chronic diseases including diabetes, heart disease, stroke, and is even associated with premature births and low birth weight. Frontier and rural communities in Alaska have had limited options and capacity to provide dental services. The dental health aide training program was created to address this and has provided an evidence-based model in remote villages in improving oral health. Supporting Dental Services and oral health is essential in protecting health.

Information Technology

TELEHEALTH

Reliable, high-speed connectivity allows Tribal health programs to avoid unnecessary travel by sending data about patients rather than the patients themselves. The coordination and provision of care across these extensive, almost entirely rural regions not only depends on reliable, high-speed networks but also utilizes those networks to their limits. It is not uncommon for minutes to be the difference between negative and positive medical outcomes, and connectivity allows for real-time, potentially life-saving diagnoses by doctors who may be hundreds of miles away. Stable internet connectivity is necessary to the Tribal health programs hospital operations, as they require medical diagnostic imaging to be digitally sent online for interpretation by remote radiologists and must routinely consult with remote medical specialists to determine if a medevac is appropriate.

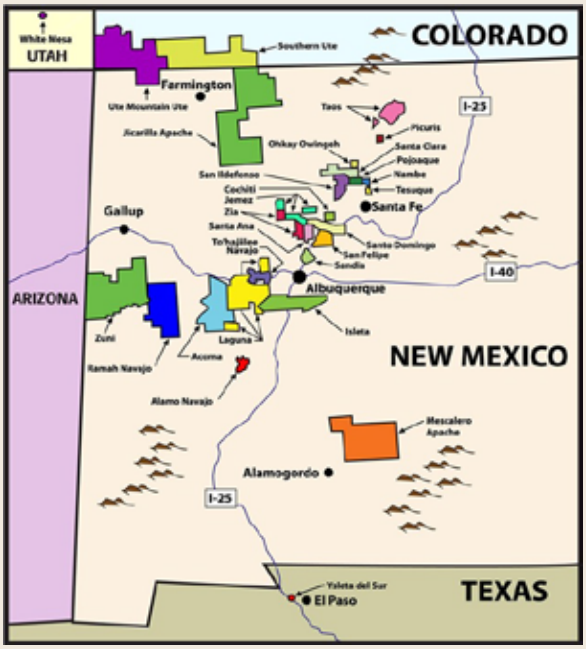
In addition to making a critical difference in emergency situations, Tribal health programs rely on supported networks to provide a high level of preventive care to maximize their resources and secure the best outcomes for their patients. This includes early and regular screenings and addressing root causes of health issues by providing community-level interventions such as nutrition education, tobacco cessation programs, opioid abuse prevention programs, and increasing access to educational and job training programs. Telehealth connectivity also makes it possible to provide mental health treatment in communities where it is much needed and there is otherwise no qualified provider on-site. The ability to provide these preventive services requires connectivity, as do the EHR systems that make care coordination possible.

Funding is for tele-behavioral health capabilities like Video Teleconferencing (VTC), which are essential in Alaska to expand services to rural communities. In Alaska, recruiting and retaining clinicians, psychiatrists and other behavioral health providers statewide is challenging. Due to the remoteness of villages across the state and the difficulty with transportation to these villages, maintaining licensed providers in every rural community is impossible. Resources must include appropriately supplying Tribal clinics with VTC equipment and the internet connectivity necessary to sustain and expand service delivery and health care access. VTC offers promise, but some areas still require physical infrastructure development. In many villages, digital connectivity is non-existent or relies on a satellite-based internet system that is slow and unreliable.

TRIBAL INVESTMENT IN MODERNIZATION OF HEALTH INFORMATION TECHNOLOGY

Alaska Tribes have invested millions of dollars of their resources to modernize their electronic health records management system. Tribal health programs who have already converted from the Resource and Patient Management System (RPMS) to more efficient technological solutions should receive financial support, along with IHS, for modernization efforts. If IHS is seeking funding from Congress for its modernization through the IHS appropriation and budget formulation process, it must include a proposal to fund Tribes that have already invested their own resources for modernization as well as ongoing maintenance. We recommend IHS work with Tribes on the process of determining PFSAs and shares distribution in preparation for future appropriations. IHS must provide financial resources for the modernization efforts that have already been carried out by Tribal health programs and address the lack of parity for those have already who had to move away from RPMS for the safety and benefit of their patients.

Albuquerque Area



Albuquerque Area Office Summary of Service Area and Demographic Information

- The Albuquerque Area Office serves 27 distinctly different Tribal groups:
  - 20 Pueblos
  - 3 bands of the Navajo Nation
  - 2 Apache bands
  - 2 Ute Tribes
- Health care facilities are located across four Southwest states to include New Mexico, Colorado, Texas and Utah
- 2 Urban Health Care Centers located in Albuquerque, NM and Denver, CO
- 1 dental clinic
- 1 youth residential treatment center
- 10 Tribally run health care clinics
- Approximately 84,000 active user population

The Albuquerque Area Indian Health Service extends from southwestern Colorado to El Paso Texas. It is made up 8 federal service units, one youth residential treatment center and one stand-alone dental health clinic. There are also ten Tribally run clinics throughout the Area. The eight federally run service units represent the priorities of 27 distinctly different Tribal groups including 20 Pueblos, three bands of the Navajo Nation, two Apache Tribes and two Ute Tribe. There are also two urban clinics within the Albuquerque Area, one located in Albuquerque, NM and one located in Denver, Colorado. In preparing the budget submission for this Area each of the service units conducted outreach and met with Tribal leaders with that service unit to discuss local priorities and concerns.

The Albuquerque Area is in support of a mandatory full funding proposal for FY27 and a full funding budget policy as recommended by the IHS National Tribal Budget Formulation Workgroup.

The Albuquerque Service Unit (ASU) consists of the Albuquerque Indian Health Center, Zia Health and Dental Clinic and Santa Ana Health Center. The ASU is located in Albuquerque, NM and provides outpatient services to approximately 35,000 Tribal members of the Laguna, Acoma, Isleta, Sandia, Zia and Santa Ana Pueblos, as well as members of the Navajo Nation and other urban Indians who reside in the metro area. ASU conducts approximately 130,000 outpatient visits annually. Services include preventive and chronic care management for patients of all ages. Specialty services include rheumatology, gynecology, colposcopy and podiatry. Additional services include medication assisted therapy, optometry and integrated behavioral health. Routine and emergency dental services are also provided at Zia Health and Dental Clinic. In general, due to the geographic location of the ASU, there has been a consistent increase in new patient enrollment and overall patient visits.

Zuni Comprehensive Health Clinic provides services to the Zuni Community in addition to residents of the New Lands Area from Arizona and residents from outlying areas outside of Gallup, NM. Presently Zuni Hospital has only one dentist providing services creating a backlog for community members requiring appointments as long as several months. The same issue is with the Optical Department.

Granted IHS cannot discriminate against anyone of Native American descent, but our Zuni community members are at the negative end of this ruling. Our community members are having a difficult time getting appointments or are unable to get appointments. This is due to IHS trying to provide

services to all the outlying areas even with the lack of personnel.

A majority of the community qualifies for Medicaid/Medicare but are unable to access the services due to the distance of travel.

The Indian Health Care Improvement Fund was added as a line in FY 2018 Enacted appropriations. This was to address deficiencies in health status and health resources and eliminate backlogs in providing health care service. With the lack of health personnel at Zuni Comprehensive Health Clinic, the IHS is failing in this category by not providing the needed personnel to provide quality care.

The Indian Health Care Improvement fund is intended to address the ability of IHS to meet health service responsibilities for Tribes with the highest levels of health disparity and resource deficiency. Yet, how is this going to be done with the lack of personnel. Zuni Hospital initially started out as a 44-bed facility, and it is now down to 20 beds. IHS cannot staff this area adequately due to the lack of nursing personnel. Patients wait long hours in urgent care before admission.

IHS/IHP manages funding for individuals interested in health professions within IHS. This funding needs to be provided to the local health care units so they can recruit their own home-grown personnel. These facilities know the needs of the community much better and know individuals that are dedicated to working in their communities and can better be able to recruit. Area Offices are not fully aware of the needs of our communities. The most needed community do not benefit from the professionals that are awarded these funding. Home grown should be at the local level.

Albuquerque Area Office Budget Recommendations

Hospital and Health Clinics – $20.5 Billion

The Tribal Leaders/Tribal Representatives of Acoma and Laguna Pueblos, Canoncito Band of Navajos, Southern Ute Mountain and Ute Mountain, the Pueblos of Santa Clara, San Felipe, San Ildefonso and Ohkay Owingeh, and the Jicarilla Apache Tribe recommend that 37% of all budget increases be directed towards Hospital and Health Clinics.

The chronic underfunding of the Indian Health Service has resulted in an inadequate core health care system. Increases in funding will support primary care staffing levels and increase access to care, as well as quality of care for the community members. The increase in funds will allow the service units to maintain staffing levels in the clinical departments including the critical needs of staffing primary care providers, nursing, laboratory, and pharmacy staff. Maintaining staff promotes trusted relationships to grow in the community and allows the clinics to focus on not only battling health conditions but support preventative services for better outcomes.

The budget increases in Hospitals and Health Clinics will also provide opportunities to allow specialty services to join our clinical team and provide a more comprehensive level of care; we need to bring specialty clinics back into our clinics. For example, providing maternal health services and providing resources for pregnant mothers is the key to maintaining a healthy community. Family is the key unit of society, and that lies in maternal health, women, and children. Bringing in more specialty clinics at least twice a month will eliminate the wait time of getting an appointment outside of Indian Health Services as outside referral appointments may take months.

The Tribes have expressed the underfunding of Indian Health Services, and the increase in funds will be used primarily to support staffing and services in the service units which in return will increase access and flexibility to quality health care services and address critical health care needs of our people and communities.

The Tribal leaders/representatives from the Mescalero Service Unit recommends increase funding to Hospitals and Clinics (H&C) Line item, it has been underfunded for many, many years. Funding this line item will support current services, expansion of services, purchases of necessary supplies and equipment and hire additional staff. This line item should be funded at the highest level it needs to be funded at. Historically, H&C has not been funded fully making it extremely difficult to provide appropriate levels of services in Indian Country. If MSU is to maximize the service delivery, increase funding is necessary and will enable increased hours of our much needed Urgent Care hours and other levels of services. These are the most requested and most used services in the community.

Health Care Facility Construction – $8.9 Billion

The Tribal Leaders/Tribal Representative have strongly expressed the need for new health care facilities and construction. The clinic/facility at the Sandia Health Center is outdated built in 1995 and scarcely meets the space to accommodate and provide health care services. Lack of space to add or provide behavioral health, physical therapy, onsite lab, and optometry services continues to be a challenge today and in the last few years. A new clinic/facility or an expansion will meet the demand of services needed by the community, and it will also provide an opportunity to add other services and/or increasing access to services. Currently, the clinic only has two exam rooms, two optometry rooms, and an audiology space. The clinic is limited to see two patients at a time which at times impacts continuity of health care.

The Jicarilla Apache Nation expressed a dire need of an expansion of the Ambulance Services for their communities which consists of staffing, vehicles, equipment, etc. The southern end of the Tribal lands is currently being developed to support community expansion. Water lines from the Cutter Dam now fully support the Apache Nugget Casino and developing community. The Tribal leadership has requested to begin EMS operations by February 2025. An EMS and Fire station is currently underway to be built; however, it's still in the planning stages. The highway 550 corridor is a severely underserved region with Cuba EMS, Sandoval County Fire and San Juan Regional EMS covering this section. These responding agencies all have a greater than 30 minutes response time due to the frontier environment. The Jicarilla Apache Nation EMS expansion will greatly improve emergency services access to the communities, public and visitors to the Jicarilla Apache Nation.

The Mescalero Service Unit recommends a program increase for Health Care Facilities Construction (HCFC) line item. The current government quarters are obsolete and has long surpassed its useful life. Some improvements have been made regarding minor renovations but a full replacement of each unit is needed. The quarters were built approximately during the same timeframe of the original health care facility, most likely in the 1960's. They require constant maintenance work and repair for current tenants. Also, not all quarters/units are currently being occupied due to the extensive time, funding, and other resources needed for repair. Not having adequate government quarters available hinders our recruitment efforts for the Service Unit. Acquiring housing accommodation in nearby communities can be expensive. Housing availability is one of the most common questions asked when recruiting full-time, permanent employees. Therefore, it can be detrimental to our efforts to improve health care services for the Mescalero community if we cannot provide local accommodation to key personnel in essential positions.

Fully funding this line item will allow the facilities on the list to complete their existing projects and allow other projects such as MSU the opportunity to initiate a replacement project.

Mental Health – $7.6 Billion

Tribal Leaders/Tribal Representatives recommend the budget increases go toward funding behavioral health programs. This is a critical health need for the community with continued increase in need. Ute Mountain Tribal leaders note that the available behavioral services in the Southwest Colorado region remain inadequate and that the Tribal community has an immense need for available and culturally appropriate behavioral health services. The increase in funding will allow the local service unit to fully staff behavioral health department including counseling, therapy, and psychiatry services. While also trying to prioritize Mental Health among juveniles; in hopes for better outcomes as adults.

Tribal Leaders/Tribal Representatives from the Albuquerque Service Unit expressed mental health services is desperately needed. Our hope is to recruit individuals with expertise with viable resources, right now it is minimally present. The impact of mental health on the reservation needs to be addressed long term because it is multi-generation. For example, a child born with fetal alcohol syndrome that is transmitted multigenerational until 3 or 4 generations then can get that out of the system. A big issue in our native communities, we hear and witness a wide range of substance abuse. We can't continue as is, there are so many issues with substance abuse and drug abuse and we have to combat this epidemic.

The Tribal Leaders/Tribal Representatives from the Santa Fe Service Unit recommend funding increases go towards Mental Health. Our Tribal Leaders/Tribal Representatives recognized that even post-pandemic our communities have been greatly affected. The mental state of our community

members has caused major health issues, stress and anxiety. Our community members would like to see consistency with mental health care services. The increase in funds will primarily be used for additional staffing to provide consistent services and increase access to mental health care.

The Tribal Leaders/Tribal Representatives from Taos/Picuris Service Unit recommend increase funds in mental health services for prevention and treatment services and exercise the National plan for Indian Mental Health Services. An increase of the funding is needed by the service unit to meet its responsibilities under the plan.

The lack of mental health providers in the Mescalero community is at an all-time high. Access is severely limited due to a shortage of staff. Our facility is in critical need of the mental health providers that provide crisis intervention treatment and stabilizations for serious issues. As of this date, we are staffed with one contractor clinical psychologist. We are not exempt from facing staff shortages and the challenges faced with filling these positions. Our positions have been vacant for several years with continued recruitment efforts but without success. Further, the background process remains to be a significantly long process to complete which results in potential applicants losing interest and considering other opportunities

Alcohol & Substance Abuse – $7.3 Billion

The Tribal leadership of the Ute Mountain Tribe recommends the budget increases go toward funding the alcohol and substance abuse program. Abuse of substances was a critical health need of the community before the COVID-19 pandemic, has unfortunately grown substantially post-pandemic. Increases in funding for alcohol and substance abuse services will allow the Tribes and the service unit to fully staff and expand these services. Substance abuse counselors, peer counselors, education and after-school programs, in-patient rehab, recovery, and post re-habilitation transitional housing are considered critical needs of the community. It would be beneficial to provide services close to home to mitigate family disruption and also assist the members seeking services to be able to find successfully recovery in their community when warranted.

The Santa Fe Service Unit Tribal Leaders/Tribal Representatives recommend funding increases go to Alcohol and Substance Abuse line item. For the past years, the Tribal leaders have declared that within our local Tribal communities, the greatest unmet need is for the treatment of conditions related to mental health disorders, alcohol and substance abuse. The Tribal leaders recognize the untreated mental health disorders can lead to an increase in risk for alcohol and substance abuse, and that those with alcohol and substance abuse disorders oftentimes have co-existing mental health diagnosis. The increase in funding will be utilized to increase personnel and services for alcohol and substance abuse counseling.

The Acoma-Canoncito-Laguna Tribes recommend funding increases go to Alcohol and Substance Abuse line item. For the past years, Tribes have declared that within our local Tribal communities, the greatest unmet need is for the treatment of conditions related to mental health disorders, alcohol and substance abuse. ACL recognizes the untreated mental health disorders can lead to an increase in risk for alcohol and substance abuse, and that those with alcohol and substance abuse disorders oftentimes have co-existing mental health diagnosis. The increase in funding will be utilized to increase personnel and services for alcohol and substance abuse counseling. The Tribal Leaders recommend funding increases to go towards Alcohol/Substance Abuse and Mental Health. Recognizing that even post-pandemic our communities have been greatly affected. The mental state of our community members has caused major health issues, stress and anxiety. Our community members would like to see consistency with mental health care services. The increase in funds will primarily be used for additional staffing to provide consistent services and increase access to mental health care.

The Tribal leaders from the Albuquerque Service Unit acknowledges that in recent years, mental health issues have exacerbated among Native American communities. There has been an increased prevalence of grief, depression and suicidal ideation and has amplified the need for psychotherapy services within the primary care arena, as well as schools and outlying field clinics. Similarly, local community behavioral health clinics are experiencing full or extensive waitlists for services and recruiting/retaining behavioral health care professionals has been a challenge. Proactive approaches to routine screening within primary care clinics have been successful in early intervention and increased funding would allow for further expansion of much needed services within the spectrum of holistic health care.

The Tribal leaders from Taos/Picuris Service Unit recommend increasing funding in mental and behavioral health prevention and treatment services. The Tribal leaders exercise their right to authorize and direct the Secretary, acting through the Service, Indian Tribes, and Tribal organizations to develop a comprehensive behavioral health prevention and treatment program which emphasizes collaboration among alcohol and substance abuse, social services, and mental health programs.

The lack of mental health services in the Mescalero community is at an all-time high. Access is severely limited due to staffing shortages. Alcohol and substance abuse cause an increase in the number of injury related patient visits to our clinic and urgent care unit as well as to the private sector and local emergency departments. An increase in funding is necessary to allow opportunities for our members to participate in a long-term inpatient treatment program. Although the Mescalero Apache Tribe has a 90-day inpatient program through a 638 contract, the complexity of substance abuse disorders may require a longer duration for treatment.

Public Health Nursing – $5.7 Billion

The Tribal leaders from Acoma/Canoncito/Laguna Service Unit recommends funding to go toward Public Health Nursing. Public Health Nursing is an integral part of health care services and there is an extreme need for these services in our community. The Tribal leaders expressed the need of continuous and comprehensive care services for their aged, disable and community population. The need for PHN services has increased in the past years and it seems staffing is a great concern. More PHN employees are desired to provide services in our communities to work the CHR. PHN is the forefront of disease prevention in the communities and they safeguard the health of our communities; we are in dire need of increased funding for PHN services.

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 Tribal members. These home-based services are most often related to chronic disease management, safety and health maintenance care for elders, investigation and treatment of communicable disease, and screening for early diagnosis of developmental problems. Public Health Nurses need to have the resources to collaborate more closely with Community Health Representatives, Behavioral Health Services and EMS. As such, more funding is needed to hire personnel to fully staff up CBNHC.

During COVID-19 the PHN employees were front and center leading community-based, pandemic-related efforts and were integral to the communities' well-being. Tribal PHN were at the frontline in responding to COVID-19 as well as organizing and administering vaccines, resulting in Native Americans having the highest COVID-19 vaccination rate. PHN also led efforts in contact tracing and provided valuable leadership in the emergency response efforts

Purchased Referred Care – $5.6 Billion

The Tribal leaders and Tribal representatives from Ute Mountain Ute Service Unit recommend that funding increases go to the Purchased/Referred Care program. The Southern Colorado Ute and Southern Ute has a large number of specialty referrals that include OB/GYN services, general surgery, emergency care, hospitalizations, oral surgery, behavioral health, and other specialty care services. Referrals are generated to local and regional vendors including Cortez, Durango, Grand Junction, Denver and Colorado Springs, CO, as well as New Mexico vendors in Farmington and Albuquerque. While the PRC program is the payer of last resort, the Tribe recognizes that the health care needs of the community will always rely on these regional specialty services and that the costs for these services is ever increasing. The Tribe wishes to ensure that the Indian Health Service is adequately funded in future years to continue to meet the needs of the community.

The Santa Fe Service Unit Tribal Leaders/Tribal Representatives recommends funding increases go to Purchased/Referred Care. Beneficiaries in the Santa Fe Service Unit who are PRC eligible have benefitted significantly since the full implementation of the Affordable Care Act. The PRC program is the payer of last resort, and with expanded Medicaid under the Affordable Care Act, a marked increase in PRC eligible patients are also Medicaid eligible. This has led to a sizeable PRC surpluses in the SFSU allowing all PRC referrals to be approved. Despite this, the Tribal leaders and Tribal representatives recognize that changes to Medicaid eligibility can occur in the future, and they endorse continuing to increase PRC funding at a national level to ensure expanded access

to non-IHS specialty services that are crucial to fulfilling the agency's mission.

The Tribal leaders/representatives from Albuquerque service unit feel that increasing purchased/referred care funds for eligible patients within the Albuquerque Service Unit is essential to ensure access to care that is not available at IHS facilities. Increased funds would support preventive care and screenings, such as mammograms and colonoscopies, as well services for emergent care, inpatient care, specialty care, cancer treatment, diagnostic imaging and dental care.

The Laguna Tribal Representative recommends that funding increases go to Purchased/Referred Care. Beneficiaries of ACL who are PRC eligible have benefited significantly since the full implementation of the Affordable Care Act. The PRC program is the payer of last resort, and with expanded Medicaid under the Affordable Care Act, a marked increase in PRC eligible patients is also Medicaid eligible. This has led to a sizeable PRC surplus in ACL allowing all PRC referrals to be approved. Despite this, the Pueblo of Laguna recognizes that changes to Medicaid eligibility can occur in the future, and they endorse continuing to increase PRC funding at a national level to ensure expanded access to non-IHS specialty services that are crucial to fulfilling the agency's mission.

Hot Issues

Canoncito Band of Navajos Health Center, Inc.

1. ISSUE

Behavioral Health

BACKGROUND

Our local clinic is unable to maintain services to the 100% population needs. The P.L. 93-638 funding to local programs dealing with mental health and substance abuse is not adequate. Without adequate funding the crisis triage, case management, community-based prevention programing, outreach, and health education activates geared towards substance abuse and mental health issues cannot be achieved including, developing effective aftercare treatment programs that are sustainable. In the same respect, IHS goals to lower the incidence and prevalence of alcohol cannot be achieved. Without adequate funding for facilities such as alcohol inpatient, outpatient treatment and rehabilitation services support Tribes to develop these programs will never be realized at the local level

RECOMMENDATION

More resources for behavioral health programming and staffing.

2. ISSUE

Facility renovation/improvement/expansion and Infrastructure

BACKGROUND

CBNHC facilities were added to the footprint over many years and given that patient loads have dramatically increased coupled with expanding staffing, CBNHC requires facilities over twice the size of its existing footprint. Tied with the facilities challenge, the To'Hajiilee community faces unreliable water supplies and wastewater systems that are environmentally appropriate. The To'Hajiilee community provides water through a small water system through local wells that have continued operational challenges. There is in process expansion and installation of a water system from the Albuquerque area, but that project will only provide water to the community boundary line. An up-to-date local system, that also services the health center, is needed. Connected to the issue is the need for a central based sewage system. Currently, the community uses local septic systems that are gradually contaminating the underground environment.

RECOMMENDATION

More resources are required to install an up-to-date water and waste-water sewage system.

3. ISSUE

Patient Migration

BACKGROUND

CBNHC, Inc. is in close proximity to Albuquerque, NM and on many occasions is inundated with patients who are from other services areas and/or Indian Tribes. Given that CBNHC does not turn away patients for any reason, CBNHC provides the much need health service and deals with the financial arrangements afterwards. This situation strains CBNHC's resources.

RECOMMENDATION

Develop an all-encompassing financial payment system for IHS eligible patients on a universal basis.

4. ISSUE

Recruiting

BACKGROUND

Due to the geographic location of CBNHC, recruiting staffing at all levels is challenging and prevents CBHHC from providing complete health care services. Also, there is limited availability of housing in the area and the higher costs of housing

have created a shortage of available housing for staff who cannot afford it, and for those who can, it still poses a challenge.

RECOMMENDATION

More resources for employee compensation, facilities, and local accommodation.

5. ISSUE

Public Health Nursing (PHN)

BACKGROUND

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 Tribal members. These home-based services are most often related to chronic disease management, safety and health maintenance care for elders, investigation and treatment of communicable disease, and screening for early diagnosis of developmental problems. Public Health Nurses need to have the resources to collaborate more closely with Community Health Representatives, Behavioral Health Services and EMS. As such, more funding is needed to hire personnel to fully staff up CBNHC.

RECOMMENDATION

The request for the increase is primarily based on an expansion of services and promotion of well-being, health promotion and health education.

Picuris Pueblo

1. ISSUE

Program Cuts and Over-Reliance on Referrals: Due to program reductions, our health station is increasingly forced to rely on referrals for almost all specialized care. This approach imposes delays, increases costs, and places a heavy burden on our residents, who often must travel long distances to access essential services. We urge the committee to prioritize funding that enables rural health stations like ours to provide comprehensive in-house services. Ensuring continuity on our local programs is vital for maintaining the health and well-being of our community, particularly given the barriers to accessing distant health care facilities.

BACKGROUND

Small outpatient clinic.

RECOMMENDATION

More staff to assist with processing referrals.

2. ISSUE

Decentralized Hiring for Health Stations: The centralized hiring process managed by the Albuquerque Area IHS office has proven to be inefficient, with delays in filling positions severely impacting our ability to provide timely health care. Health Stations should have the autonomy to manage their own hiring to expedite staffing for critical roles. We recommend policy adjustments that grant hiring authority to local health stations, allowing us to promptly address staffing needs and reduce dependency on a single office responsible for the entire State of New Mexico.

BACKGROUND

ONE HR developed by HQ.

RECOMMENDATION

Assess new process on a test of change, advocate to decentralize if new process is not adequate.

3. ISSUE

Systemic Discrimination and Inequity: There is a serious and pervasive sense of discrimination within the IHS network, where smaller health stations like ours experience disparities in funding, resources, and decision-making power. It often feels as though smaller facilities are subject to arbitrary decisions that limit our ability to serve our communities effectively, creating a dynamic where the IHS "plays God" with the health and well-being of our people. This inequity within a federal system designed to serve all Native communities fairly is unacceptable and must be addressed. We call for a thorough examination of these practices to ensure that smaller health stations receive equal treatment and respect within the IHS network.

BACKGROUND

N/A

RECOMMENDATION

Advocate Legislation

4. ISSUE

Implementation of Best practices from High-Performing IHS Facilities: We advocate for a comprehensive review of IHS facilities nationwide to identify those that excel in meeting basic health care needs. By benchmarking best practices from these high-performing sites, we can establish equitable health care standards across the IHS network, Such an intuitive would not only improve health care quality in underserved areas like Picuris Pueblo but also address discrepancies within a federally managed system that should strive for equal standards across all locations.

BACKGROUND

N/A

RECOMMENDATION

Advocate at HQ

5. ISSUE
Justification for Funding Beyond Population Count: Small Pueblos like Picuris face unique operational challenges that increase the per capita cost of delivering health care. Without sufficient funding rural and smaller Pueblos bear a heavier burden due to travel requirements and the scarcity of local health care resources. We request that the budget formulation process take these factors into account, adjusting funding models to address the unique needs of small, isolated communities.

BACKGROUND
IHM: Chapter 4, part 6

RECOMMENDATION
Explore options and advocate at HQ

Taos Pueblo

1. ISSUE
Taos Pueblo supports the proposals to make all funding for the IHS mandatory.

BACKGROUND
The IHS budget has historically been in the discretionary budget. It is critical that Contract Supports Costs and 105(l) lease payments become part of the mandatory budget.

RECOMMENDATION
We support the proposals to shift the IHS budget from discretionary to mandatory funding to protect the overall appropriation for the IHS and create more adequate and stable funding into the future. Keeping CSC and 105(l) lease payments as discretionary in practice, though they are mandatory in reality, has only kept the IHS and BIA budgets flat, despite significant medical inflation and population growth over the last decade. Thios means, we are doing more with less.

2. ISSUE
Housing is a major issue in the recruitment and retention for both Tribal and IHS staff. There is limited to no support for building units that would benefit both the Service unit and Tribal Health Programs, which in turn would benefit the clients we both serve.

BACKGROUND
During the Pandemic and with the increase in the "Air BnB" market, long term rental units in Taos County have become extremely limited and quite expensive. Taos County recently passed an ordinance to try and limit the number of short-term rentals in the area, but inventory is still limited. This is a huge barrier in recruiting and retaining staff, especially those on the "lower" end of the PayScale, which are of course vital to the day-to-day operation of a health care clinic. Staff are having to commute for over an hour one way, some up to 2 hours, so that they can find affordable housing. This is not feasible economically, especially when the winter months make travel dangerous at our elevation (7,000 ft above sea level) and climate.

RECOMMENDATION
Increase access to funds that would facilitate the construction of quarters for IHS and Tribal Health staff in a HIS/Tribal Partnership.

Ohkay Owingeh

1. ISSUE
Community Health Representative (CHR), Public Health Nursing (PHN) 638 program as well as Special Diabetes Program for Indians (SDPI) have no access to the Indian Health Service Electronic Health Records. This has resulted in lack of Continuity of Care and does not provide Patient Centered Care.

2. ISSUE
Health Board. Tribal representation on discussion of health issues affecting Tribal members.

3. ISSUE
Lack of Data. From annual GPRA #s to specific request of data.

4. ISSUE
Reports. From Pharmacy & Therapeutics committee discussion on formulary, safety data and Morbidity/ Mortality data.

ISSUE
Tribal Consultation. No yearly visit by Santa Fe Service Unit CEO or Albuquerque Area Office.

BACKGROUND
- IHS has yet to fulfill access for data entry to allow for consistent monitoring and follow up of patient care.
- Health Board dissolved and no support by service unit.
- Tribal Consultation should be individualized as IHS has invited Tribes to consultation in Albuquerque that only provide what IHS topics of discussions.

RECOMMENDATION
- Provide 638 programs access to upload PCC data and view provider notes.
- Encourage and assist in re-establishment of the local Health Board.
- Provide all data that is submitted to Area Office and specific data requested by Tribes.

Mescalero-Suicide Prevention

1. ISSUE

The lack of mental health services in the Mescalero community remains at an all-time high. It is the position of the Mescalero Apache Tribe to use the same priorities from last year, as the Tribe remains committed to ensure we take the necessary steps to prevent suicide and in addressing these critical matters. The Mescalero community has seen a significant increase in suicidal ideations, suicide attempts and suicide completions since the beginning of the pandemic.

BACKGROUND

Historically, the Mescalero Service Unit was fully staffed to meet our community needs. As of this date, the service unit is without permanent staff in our behavioral health department and is temporarily filled with one contractor to provide services to over 5500 enrolled members. Trying to fill these critical positions is extremely challenging. Our positions have been vacant for several years with continued recruitment efforts but without success in finding staff willing to stay due to our rural area and challenges in finding adequate services for family or individual needs and particularly with the recruitment to onboarding issues, the timeframe it takes for background clearances that are affecting permanent positions. The delays, bottle necks and overall processes has a critical impact on the hiring process. We are not exempt from staffing shortages as there is a staffing shortage of providers/professionals nationwide. Our own systemic issues are causing a huge delay in hiring. This continues to put a high level of stress on our behavioral health department as rural practice is often isolating for its practitioners. It is proven that some of our providers are so overwhelmed by the high demands for services, particularly during suicide breakouts, resulting in risk of burnout of our permanent staff. Increasing protective factors, such as hiring of permanent staff, timely demonstrates a clear need to develop and implement strategies to improve the overall hiring process and close the gap to increase access to much needed services.

RECOMMENDATION

Provide competitive funding, and streamline/improve the long timeframe of onboarding process so MSU will be able to provide advanced care to our patients by aligning our outpatient clinic with mental health staff to address any mental health or addiction problems that present to the clinic. An increased program at this level will demonstrate a strong presence in the community and create more services to meet the need. To do this, housing is a much-needed asset, as well as recreational activities and the opportunity to grow with the complex structure and cultural realm, will go a long way in filling these already challenging positions.

Quarters Replacement Project for Mescalero Service Unit

1. ISSUE

The Mescalero Service Unit is in dire need of government quarters replacement. Our quarters were built at approximately the same timeframe as the original health care facility in 1967 and has remained the same units since.

BACKGROUND

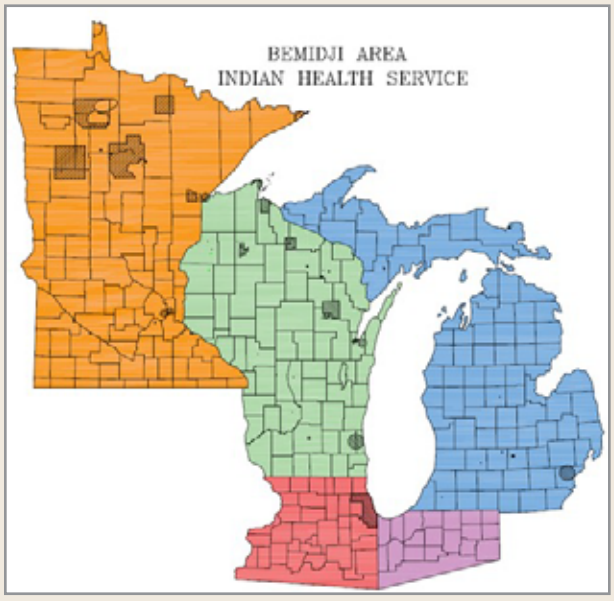
The Mescalero Service Unit was originally built in 1967 and was the medical system for the Mescalero Apache Tribe and other Indians affiliated with the Tribe and Tribal enterprises. The current government quarters were built at the approximate same time as the health care facility and there are 11 units. Of the 11 units, seven (7) are occupied, one (1) is serving as a transient unit for temporary living, one (1) is almost in full repair for occupancy, and two (2) require extensive work due to pest control and electrical issues. Because of the age of the units, there have been multiple issues with both occupied and unoccupied units. These issues are related to lack of adequate HVAC systems (either no central air condition or furnace/heating issues), electrical loads for original use is not sufficient for today's usage, roofing replacement, and pest control (termites).

Not having adequate government quarters available hinders our recruitment efforts for the Service Unit. Acquiring housing accommodation in nearby communities can be expensive. Housing availability is one of the most common questions asked when recruiting full-time, permanent employees. Therefore, it can be detrimental to our efforts to improve health care services for the Mescalero community if we cannot provide local accommodation to key personnel in essential positions.

RECOMMENDATION

Due to the extensive resources needed to repair current units, it is recommended to move in the direction of full replacement. The current government quarters are obsolete and have long surpassed it useful life. Some improvements have been made regarding minor renovations, but a full replacement of each unit is needed. They require constant maintenance work and repair for current tenants.

Bemidji Area



Population: 101,309 (2022)

- Tribes: 34 – 200-30,000 members
  - 20 Title I
  - 14 Title V
  - 3 Federal Service Units: 2 Hospitals/1 Ambulatory Clinic
- Urban facilities: 6
  - Minneapolis, St Paul, Chicago, Detroit, Milwaukee (2)

Budget Recommendations

Hospitals and Health Clinics (H&C) +$31.64 B

The Bemidji Area recommends $34.19 billion or $31.64 billion above the FY 2024 enacted amounts to be applied to the Hospitals & Clinics (H&C) budget line item.

Increases in the H&C line not only allows Areas and Tribal programs to apply the funding in a targeted, applicable, independent, and program specific manner but also utilizes individual clinic functions to support the direct care needs unique to each Tribal community.

Increased H&C funding provides the much needed boost for resources to AI/AN health programs, flexibility in finding effective treatments, and reducing the health disparities of community members while including traditional healing and long-term care.

Bemidji Area Tribes experience serious underfunding that creates an environment of uncertainty for planning, development, and implementation of Tribal health programs. Most Tribes are unable to compete with more populated areas due to the geological and historical territory of the Bemidji Area.

High rates of vacancies continue in the Bemidji Area office and Tribal settings especially since the COVID 19 pandemic. Recruitment and retention practices need to be more aggressive and competitive to bring in qualified health care medical professionals. The I.H.S loan repayment program is a tremendous help, however current Federal wages cannot compete with the private sector, thus Tribes must provide significant increases in salary and fringe packages to bring in qualified medical professionals. The increase in funding will assist with demands to compete with the private sector.

Bemidji Area is impacted by inflation, whether for salaries and fringe packages, medical inflation, population growth and increased disease burden post pandemic. Increased reliance on grants and 3rd party billing due to the recent pandemic but remain a major source of Tribal infrastructure. Staffing shortages remain impactful on all aspects of treating patients, from scheduling, hours of operation, billing, but more importantly quality health care, and patient satisfaction.

Mandatory funding reduces financial instability, increases necessary primary care and ancillary services needed for American Indians in the Bemidji Area. Bemidji Area Tribes invest large amounts of Tribal, Federal resources and time to plan, develop and implement Tribal health programs. Assuring Advanced Appropriations and Mandatory funding are permanent will protect and preserve the health and welfare of Tribal populations. Moving the increased IHS budget into the Mandatory budgetary process would secure the future of IHS Federal and Tribal resources to allow Tribes a path to sustaining their budgets, reduction in costs associated with vendor contracts, stabilizing staffing levels and improving Recruitment and Retention practices.

In addition, many Tribes are seeing an increase in Tribal elder populations living longer but continue to experience complicated health conditions as they age. This can create situations that impact an elder living in their own home, if they are unable to take care of themselves. Our elders are considered the keepers of our cultural practices, our religious practices and the language that identifies us. They are our national treasures. If our elders are removed from the Tribal community due to a lack of needed services it is a deemed a major detriment to that Tribal community. A new line item for Long Term Care could give Tribes the flexibility to design programs that meet the needs of their community in providing care to Elders, and those who are medically or mentally incapacitated.

The additional funding further supports a Tribe's sovereignty over ~~its~~ Tribal data as a priority which requires mandated education to all federal, state and local agencies and to create a process that meets the Tribe's approval through signed MOUs, which clearly outlines ownership of Tribal data, access and restriction while also assuring that Tribal data security processes doesn't create barriers for data exchanges with IHS and other agencies. Data Sovereignty is critical for how Bemidji Area tell Bemidji Area stories and plan for Bemidji Area Tribal future.

Without access to real time data, Bemidji Area is at a greater risk for increases in Public Health Emergencies in the future. Poor or outdated data has restricted Tribes' ability to access funding to educate, prevent, and treat public health crises. This could also benefit Tribal health centers quality improvement practices. Additionally, information learned could assist with recruitment and retention practices by the IHS and Tribes.

Alcohol & Substance Abuse (ASA) +$4.2B

The Bemidji Area recommends $4.2B above the FY 2024 enacted amounts to be applied to the Alcohol & Substance Abuse budget line item to address the unmet need for treatment and recovery service within the Bemidji Area.

Specifically, Bemidji Area Tribes desire increased funds to fully support programs in bio-psycho-social-emotional healing, wellness, and recovery for patients with diagnosed substance use disorders and co-occurring conditions. A holistic approach to healing and wellness, grounded in cultural identity and proximal to family and community, is needed in the Bemidji Area. Currently, patients with substance use disorders are placed outside the area or wait-listed in private-sector residential treatment facilities without access to cultural programming. The increase to recurring funding is needed to support program development. Sustainability will be achieved through strategic geo-location of programs with greater CMS reimbursement parity.

Additional funding is needed to expand access to evidence-based treatment services including new treatment and recovery strategies for broader substances of abuse — including methamphetamine. Tribes have established dedicated chemical dependency treatment services including residential treatment services; however additional funding is necessary to support integrated outpatient treatment services and aftercare services. Funding is also necessary to support new strategies that include hiring and training a workforce to support whole-health and peer recovery support strategies.

Additionally, Bemidji Area Tribes desire to expand access to integrated approaches to pain management that include evidence-based complimentary treatments such as physical therapy, acupuncture, and massage therapy; integrated behavioral health services that provide mindfulness-based interventions; and practice-based approaches that incorporate traditional medicine services. Dedicated funding to establish pilot projects within the Bemidji Area will support a growing evidence base of effective strategies to improve pain management outcomes as well as funding to support naloxone procurement activities.

The impact of alcohol and substance abuse within the Area is having a dramatic negative impact on the lives, families and communities of the American Indian population in the Bemidji Area. Many Tribes continue to report a state of emergency with increases in Opioid use occurring in overdosing and death. Current funds available through grants are too restrictive and ignores the impact culture has with health and wellness, our spiritual belief system is paramount in maintaining a sober lifestyle that American Indians can embrace, grow, and excel in. Substantial increases in this line item would improve programs capacity to assess and treat, but the need for detox centers and long-term treatment centers, short term outpatient recovery programs along with transitional housing expansion and sober living housing options that offer resources for the whole family to support their loved ones in recovery are in critical need. This is a multifaceted issue and

requires a coordinated joint agency effort and input to address issues identified and roll out a plan than can meet our regional need.

Funding Sections 708 of IHCIA for after-treatment care, adolescent care, family involvement services, and psychiatry adolescent care would be beneficial in advancing support in achieving greater success rates and breaking the addiction cycle.

Mental Health $1.95B

The Bemidji Area recommends $1.9B to be applied to the Mental Health (MH) budget line item to address the unmet behavioral health needs, establish new integrated behavioral health service lines in primary care, enhance behavioral health screening, and to advance regional zero suicide initiatives.

The additional funding is needed to support implementation of the HHS Roadmap for Behavioral Health Integration.[110] The aim of the Bemidji Area is to establish two new integrated behavioral health pilot programs in two Urban Indian Organizations. Additionally, this funding will be used to support development of Primary Care Behavioral Health integration models and provide start-up costs for new programs and to enhance integration levels from Level II to Level III (Basic Collaboration on-site). These funds will be used to hire integrated behavioral health clinicians, to enhance patient screening for behavioral health conditions within primary care settings, enhance whole-health approaches and health behavioral interventions to include high-intensity follow-up in a community outreach model. Additional funding is requested to establish a pilot project within the Great Lakes Tribal Epidemiology Center to determine feasibility for measurement-based care for behavioral health. Targeted, data-driven solutions will create capacity for precision medicine models as well as enhance preventative strategies to achieve 'zero suicide'.

Bemidji Area Tribes are also interested in expanding residential treatment capacity, including treatment for co-occurring substance use disorders. Braided funding streams to support construction costs as well as ongoing operating expenses are needed while sustainability mechanisms are considered.

Mental Health needs critical funding to support the increase demands on Tribal programs that offer limited services now for mental health issues. The Bemidji area is experiencing higher rates of depression, suicide, and co-occurring disorders in addition to complicated addiction issues. The inadequate financial resources available impact a Tribe's ability to recruit or retain qualified staffing to work in Tribal health settings and create barriers to accessing necessary treatment to support complicated mental health issues.

Continued support for the IHCIA section 127- 704 and 705 would address the barriers to access and treatment. While Telehealth has supported our Tribes with qualified staff, staffing issues at the local Tribal level remain, we still are lacking in offering those on-site services and support necessary for treatment.

As the Bemidji Area has found, the inability to address the root cause has manifested into an increasing problem of prescription and synthetic drug abuse/misuse as well as experimentation and addiction to illicit drugs. This funding recommendation supports Section 127 of the IHCIA for increasing the number of mental health providers and funding training/education as well as Sections 704 and 705, which advance the behavioral health programs and programming to address community issues.

Bemidji Area Tribes expressed Mental Health program increased funding needs specifically to be for long-term treatment and after-care facilities/ staffing to combat mental health diseases. There was also discussion on increases of funding for mental health education resources for prevention and dealing with the onset of mental health issues within the communities. Strengthening funding for Section 702 of the IHCIA would include support in meeting these needs.

Purchased/Referred Care (PRC) $10.02 B

The Bemidji Area recommends $10.02 B be applied to the Purchased/Referred Care (PRC) budget line item.

This increased funding will facilitate increased access to specialty/referral care within the Bemidji Area. The level of unmet need and lack of CMS parity within the Bemidji Area contributes to health disparities with varying access to preventative health services contributing potentially to increased catastrophic care costs. Consistent access to specialty care for cancer diagnoses and rehabilitative services through PRC funding is necessary to reduce overall health care burden and

110 https://aspe.hhs.gov/sites/default/files/documents/84a701e0878bc26b2812a074aa22a3e2/roadmap-behavioral-health-integration.pdf.

improve community population health outcomes. This additional funding will also assist the Bemidji Area with applying PRC medical priorities for substance use disorder treatment, expanded dental priorities for primary and secondary dental disease, as well as medical services for rehabilitative oral health services for patients with poor prognosis. This funding may also support access to gender-affirming care services.

In addition, this funding will address social determinants of health and address risk factors related to access to transportation services as non-emergency transportation is not currently a Medicaid covered service in the states of WI or MI.

The Bemidji Area Tribal programs are heavily dependent on PRC. Historically, the Bemidji Area Tribal programs primarily delivered services as PRC programs until the (ISDEAA 93-638). Approximately 2/3 of the Area Tribes are considered small Tribes and, therefore, do not typically have the capacity to provide comprehensive health services through conventional methods of a clinic and are heavily dependent upon PRC to provide services to their communities. Combining with rural locations increases the demand on PRC for patient transportation costs. Overtime, all Area Tribal programs have invested their own resources to build primary and direct care arrangements for their respective communities to meet the need. While primary and direct care programs exist, access to more advanced care is still needed and PRC funding increases will assist with this need along with augmenting direct care services.

Dental $2.96B

The Bemidji Area recommends $2.96B be applied to the Dental budget line item to address the Area and Tribal oral health needs.

Poor oral health is associated with other chronic disease (diabetes, heart disease, addiction, and stroke) with compounded impacts from intergenerational, historical trauma contributing to disparate rates of tobacco product use and unhealthy diet.[111] Increased funding will be used to purchase preventative oral health patient education materials, support early head-start prevention interventions, and to address social determinants of health. Increases in the dental budget line-item will support implementation of the IHS Oral Health Status Report patient screening tool to identify high-risk dental patients and to provide high-intensity dental care follow-up and education. Routine use of this tool may also create data flows and support metrics to better understand the impact of oral health disease on overall population health outcomes.

The increased funding will also support recruitment and retention of dental providers to rural, underserved areas. This funding will also support recruitment and retention of expanded function dental assistants as well as exploration of pilot projects and collaborations with academia to train and place Dental Health Aide Therapists to improve access to preventative dental services.[112]

Dental services are a growing need in the Area and a recent analysis of the funding received showed that the current level of funding equates to only $20 per individual in the Bemidji Area. In the Bemidji Area specifically, Tribal programs are establishing and expanding dental program operations but the limited funding leave the programs with the difficulty of balancing and supplementing these changes with other funding, thereby, eroding the program's purchase power. The changes to the programs are needed as Area Tribes recognize that the oral health is a component of holistic care. Oftentimes, oral health suffers/diminishes as collateral damage when the need for medical care is greater from a fiscal perspective but studies have shown that dental problems are exacerbated when coupled with chronic disease. Needed funding will improve access to dental/oral health care services and treatment. Additional funding will educate youth, families and communities on good oral health methodologies, thereby, increasing self-awareness, image and esteem.

Electronic Health Record (EHR) Upgrade $319M

The Bemidji Area recommends $319M be applied to the Electronic Health Record Upgrade.

Modernization of the Electronic Health record package for Indian Health Services and Tribal Health Centers who access this program needs to keep pace with current EHR practices in the private health care sector. The national initiative to replace the current system is in the beginning phase of implementation and a request for regular updated reporting on progress including any budgetary increases related to general inflation rate and or

111 https://www.cdc.gov/mmwr/volumes/66/wr/mm6650a2.htm.
112 https://dentistry.umn.edu/dental-therapy.

changes in product availability is needed to assist Tribes in how they will plan to support an outdated system. Many Tribes have opted to invest in off the shelf packages that assist in maximizing resources to financially support Tribal health systems. Tribes are requesting 100% costs for reimbursement of EHR packages already implemented. Many Tribes in this region have committed to this huge financial investment for improved quality of care for the American Indians they serve and to meet CMS regulations.

In addition, demands for support services through IHS is increasing while funding remains limited. Tribes are seeking reduced cost in buyback services to fulfill needs. Concerns continue to grow as these costs continue to rise and are assumed by those Tribes who elect to stay with IHS' supported EHR systems. Additionally, Tribes see an increased need in technical support and training opportunities when continuing to utilize RPMS/EHR systems and keep up with the true cost for replacement of necessary equipment (like computers) to a Tribal health center, which can be cost prohibitive.

The benefits to all Tribes and urban programs would be greatly enhanced by adequately funding the upgrading of the IHS EHR system, thus, reducing individual Tribes/urban programs overall costs. It will improve necessary data collection policies and practices outside of Tribal health centers. Accurate and reliable data collections is necessary for Bemidji Area.

Public Health Nursing $750.94M

The Bemidji Area recommends $750.94M be applied to the Public Health Nursing budget line item.

Investment into Public Health infrastructure will assist Tribes in identifying, assessing, and implementing Best Practices to reduce health disparities in Tribal Communities. Expansion of Public Health Authorities will enhance the resources and tools needed to provide quality health promotion and disease prevention services and activities that are unique to Tribal communities. These authorities also support Tribal Sovereignty and jurisdiction.

Health Care Facilities Construction +$3.2B

The Bemidji Area recommends $3.2B, above the FY 2023 enacted funding to be applied to the Health Care Facilities Construction budget line item.

Many Tribal health care facilities are outdated and in dire need of replacement. The current IHS Priority policy for New Construction does not include any facility in the Bemidji Area and current timeline to complete this will be many years out. Bemidji Area Tribes' options to provide direct health care services in the facilities which need replacement and remodeling. Other impacts in poor facilities hinders the ability to provide quality health care, improve outcomes consistently and decreases opportunities to retain current staff or recruit new hires. Examples like Patient Family Center models of care would increase optimal health care settings, health outcomes, and would increase funding opportunities for Tribal Health Centers.

Urban Health +$303.03M

The Bemidji Area recommends $303.03M applied to the Urban Health budget line item.

Urban Indian Health Centers need critical funding increases to serve large American Indian populations in the urban settings of Bemidji Area. Increase in funding would support authorized new programs and services of the IHCIA Title I – Subtitle E: Health Service for Urban Indians, Sec. 164 – Expand Program Authority for the Urban Indian Organizations {25 U.S.C. § 1660e}.

Urban health programs rely heavily on grants which can be restrictive in access and scope which makes it difficult to utilize for planning or to create a stable financial infrastructure. Increases to appropriations would allow for a more stable base and ability to offer continuity of care and improved health outcomes for the American Indian Urbans they serve.

Currently, there is an immediate need for FMAP support and expansion of funds for H&C, PRC, Mental Health, Alcohol and Substance Abuse, 105(l) leasing programs and reauthorization of SDPI to an underserved and often ignored at risk demographic region in the Bemidji Area. Assurance of urban funding keeps pace with increased population growth, medical inflation, and recruitment and retention of qualified health professionals is needed.

Community Health Representatives +$327.82M

The Bemidji Area recommends $327.82M be applied to the Community Health Representative (CHR) budget line item.

This funding is instrumental in supporting Tribally-administered program of AI/AN community members trained in basic disease control and prevention. These activities include serving as outreach workers with the knowledge and cultural sensitivity to effect change in community acceptance and utilization of health care resources and use community-based networks to enhance health promotion/disease prevention.

The CHRs are one of the main hubs connecting the Indian health care facilities to the AI/AN communities. They are instrumental in delivering much needed services and are often overlooked in their contribution in fighting the health service disparities in Indian Country. Full funding of this valuable resource will greatly enhance the quality of life for the patients they serve.

Additionally, this funding will help address social determinants of health and address risk factors related to access to transportation services (non-emergency transportation is not currently a Medicaid covered service in WI or MI).

Hot Issues

Summary

URBAN INDIAN HEALTH CENTERS NEED CRITICAL FUNDING INCREASES

Increase in funding would support authorized new programs and services of the IHCIA title I – subtitle E: Health Service for /urban Indians, Section 164-Expand Program Authority for the Urban Indian Organizations.

SECURING ADVANCED APPROPRIATIONS & MANDATORY FUNDING FOR UNDERFUNDED I/T/U HEALTH CARE PROGRAMS

to support financial stability in all budget line times (including CSC, 105(*l*)) and reduce interruptions in health care services.

SECURE AND SUPPORT PERMANENT SPDI REAUTHORIZATION

Requesting to support Permanent SDPI Reauthorizations at $250M with automatic annual funding increases tied to medical inflation rate. Allowing Tribes to receive SDPI funding through their IHS funding agreements via compacts or contracts if requested. Hold grantees harmless if any future declarations of sequestration occur which in past years have reduced the annual funding amount Tribes can access. Increase stagnant funding and expand the reach of SDPI program to Tribes not currently participating in SDPI. Requesting Tribal Consultation to make recommendations at redirecting unspent SDPI funds that need to be returned to HHS.

SECURE AND SUPPORT OMB RATE FOR MEDICARE SERVICES

Current discussions of OMB Medicare All-inclusive Rate with the coordination of Medicaid programs that Tribes rely on as an additional resource for reimbursement when treating patients through Tribal health programs. Support preservation of Medicaid through IHCIA and other Indian provisions of the ACA (P.L., 111-148).

SECURE AND SUPPORT REIMBURSEMENT FOR HOLISTIC TREATMENTS

There is no reimbursement mechanism in place to provide traditional healing, acupuncture, dry needling, and chiropractic. Support financial stability for cultural and holistic healing approaches. Increase revenue and billing capacity for 3rd party by supporting the reauthorization of the Indian Health Care Improvement Act and expanding authorities of the bill. Coordination with Federal agency CMS (TTAG) workgroup, State and local agencies.

ADVANCED RECRUITMENT AND RETENTION EFFORTS

The IHS Loan Repayment program is not keeping pace with current standards and require significant increase in salary, fringe and housing packages to bring in qualified medical professionals.

ACCESS TO RELIABLE DATA TO SUPPORT TRIBES SOVEREIGNTY

Data collection policy and practice outside of Tribal health centers need addressing to improve and increase accurate and reliable data collection for Tribes in the Bemidji Area.

EHR MODERNIZATION FUNDING INCREASE FOR ADDED TECHNICAL SUPPORT, DATA RETRIEVAL, & INFLATION

CONSTRUCTION FUNDING TO ADD HEALTH CARE FACILITIES TO INCLUDE HOUSING AND PRIORITIZATION OF BEMIDJI AREA

LONG-TERM CARE FUNDING

A new line item for Long Term Care could give Tribes the flexibility to design programs that meet the needs of their community in providing care to

Elders, and those who are medically or mentally incapacitated.

ADDITIONAL RESOURCES TO FURTHER SUPPORT ALCOHOL AND SUBSTANCE ABUSE REHABILITATION

Current funds available through grants are too restrictive and ignores the impact culture has with health and wellness, our spiritual belief system is paramount in maintaining a sober lifestyle that American Indians can embrace, grow, and excel in.

ADDITIONAL RESOURCES TO FURTHER SUPPORT MENTAL HEALTH NEEDS

The inadequate financial resources available impacts a Tribe's ability to recruit or retain qualified professionals to work in Tribal health settings and to reduce barriers to accessing necessary treatment to support complicated mental health issues. Funding is needed to increase access.

Urban Indian Health Funding

ISSUE

Urban Indian Health Centers need critical funding increases to serve the large American Indian populations in the Bemidji area. Increase in funding would support authorized new programs and services of the IHCIA title I – subtitle E: Health Service for /urban Indians, Section 164-Expand Program Authority for the Urban Indian Organizations.

BACKGROUND

Urban health programs rely heavily on grants which can be restrictive in access and scope and makes it difficult to utilize for planning or to create a stable financial infrastructure. Increases to Appropriations would allow for a more stable base and ability to offer continuity of care and improved health outcomes for the American Indian Urbans they serve.

RECOMMENDATION

Request Urban confer in timely manner.

Continue to support 100% FMAP and allow for expansion of funds for H&C, PRC, Mental Health, Alcohol and Substance Abuse, reauthorization of SDPI and 105 L leasing program to an underserved and often ignored at risk demographic of Indian Country.

Assure Urban funding keeps pace with increase in population, medical inflation, Recruitment and Retention of qualified Health professionals.

Advanced Appropriations & Mandatory Funding

ISSUE

Lack of Mandatory Funding and Advance Appropriations lead to financial instability, interrupt necessary primary care and ancillary services needed for American Indians in the Bemidji Area.

Critical Under Funding of ITU Health Care Programs has created an environment of uncertainty when it comes to planning, development, and implementation of Tribal health programs. Applying limited financial resources to the delivery of health care in the Bemidji Area.

BACKGROUND

Tribes invest large amounts of resources and time to plan, develop and implement Tribal health programs.

Most Tribes are unable to compete with more populated high demand areas due to their geological and historical territory of the Bemidji area which makes recruitment and retention of medical health professionals a challenge. We are unable to keep up with inflation, whether it's salaries and fringe packages, medical inflation, population growth and the increased disease burden that we are experiencing. The high rates of vacancies in the Area office and Tribal settings continue especially since the COVID 19 outbreak.

RECOMMENDATION

Assuring Advance Appropriations are permanent will protect and preserve the health and welfare of our Tribal populations.

Moving the budget into the Mandatory budgetary process would secure the future of IHS federal and Tribal resources to allow Tribes a path to sustaining their budgets, reduction in costs associated with vendor contracts, stabilizing staffing levels and improving Recruitment and Retention practices.

Recruitment and retention practices need to be more aggressive and competitive to bring in qualified Health Care medical professionals. Increased reliance on grants and 3rd party billing have been limited due to the recent COVID 19 pandemic but remain a major source of our Tribal infrastructure. Staffing shortages has an impact on all aspects of treating patients, from scheduling to hours of operation, billing, but more important quality health care, patient satisfaction.

Secure and Support Permanent SPDI Reauthorization

ISSUE

Special Diabetes Program for Indians Permanent Reauthorization Need

BACKGROUND

Efforts to renew the SDPI program have been hampered by Budget discussion at the National level, limited reauthorization has occurred for the time being.

RECOMMENDATION

Permanent Reauthorization of the SDPI at 250M. Legislative authority to add into Tribes 638 contract or compact. Hold grantees harmless if sequestration occurs in future, which in recent past reduced the amount of funds available to Tribes. Increase stagnant base funding amounts and provide opportunity for new Tribes to apply. Support Tribal consultation regarding any unspent SDPI funds that need to be returned to the agency.

OMB Rate for Medicare Services

ISSUE

Current discussions of OMB Medicare All-inclusive Rate with the coordination of Medicaid programs that Tribes rely on as an additional resource for reimbursement when treating patients through Tribal health programs. Support preservation of Medicaid through IHCIA and other Indian provisions of the ACA (P.L., 111-148).

BACKGROUND

The Medicaid program is a federal responsibility and an essential service for closing health care gaps while supporting health care services in remote areas. At risk populations experience barriers to access in so many areas and this program is a vital piece of a Tribal health system.

RECOMMENDATION

- Establish uniform and consistent regulations for MLR with all Tribes regardless of what state Tribes are from.
- Support preservation of Medicaid through IHCIA and other Indian provisions of the ACA (P.L., 111-148).
- Provide the funding to implement these new authorities. The Medicaid program is a federally responsibility and should additionally protect American Indians from premium cost sharing requirements and allow Indian Health Care Provider to be compensated immediately at the IHS Reimbursement rate (OMB) rate, or at a rate set out by a state plan.

Secure and Support Reimbursement for Holistic Treatments

ISSUE

No reimbursement mechanism in place for complimentary healing practices within Tribal settings.

BACKGROUND

Complimentary services like traditional healing, chiropractic services and acupuncture are one part of the healing process for body, spirit, and mind.

RECOMMENDATION

Support Reauthorization of the Indian Health Care Improvement Act Authorities. Coordination of Federal agency through Federal Workgroup (TTAG), facilitation with State and local agencies as well.

Recruitment and Retention

ISSUE

The IHS Loan Repayment program isn't keeping pace with current standards and require significant increase in salary and fringe packages to bring in qualified medical professionals.

BACKGROUND

The current loan repayment program does not cover all necessary professionals to run health programs efficiently and effectively nor does is compare to what is being offered in the private sector to leverage recruiting efforts.

RECOMMENDATION

Allow for increase in bonus packages to retain staff, offer moving expenses and housing allowances in Tribal housing settings where applicable. Increase the total amount eligible for active applicants in the Loan Repayment program and expand incentives for medical students to work in Tribal health community settings to reduce or write off tuition scholarships. Assure accurate data reporting in HPSA scoring system is reflecting accurate staffing level and need. Confirmation process needed in securing Area recruiting staff at Tribal and Regional events to promote the potential employment opportunities throughout the Bemidji Area.

Access to Reliable Data

ISSUE

Data collection policy and practice outside of Tribal health centers need addressing to improve and

increase accurate and reliable data collection for Tribes in the Bemidji Area.

BACKGROUND
How Tribes benefit directly from the data collection, to tell our stories and plan for our future is Data Sovereignty. Without access to real time data, we are at a greater risk for increases in Public Health Emergencies in the future. Poor or outdated data has restricted Tribes' ability to access funding to educate, prevent, and treat public health crises. This could also benefit Tribal health centers quality improvement practices. Additionally, information learned could assist with recruitment and retention practices by the IHS and Tribes. Tribes see an increased need in technical support and training opportunities when continuing to utilize RPMS systems and will an increase in financial support to keep up the true cost for replacement of necessary equipment (like computers) to a Tribal health center, which can be cost prohibitive.

RECOMMENDATION
Supporting a Tribe's sovereignty over its data is a priority which requires mandated education to all federal, state and local agencies and to create a process that meets the Tribe's approval through implementation of signed MOUs, clearly outlining who owns Tribal data and whom will have access or not, while also assuring that data security processes doesn't create a barrier from our own data with IHS and other agencies.

Electronic Health Records Modernization

ISSUE
Modernization of the Electronic Health record package for Indian Health Services and Tribal Health Centers who access this program needs to keep pace with current EHR practices in the private health care sector.

BACKGROUND
The national initiative to replace the current system is in early stages of implementation and a request for regular updated reporting on progress including any budgetary increases related to general inflation rate and or changes in product availability is needed to assist Tribes in how they will plan to support an outdated system. Many Tribes have opted to invest in off the shelf packages that assist in maximizing resources to financially support Tribal health systems.

RECOMMENDATION
Tribes are requesting 100% costs for reimbursement of EHR packages already implemented. Many Tribes in this region have committed to this huge financial investment for improved quality of care for the American Indians they serve and to meet CMS regulations. In addition, Tribes are requesting for the IHS to offer buy back services at a much more reduce costs, concerns that costs are too high, and these costs are passed on to those Tribes who haven't purchased separate EHR packages. Tribes need the option to negotiate this.

Construction Funding

ISSUE
Many Tribal health care facilities are dated and in dire need of replacement.

BACKGROUND
The current IHS Priority policy for New Construction does not include any facility in the Bemidji Area and current timeline to complete this will be many years out. Our only option to provide direct health care services to our Tribal populations, is to work in the facilities which need replacement and directly impact on our ability to provide quality health care or improved outcomes consistently and decreases opportunities to retain current staff or recruit new hires.

RECOMMENDATION
Examples like Patient Family Center models of care would increase optimal health care settings, health outcomes, and would increase funding opportunities for Tribal Health Centers.

Long-Term Care

ISSUE
Many Tribes are seeing an increase in Tribal elder populations living longer but continue to experience complicated health conditions as they age. This can create situations that impact an elder living in their own home, if they are not able to take care of themselves.

BACKGROUND
Our elders are considered the keepers of our cultural practices, our religious practices and the language that identifies us. They are our national treasures. If our elders are removed from the Tribal community due to a lack of needed services is a major detriment to that Tribal community.

RECOMMENDATION

A new line item for Long Term Care could give Tribes the flexibility to design programs that meet the needs of their community in providing care to Elders, and those who are medically or mentally incapacitated. Supportive home care services can offer families who can care for their family member staffing assistance to provide respite care, activities of daily living, like bathing and meal preparation or medication assistance and would enhance and improve the quality of life that our Elders and Tribal Community need to thrive, remain intact. Multiple generational living is and can be a loving, supportive and creative environment. Alternatives to nursing homes like adult day care centers, or respite centers can offer families much needed emotional support to alleviate the demands on families who want to keep their families together.

To maximize on all available resources, expand training opportunities, certification and credentialing processes to assure that supportive services are available from all local, state and federal partners for Tribes to access thereby a Tribe's ability to seek reimbursement to sustain Tribal programs.

Alcohol and Substance Abuse

ISSUE

Impact of alcohol and substance abuse with the Area is having a dramatic and negative impact on the lives, families and communities of the American Indian population in the Bemidji.

BACKGROUND

Many Tribes continue to report a state of emergency with increases in Opioid use occurring in overdosing and death. Current funds available through grants are too restrictive and ignores the impact culture has with health and wellness, our spiritual belief system is paramount in maintaining a sober lifestyle that American Indians can embrace, grow, and excel in.

RECOMMENDATION

Substantial increases in this line item would improve programs capacity to assess and treat, but the need for detox centers and long-term treatment centers, short term outpatient recovery programs along with transitional housing expansion and sober living housing options that offer resources for the whole family to support their loved ones in recovery are in critical need. This is a multifaceted issue and requires a coordinated joint agency effort and input to address issues identified and role out a plan than can meet our regional need.

Mental Health

ISSUE

Mental Health needs critical funding to support the increase demands on Tribal programs that offer limited services now for mental health issues.

BACKGROUND

The Bemidji area is experiencing higher rates of depression, suicide, and co-occurring disorders in addition to complicated addiction issues. The inadequate financial resources available impact a Tribe's ability to recruit or retain qualified staffing to work in Tribal health settings and create barriers to accessing necessary treatment to support complicated mental health issues.

RECOMMENDATION

Continued support for the IHCIA section 127-704 and 705 would address the barriers to access and treatment. While Telehealth has supported our Tribes with qualified staff, staffing issues at the local Tribal level remain, we still are lacking in offering those on-site services and support necessary for treatment.

Billings Area



1H	Blackfeet Community Hospital	Browning, MT	Hospital
2H	Crow/Northern Cheyenne Hospital	Crow Agency, MT	Hospital
3H	Fort Belknap Hospital	Harlem, MT	Hospital
4	Chief Redstone Clinic	Wolf Point, MT	Health Center
5	Eagle Child Health Station	Hays, MT	Health Center
6	Fort Washakie Health Center	Fort Washakie, WY	Health Center
7	Heart Butte Health Station	Heart Butte, MT	Health Center
8	Lodge Grass Health Clinic	Lodge Grass, MT	Health Center
9	Northern Cheyenne Health Center	Lame Deer, MT	Health Center
10	Pryor Health Clinic	Pryor, MT	Health Center
11	Verne E. Gibbs Clinic	Wolf Point, MT	Health Center
12	Helena Indian Alliance	Helena, MT	Urban Health Center
13	Indian Family Health Clinic	Great Falls, MT	Urban Health Center
14	Missoula Urban Indian Health Institute	Missoula, MT	Urban Health Center
15	North American Indian Alliance	Butte, MT	Urban Health Center
16	Flathead Community Health	Kalispell, MT	Tribal Health Center
17	Rocky Boy Tribal Health Center	Box Elder, MT	Tribal Health Center
18	Wind River Family and Community Healthcare	Arapahoe, WY	Tribal Health Center

H Hospitals range in size from 8 - 45 inpatient beds, employing 225 - 475 employees.
Outpatient health centers average 35 - 180 employees.
American Indian Reservation

- Billings Area FY 2021 User Population = 70, 219
- The Billings Area consists of 8 Reservations – Blackfeet, Crow, Fort Belknap, Fort Peck, Northern Cheyenne, Wind River (Eastern Shoshone/ Northern Arapaho), Flathead and Rocky Boy
- The Billings Area has 10 Direct Service Tribes.
- Seven (7) Title I ISDEAA Contracts (5 in Montana and 2 Wyoming)
- Two (3) Title V ISDEAA Self-Governance Tribes (Confederated Salish and Kootenai Tribes, Northern Arapahoe & Rocky Boy)
- There are five (5) Urban Health Centers in the Billings Area: Helena, Great Falls, Billings, Missoula & Butte
- There are three (3) Federally Operated Hospitals and several Satellite Clinics in the Billings Area

Budget Recommendations

Mental Health

Mental Health is a high priority for the Billings Area for the FY2027 Budget Formulation. The Billings Area Office (BAO) Indian Health Service (IHS) and Tribal Behavioral Health Departments are striving to increase behavioral health services. The BAO has devoted personnel and resources to assist behavioral health delivery in all of the service units. The IHS has been historically vastly underfunded, which continues up to today. More resources are needed to address the true mental health needs of our beneficiaries. This is a treaty obligation of the federal government that the federal government has violated decade after decade.

COMMUNITY HEALTH AIDE PROGRAM

The Community Health Aide Program (CHAP), with Medicaid authorization extended in 2023 by the Montana Legislature, has great potential for increasing behavioral health clinical and community-based services. The IHS and Tribes in Montana and Wyoming are working to implement this program as soon as possible.

AVEL TELE-BEHAVIORAL HEALTH SERVICES EXPANSION

Behavioral Health Services have been bolstered with the increasing provision of tele-behavioral health through Avel. The IHS has contracted with Avel to provide services at all of the IHS Service Units. These services are expensive, but necessary in the context of our difficulty in filling behavioral health provider positions in the Service Units. Avel has been instrumental in providing both emergency behavioral health assessments and ongoing psychotherapy.

RECRUITMENT AND RETENTION OF BEHAVIORAL HEALTH STAFF

BAO has had a high degree of difficulty in recruiting and retaining Behavioral Health clinicians. IHS is working to increase compensation to behavioral health providers. Furthermore, the entire State of Montana is designated as a High Professional Shortage Area (HPSAs) for Mental Health Care (Montana Department of Public Health and Human Services, Primary Care Office, 2018, p. 13). Tribal Leaders for the Billings Area have expressed concern

about the lack of mental health services and a need for more mental health clinicians and professionals. It is imperative that behavioral health and primary care services are coordinated between both the IHS and Tribes to overcome challenges with recruitment and retention of mental health clinicians and other providers such as social workers. Increased mental health funding will assist with the ability to hire and retain quality professionals and provide improved mental health services to our patients. An increase in mental health funding will also provide for increased staffing of qualified mental health workforce. WE NEED TO RAISE LEVELS OF COMPENSATION TO BE MORE COMPETITIVE IN HIRING.

REDUCING SUICIDES

THERE HAS BEEN AN ALARMING INCREASE IN SUICIDES OF NATIVE AMERICAN WOMEN AND VERY HIGH LEVEL OF SUICIDE OF NATIVE AMERICAN MEN. Suicide rates among non-Hispanic AI/AN persons increased nearly 20% from 2015 (20.0 per 100,000) to 2020 (23.9), compared with a <1% increase among the overall U.S. population (13.3 and 13.5, respectively) (CDC, 2023)

American Indian and Alaska Native (AI/AN) populations have disproportionately high rates of suicide, unintentional injuries, and drug overdose deaths. The IHS Strategic Plan aims to strengthen the overall health status of the AI/AN population. The tragedy of suicide continued with suicide clusters on several reservations over the past few years. Suicide rates are high in Montana, higher for Native Americans but also much higher overall than the national average. From 2009 to 2018 Native Americans in Montana committed suicide at a rate of 31.39 per 100 thousand, while Caucasians did so at a rate of 23.37 per 100 thousand. (Carl Rosston, MT DPHHS Suicide Prevention Specialist). From the Centers for Disease Control (CDC), in 2018 the national rate of suicide in the United States was 14.21 per 100 thousand, while the overall rate in Montana was 24.86 per 100 thousand. (CDC, cdc.gov/injury/wisqars/fatal.html on 3/1/2020).

In 2020, the Native American population of Montana was 66,839. There were 36 deaths by suicide by Native Americans in 2020 (Matthew Ringel, MPH Vital Statistics Epidemiologist; Office of Epidemiology and Scientific Support. MRingel@mt.gov).

QUESTION, PERSUADE, REFER (QPR), MENTAL HEALTH FIRST AIDE, COMMUNITY RESILIENCY MODEL (CRM) AND ZERO SUICIDE

IHS has increased our efforts to train our own staff and to provide outreach services to reduce the incidence of suicide. Numerous staff have been trained in QPR during the past year, along with Mental Health First Aide, Community Resiliency Model and Zero Suicide. We have sent our staff to meetings with Tribal and state agencies to coordinate these efforts. In 2023, we are extending trainings to urban programs and continuing training offering to Tribal programs.

MENTAL HEALTH AND SUBSTANCE USE DISORDERS

IHS and the Tribes of Montana and Wyoming identify a strong correlation between substance abuse and trauma issues stemming from mental health disorders. Data available indicates Mental Health is severe in Native Country. For every life lost to suicide, 135 lives are exposed (Julie Cerel, 2019). Native Americans are three times more likely to commit suicide compared to the national average. American Indians communities did not fare as well as other communities for several socio-economic indicators, including lower high school graduation rates, higher unemployment, and lower household income (Montana Department of Public Health and Human Services, 2017). The report indicates in Montana: 66% of American Indian students graduate high school in 4 years; nearly 2 in 5 children live in poverty; 84% American Indian adults reported one or more adverse childhood experience; 15% of American Indian people report frequent mental distress; Nearly 1 in 5 American Indian high school students reported attempting suicide and 15% of American Indian adults report frequent mental distress.

DEPRESSION: GOVERNMENT PERFORMANCE AND RESULTS ACT (GPRA)

The GPRA data establish that there is a very high incidence of depression and mood disorders in Native American youth. The Billings Area has collected the Government Performances and Results Act of 1993 (GPRA) measures for Depression Screening or Mood Disorder, which show an incidence of depression and mood disorders of 44.4% in 12-17 years old and 48.02% in 18 years and older. (Mental Health Services is authorized by the Indian Health Care Improvement Act, 25 U.S.C. § 1621h.)

Mental health funding is requested for the following budget priorities:

1. Forty-eight hour Stabilization Facility on each reservation, with particular emphasis on those reservations that are most isolated; there is a critical need for these facilities given the increasing difficulty with placement in inpatient facilities, increasingly brief stays in inpatient facilities, and extreme difficulty with transportation to and from distant facilities.
2. Increased Pay Scales for masters-level behavioral health clinicians (LCSWs and LCPCs); we are currently losing behavioral health clinicians to agencies such as the Veterans Administration (VA) who have higher pay scales for these clinicians
3. Purchase Authority for Essential Operating Equipment: Making it easier for Behavioral Health Departments to directly order office and telehealth equipment.
4. Increase Training Funds; current levels of funding are not sufficient for in-depth training in areas such as Post-traumatic Stress Disorder.
5. Increase bonuses for Relocation, Recruitment, and Retention (3Rs): This is very important for recruiting and retention of qualified mental and behavioral health professionals.
6. Increase Funds for transportation of patients to critical care facilities located off of Tribal lands.
7. Human Resources (HR) funding to hire more staff to assist with filling of Mental and Behavioral Health positions (HR staff have overwhelming caseloads).
8. Maintain or increase Funds for Telehealth services for Mental and Behavioral Health. Telehealth services provide critical services at our IHS facilities particularly during the pandemic as the need for mental health has increased.

IHS STRATEGIC PLAN

- The IHS Strategic Plan FY 2019-2023 advocates an increase in our ability to provide Behavioral Health Services.
- Goal 1 Objective 1.3: Increase access to quality health care services
- Goal 2 Objective 2.2: Provide care to better meet the health care needs of American Indian/Alaska Native (AI/AN) communities.
- Goal 2 Objective 2.3: Reduce the impact of mental and substance use disorders through prevention, early intervention, treatment, and recovery support.

Alcohol and Drug Abuse Programs

AGENCY DESCRIPTION

The Billings Area Indian Health Service office in Billings, Montana, oversees the delivery of public health, environmental health, health care services and community-based disease prevention services to more than 70,000 American Indian and Alaska Native people in Montana and Wyoming. These services are delivered through IHS-operated Service Units, Tribally-operated health departments, and urban Indian health programs. Our mission is to raise the physical, mental, social, and spiritual health of American Indian and Alaska Native to the highest level possible. We are committed to accomplishing this through strong partnerships with Montana and Wyoming Tribal leadership and other health care partners serving the American Indian and Alaska Native population in these two states.

Within in our Office of Health care and under the direction of our Chief Medical Officer, Dr. Steve Williamson from the Blackfeet Nation is our Behavioral Health Department overseen by Dr. Alan Ostby who is a prescribing Psychologist and our Mental Health Consultant. The Alcohol & Substance Abuse Programs within the Behavioral Health department work closely with our Behavioral Health Specialist, Robyn Gladue, who has been in the field of addictions for 20+ years. This department serves as the primary source for advocacy, policy development, management, and administration of behavioral health, alcohol and substance abuse, and health promotion & disease prevention programs for American Indian and Alaska Native (AI/AN) people in the Billings Area. Working in partnership with Tribes, Tribal organizations, and Urban Indian health organizations, our department continues to support efforts to share knowledge and build capacity through the development and implementation of evidence-based, practice-based and culturally-based activities in Indian Country.

ALCOHOL & SUBSTANCE ABUSE PROGRAMS

The Alcohol and Substance Abuse Programs (ASAPs) within the Billings Area include (10) individual Tribes of which each Tribe provide Alcohol & Substance Abuse Programming, except for the Salish & Kootenai Tribes who have a combined effort and a total of five urban Indian programs located in Billings, Great Falls, Helena, Butte and Missoula. Each of these ASAPs strive to be a place where individuals can access prevention, treatment & recovery services and information about other community resources to support a Alcohol & Drug free lifestyle.

BACKGROUND

These programs serve as model programs for a client-centered recovery-oriented system of care. Individuals who have a Substance Use Disorders are dealing with a chronic biologically based disease of the brain and as such requires a system of care designed to treat a chronic condition rather than an acute illness. With other chronic conditions, e.g., diabetes, hypertension, heart disease, that are characterized by periods of wellness and acute episodes of care, the care system and intervention are designed to manage the illness in order to promote sustained periods of wellness and eliminate or minimize the need for acute care. Similarly, the addiction treatment system must adapt so as to support the process of sustained recovery.

SERVICES OFFERED

Within the Billings Area there are advocates at the State level for policies and priorities that are pro recovery, develops and delivers numerous training programs to those in recovery as well as addiction professionals, of which our addiction professionals obtain and maintain licensure for continued professional development. These programs are a recovery oriented sanctuary anchored in the heart of the urban and reservation communities. It is a place where recovery-related workshops, trainings, meetings, services and social events are consistently delivered. These programs have demonstrated positive outcomes that produce participants being drug and alcohol free after having lifestyles that were once using and destructive, promote & support finding jobs or returning to school to work towards self-sufficiency and assist in gaining a goal-orientated routine and finding safe and affordable housing to work towards family reunification, eliminating legal issues and overall renewed sense of purpose.

There are several considerations that our ASAPs face on a daily re-occurring basis that include positive and negative attributes. These include:

- Alcohol & Drug Treatment Equity: The right for anyone, anywhere to have access to quality Alcohol & Drug prevention, treatment and recovery services. That promotes and support a recovering lifestyle & delivered in a person centered way within their community or communities directly accessible to them. Care that seeks to overcome social disparities that contribute to challenges and is delivered in a culturally appropriate way that addresses historic trauma, stigma, and individual challenges regardless of personal challenges and history.
- Challenging Behaviors: Persistent pattern of behaviors that inhibit the individual's functioning in their everyday life that negatively affect their own life and others around them. These behaviors may have been present for long periods or have revealed as a severe onset directly related to their use of alcohol and/ or drugs.
- Culturally Competent Services: The application of cultural competence as a function of treatment and services. Per HHS this includes "the ability to honor and respect the beliefs, languages, interpersonal styles, and behaviors of individuals and families receiving services, as well as staff members who are providing such services. Cultural competence is a dynamic, ongoing developmental process that requires long-term commitment and is achieved over time. (HHS 2003a, p. 12)" (TIP 59 2014, p. xv)
- Complex SUD Needs/ Co-Occurring Diagnosis: Long term use, in high quantities and/or use of 2 or more drugs at each use and having either a diagnosed and/or undiagnosed mental health condition.
- Complex Behavioral Health Needs: Issues presented by a person with severe behavioral health challenges that presents with difficult to work with and/or unsafe presentation that is caused by mental health, SUD, and or some combination of co-occurring challenges.
- Decompensate: In medicine, decompensation refers to the deterioration of an individual's mental or physical structure or system that was previously functioning. A system that is compensated can function despite the presence of stressors or defects. Often times our AI/AN people received injury(s) that directly affect their functioning, coping and or ability to comprehend the need(s) that may exist.
- "Habilitative": Services designed to help teach, keep, and improve skills for daily living. It is often in the ASAPs that support an environment of sharing and overall an avenue to other opportunities of growth outside of alcohol & drug use.
- Health Disparity: The rate of disease incidence, prevalence, morbidity, mortality, or survival rates a specific population as compared to the health status of the general population. It has been documented that our AI/AN people are leading in this area related to use of Alcohol and/or Drug Use.

- Crisis Stabilization/Intervention Model: This model is a community crisis center that offers people experiencing a "crisis" an alternative to hospitalization. Where people are provided services immediately in a calm safe environment 24/7 where a person is given tools to resolve their crisis or be referred to their next option.
- Referrals to Residential Setting: These programs work tirelessly to get their clientele into this level of care that is often a lengthy process with pressures received by those wanting immediate help from individuals/families/communities.
- Recovery: Recovery is a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential.

CULTURE OF ASAPS

The funding these programs depend on is designed for their client-centered approach to provide a variety of services supportive of sobriety and a recovering lifestyle. Several states have recognized the importance of peer run services and addiction recovery-based programs to support individuals in their individual journeys to recovery. To deliver peer-to-peer recovery support services that help prevent relapse and promote sustained recovery from alcohol and drug use disorders. Often times it is the person who first entered the treatment programs doors as a client to later become a peer support specialist to provide peer-to-peer recovery support services that are responsive to community needs and strengths and will carry out a performance assessment of these services. This service is intended to support peer leaders from the recovery community in providing recovery support services to people in recovery and their family members, and to foster the growth of communities of recovery that will help individuals and families achieve and sustain long-term recovery. This promotes the system of care model and strengthens each individual community.

The programs host numerous weekly meetings to support those receiving services and their families. The impact and use of these programs continue to grow as they become an increasing critical component of the substance abuse services continuum of care. Some of their visitors have never attended treatment, but share these efforts help them by maintaining and supporting their recoveries and helped them reduce the length and frequency of relapse. These programs are important for community-based leadership to develop a self-led advocacy movement in support of recovery, effectively battling the stigma of addiction with the positive strides in their own lives. These programs continue to expand services and partnerships in support of the continuum of care to include an array of services that support individuals in their recovery from addiction. Recognizing the need to support individuals in their pathway to recovery. These programs have often been the only nurturing and empowering force that they have only known due to the attitude supportive of a recovering environment in which they can learn new skills and develop a social network. These programs help prevent relapse and provide support for sustained recovery within the community. Services will be provided by peers who will also serve as positive role models. These programs also offer training, social, educational and recreational opportunities. There are classes focused on wellness, nutrition and illness management, including classes on self-care, stress management, financial management, literacy education, and job and parenting skills and housing assistance. It is expected that these services result in improved social functioning, reduced substance abuse and an improved quality of life, including more social connectedness.

BUDGET PRIORITIES

Facilities

The Billings Area ASAPs recommend an increase in Health Care Facility Construction. Many are utilizing facilities that lack space for both their staff and clientele. There is a great need for classrooms, group rooms and confidential rooms to provide care but the availability cannot be met at times due to limited or no space. For example, one program encountered a situation in which a closet was repurposed as office space. The primary method of treatment is therapeutic group interaction. Every program has at least one group room but could easily run 2-3 groups/classes simultaneously if space constraints were addressed. In an outpatient setting, there needs to be a private room with a door for client confidentiality, therapeutic individual or crisis stabilization sessions and sometimes staff must share these rooms due to limited and/or shared office space.

In regards to facility construction, another challenge many ASAPs face is being unable to meet health care facility standards. The lack in facility infrastructure make it a challenge to achieve or possibly maintain accreditation to meet building codes and standards that can include energy conservation, environmental issues, handicapped accessibility, security and patient confidentiality.

The programs support the IHS to strengthen organizational capacity to improve our ability to meet and maintain accreditation as Health Care Facilities, work to align service delivery processes to improve the patient experience, ensure patient safety and establish program-wide immediate delivery of services in the area of Alcohol and Substance Abuse. With the pandemic and the varying strains of COVID-19, social distancing has become an added challenge but again the need for facility construction is undeniably a priority. These Health Care Facilities help to deliver and support prevention, education, treatment and recovery services related to alcohol and substance abuse. Ideally, every program would like new facilities, but it may be unfeasible so maintaining, repairing and improving existing facilities is of utmost importance. Every ASAPs requires renovation and expansion in order to meet the Tribal communities' needs at the local level. It is the overall desire of the ASAPs Facilities to modernize their health care facilities and staff quarters to expand access to quality health care services.

Cultural Components

The second highest priority as expressed is cultural considerations. Strengthening culturally competent organizational efforts is needed. The cultural development strategies, approaches and implementation are pillar for all of the ASA programs. Within an individual's treatment, they should experience the availability of access to cultural practices. These practices aim to utilize and promote the clients foundational beliefs. In turn, the individual will be empowered to exemplify the internal motivation to achieve sobriety (in addition to promoting, supporting & maintaining a recovering lifestyle). Some cultural practices that have proven to be essential & effective to a supportive & positive treatment experience is: 1) making available smudging; 2) utilizing talking circles; 3) hiring & utilizing cultural counselors whom are often known for knowledge & expertise in local Tribal customs; 4) Invitation of Tribal elders for life sharing experiences; 5) strength based cultural implementation; 6)invaluable knowledge sharing to promote cultural practices; 7) Tipi raises; 8) sweat lodges; 9) learning history both oral and written; 10) learning the importance of historical trauma specific to individual Tribes and the power of resiliency to assist in promoting and supporting healthy lifestyles supportive of recovery. The priority of incorporating AI/AN culture into the ASA programs is necessary. Obtaining supplies needed for individual and group work related to the client's treatment plans, working on crafts usually as a mindfulness activity to support sobriety and recovery, and incorporating AI/AN history, artwork, music, dancing, regalia, games as well as ordering cultural curriculums, workbooks, literature to assist in cultural considerations. An important area with the cultural consideration is identity and cultural identity works to promote personal development in the areas of self-esteem, self-worth and resiliency skills that will assist in an attitude and lifestyle supportive of abstinence and recovery.

Telehealth Services, Equipment & Training

The ASA programs recognize there is a substantial need for investment in telehealth capabilities. Many of the programs shifted to this delivery system at the start of the pandemic to avoid person-to-person contact but still maintaining needed services for the clients. Telehealth for the ASA programs can optimize information technology investments to improve process efficiency and enable innovation to advance their program mission goals. This type of approach has also proven to address an identified barrier on most reservations which is the lack of transportation. Our Tribes exist in rural areas thus providing telehealth services is a positive added service in order for the clients to receive assessments, individual and group sessions. The programs require equipment for both staff and clientele that include computer monitors with web camera technology, tablets and cell phones, reliable high-speed internet, software, visual aids, and training. Implementing current technology will improve team effectiveness with the highest regard for protected health information and confidentiality standards in the care setting to optimize patient flow and efficacy of care delivery as a viable option for the clientele.

Transportation

Many of the ASA programs are centrally located in the main town of each reservation, however not all Tribal members reside in the main town and many reservations do not have public transportation. Many people walk to their appointments as some do not have access to personal transportation, reliable vehicle or family to support them in this way. Each reservation can easily have more than five outlying districts and the desire is to have a facility at each district would be the preferred reality. The need for development and program expansion in locations where AI/AN people have no access to quality health care services is a constant consideration. However, the ASA programs can address immediate needs by providing and

improving transportation services provided by the ASA programs. Program vehicles would be necessary to effectively meet this need. The program vehicles would most likely include multiple passenger vehicles that can be ready for any weather condition picking up multiple clients who seek alcohol and substance abuse services.

Treatment referrals are often made to external primary residential inpatient treatment facilities and the need to get the client to the facility is necessary either by ASA program transports, families who can transport their loved ones, or via bus/train/plane tickets. Allocating funds to address the barrier of transportation is a much-needed service both locally and to/from off-reservation treatment centers if the patient is referred out. If this identified barrier can be addressed, it will only increase access to quality community, direct, specialty, long-term care and support services, and referred health care services.

Peer Recovery Support Services
The roles of social support and mutual help groups that promote healthy outcomes among individuals with substance use disorder (SUD) suggests peer recovery support services may be helpful for individuals in recovery from substance use disorders. Peer recovery support is characterized by the provision of non- clinical peer support, which can include activities that engage, educate, and support the individual as they make the necessary changes to recover from substance use disorder(s).

Peer providers offer valuable guidance by sharing their own experiences recovering from SUD(s) by helping to build skills, assisting, and addressing specific needs that someone with an SUD is faced with as they are in early recovery; by improving social connectedness; and by helping to identify new positive social environments. Peer providers have a unique perspective and an ability to empathize with those in treatment for SUDs.

Peer providers also often offer many non-clinical roles that might help support recovery activities, including but not limited to abstinence or reduced substance use, and may be an undervalued and underutilized resource. Peer providers could be better utilized to help both the recovery supporter and the individual who is in treatment. Implementing peer support service adds new organizational structure options and reporting relationships to improve oversight of the Indian Health Professions program related to the specialty field of substance use disorders.

These peer providers are becoming an increasingly important part of the treatment and recovery continuum by creating a community and environment where recovery is supported, and work toward recovery success through the betterment of their community. Incorporating peer recovery support specialist and/or programming that align with expanded use of paraprofessionals to increase the workforce to provide needed services. Allocating funds to develop peer support positions and services is a priority that the ASA programs have identified.

Detoxification Services Either Social/Clinical
There is limited detoxification or detox services for our clientele within the region. There are two local detoxification services available to our ASA programs: one is a medical detoxification service provided by Rimrock in Billings, Montana, and the other is a social detoxification service provided by Volunteers of America in Sheridan, Wyoming. In our experience, the medical detox services are nearly impossible to acquire for our clients due to limited bed availability and their program clientele have priority for acceptance. Social detox services are typically at capacity, as well. However, these services are needed at the local community level for the ASA clients to stabilize and gain admissibility to enter primary residential inpatient treatment facilities. The small window of risk is extremely delicate to life or death.

There are other detoxification services available in the nation but cost, transportation and time are barriers to access treatment services out of state. The cost of detox services are expensive and the exact cost of detox depends on whether it's part of an inpatient program, number of days in a detox program and the type of drug addiction being treated. Substances with dangerous detox side effects require more careful monitoring resulting in increased costs. Allocating funding for detoxification services is a priority for ASA programs to provide needed detox services for our clientele.

PRIMARY RESIDENTIAL INPATIENT TREATMENT (LEVEL 3.5 AND/OR LEVEL 3.7) FOR THE AI/AN PEOPLE

Throughout this region, there is a lack of available inpatient beds for all our clients when clients are ready to seek treatment. However, increased funding will provide more individuals to attend a higher level of care that includes primary residential inpatient treatment that will better address the toxicity many of our population are presenting

with. A geographical move to an outside facility can be beneficial to get the client out of their using environment. One of the ASA programs stated they only had enough funding for seven people to attend inpatient treatment in one year's time and yet there are more than seven people on this particular reservation that need this level of care. This funding shortage for treatment is attributed to all our reservations.

It is also a priority to consider culturally appropriate facilities as our local State facility has proven to be a treatment center where many AI/AN clients leave early against medical advice or are discharged as non- compliant because of low or no participation. This is an area that relates to a lack of cultural consideration. Many AI/AN will initially observe new surroundings and people and it is during this initial phase that the clients of the ASA programs are discharged. Our AI/AN clients self-report they cannot relate to the approach utilized by the State facility or just felt unwelcomed and uncomfortable.

INDIVIDUAL PROGRAM INFRASTRUCTURE

Foundational clinical practices and approaches in the area of program development is another priority. This includes purchasing testing and screening tools with consideration of special populations like pregnant using mothers, and, purchasing chemical dependency assessment packets for diagnosis and appropriate patient placement. Outpatient programming development will provide evidence-based specialty and preventive care that will help to reduce the rate of death for the AI/AN population related to alcohol and drug abuse. Program infrastructure most often includes development specific to Intensive Outpatient programming (Level 2.1), Aftercare programming (Level 1), Peer Support services & implementation (more feasible still effective), education classes that can support advance basic science knowledge and conduct applied prevention and treatment research to improve overall health and development. Program design and development for both adults and youth such as staff getting trained to provide "Prime For Life" classes. These classes address driving under the influence (DUI) or minor in possession (MIP) assessment, course and treatment. Prevention activities within the ASA facilities as well as outreach or program collaboration, participating in multidisciplinary teams that can include social services, probation and parole, other helping agencies, family members, and court systems. The need to incorporate family programming is essential for a strength-based approach. It is said that we are no longer treating the individual but the family. If the family receives the same message of support it follows that a client's home environment has a greater chance to be successful in sobriety and recovery. Implementing a family support system develops strong families and healthy marriages, and will prepare children and youth for healthy, productive lives. Program infrastructure is a consistent area the ASA programs operate and are continuously maintaining, developing and implementing.

COUNSELOR RECRUITMENT/RETENTION/ TRAINING/CONTINUING EDUCATION AND STAFF WELLNESS

The capability to "grow your own" has been one area the ASA programs are investing in that is to develop training programs in partnership with local schools, colleges, hospitals and expand opportunities to educate and mentor AI/AN youth interested in obtaining health science degrees. The ASA programs have been working in partnership with the state and local colleges to assist in providing education classes related to addiction degrees as well as providing assistance with recruitment efforts. The ASA programs are open to providing internship opportunities for students towards the completion of hours for licensure.

This type of support results in employing American Indian licensed addictions counselors; as well as proving that the ASA programs meet competitive pay related to this profession and will be a desirable place of employment. For retention efforts, training is necessary maintaining current continuing education courses (both in-person and online). Retention is another area the ASA programs continuously consider due to the demand for alcohol and substance abuse counselors and the need for adequate staffing to provide services. The Bureau of Labor Statistics projects 22.9 percent employment growth for substance abuse and behavioral disorder counselors between 2020 and 2030. In that period, an estimated 75,100 jobs should open up. It is necessary for ASA programs to support staff that provide valuable services for this specialized area of heath care. ASA programs can support staff by providing retreats for staff and schedules that incorporate leisure time to prevent burnout and fatigue. This priority aligns with current efforts to recruit, develop, and retain a dedicated, competent, and caring workforce. Consistent, skilled, and well-trained leadership is essential to recruiting and retaining well-qualified health care and administrative professionals.

Attracting, developing, and retaining needed staff will require streamlining hiring practices and other resources that optimize health care outcomes. Within the Indian health care system, staff development through orientation, job experience, mentoring, and short- and long-term training and education opportunities are essential for maintaining and expanding quality services and maintaining accreditation of facilities. In addition, continuing education and training opportunities are necessary to increase the skill sets and knowledge of employees, which enables them to keep pace in rapidly evolving field and constant changes in therapeutic approaches.

Another area or activity the ASA programs are working towards is to develop and implement a community feedback program. Community members can provide suggestions regarding services received and required. Their feedback is helpful to in developing program outcomes for evaluation, for example if knowledge is increased by assessing the clients knowledge before and after treatment. Results will provide information on the effectiveness of services provided. This can also be a tool for both negative and positive feedback. The ASA programs will use the responses for evaluation for providing quality services.

Conclusion

Drug and Alcohol use is preventable and treatable. Our ASA treatment and prevention programs are effective. Our ASA programs will continue to work towards providing treatment and recovery services and work to eliminate drugs and alcohol from the individual lives of young people, adults, couples, families, communities and reservations. However, increased funding is needed to continue to provide accessible, effective and culturally relevant prevention, outreach, education, treatment and recovery services related to alcohol and substance abuse. Our American Indian Health Leaders identified Alcohol and Substance Abuse as the number one health priority in the Billings Area. The reality is every single individual within the AI/AN population has been affected either personally or by someone they love, care for or know by alcohol and substance abuse. However, successes do happen and the services provided by our SUD recovery programs change lives for the better. The need for these services are so important and crucial for our AI/ANs the Alcohol & Substance Abuse Programs offer and provide the following much needed services: Expansion in the continuum of care for addictions services all across the Billings Area for the AI/AN people and strengthen the linkage between treatment and recovery, increase support for prevention efforts, treatment programming and sustained recovery within the individual communities and across Indian Country. They guide and support individuals in their journey's and provide them with a sense of hop. They help prevent relapse, improve life skills, provide programs for community based leadership to grow and develop, and the anticipation is to Lead to improved outcomes, such as: abstinence from alcohol, abstinence from other drugs, increased employment, increased enrollment education/vocational training, increased social connectedness, reduced involvement in the criminal justice system, reduced homelessness, family reunification and commitment to their lives.

Hospitals & Clinics

In the Billings Area, Hospitals and Health Clinics (H&C) funds essential, personal health services for AI/AN. The quality and safety of care at federally operated facilities is a top priority. The Billings Area understands it is important to continue to advocate for additional hospitals and clinics funding for our health facilities and its staff. The IHS and Tribes primarily serve small, rural populations with primary medical care and community-health services. Further, current levels of H&C funds for IHS, Urban and Tribal programs are persistently underfunded. Tribal Program areas are also limited in the services they can provide every year primarily due to stagnant budgets that do not increase with inflation and cost of living in rural areas. Third party reimbursement is necessary to fulfil fiscal shortfalls and provide services that are not funded through the IHS or other Federal funding, including programs such as suicide prevention and oral health intervention.

The successful recruitment and retention of employees is a high priority for the IHS. The Billings Area requests additional funds for the recruitment and retention of medical and support personnel for IHS facilities. An increase in medical providers would help increase primary care access leading to earlier intervention in chronic disease, disease prevention, and all patients to live fuller, healthier lives with less disease burden. Increasing patient access also requires increasing support staff to streamline hiring, security, credentialing, billing and coding, case management, housekeeping, infection control, quality, etc. in order for patient care to be delivered in a safe, reliable, and high quality manner.

The Billings Area IHS is working to implement the components to become a high reliability organization. To accomplish this goal, additional funding is necessary to staff positions in clinical quality and patient safety as well as provide education and training to leadership and staff. Providers and staff need to work in a non-punitive but accountable environment where innovation is rewarded and fostered, just culture is the norm, and people are empowered to speak up about patient safety concerns before a patient is unduly harmed.

Tribes in the Billings Area request additional funds to support and expand the Community Health Aide Program (CHAP) to improve local health outcomes related to health care access and delivery. The Montana Medicaid Program Section 53-6-101 was amended to reflect the Federal statues related to CHAP. CHAP provides a network of health aides trained to support other health professionals while providing direct health care, health promotion, and disease prevention services. The additional funds request will assist in the development of a training network with Tribal colleges and universities, CHAP certification Boards, increased partnership and collaboration with State and Federal partners, and for CHAP expansion in the Tribal communities of Montana and Wyoming.

Public Health Nursing

The Public Health Nursing (PHN) program is a community health, nursing-based program that supports prevention-driven nursing care interventions for individuals, families, and community groups. Area-wide PHN programs also focus on improving health status by early detection through screening and disease case management. The PHN provides quality, culturally sensitive health promotion and disease prevention nursing care services to American Indian/Alaskan Native (AI/AN) communities. PHNs improve care transitions by providing patients with tools and support that promote knowledge and self-management of their condition as they transition from hospital to home in an effort to decrease hospital readmissions. The PHN provides communicable disease assessment, outreach, investigation, and surveillance to manage and prevent the spread of communicable diseases. The PHN works diligently in the screening, investigation and treatment of Sexually Transmitted Infections (STI) management across all areas. PHNs contribute to several of the IHS prevention efforts by providing communicable immunization clinics, public health education and engaging their AI/AN communities in promotion of healthy lifestyles.

The program supports the IHS' Strategic Plan by remaining innovative in outreach processes, with the goal of bridging care gaps by increasing access and quality care to patients, based on the specific needs of each community. PHNs conduct home visiting services for: Maternal and pediatric populations, elder care services to include safety and health maintenance care, chronic disease care management, and communicable disease investigation and treatment. The PHN program supports the IHS' goal to decrease childhood obesity and prevent diabetes by supporting Baby Friendly designation and accomplishing the following activities: providing patient education, assessment, and referral services for prenatal, postpartum and newborn clients during home visits. PHN programs are key players in the COVID-19 response efforts for their designated communities. Through diligent education distribution practices, collaboration with Tribal partners, and continuous management of a strict contact tracing process, the PHN unceasingly strives to reduce and mitigate COVID-19 transmission throughout AI/AN populations.

PHN accomplishments are documented in several Billings Area facility reports where GPRA screening measures have been met, or very nearly met, to include the follow measurement areas: Tobacco cessation education and treatment referral; Domestic violence screening and resource networking; Depression screening and initial interventions for adolescents and adults; Alcohol screening and education; Immunization promotion activities across all ages.

PHNs are linked to several authorized programs on the Indian Health Care Improvement Act, 25 U.S.C. § 1621b, 1621c, 1621h, 1621n and 1665i. The PHN supports the IHS Strategic Plan FY 2019-2023, Goal 1 Objective 1.3: Increase access to quality health care services and Goal 2 Objective 2.2: Provide care to better meet the health care needs of AI/AN communities.

Purchased/Referred Care

The Purchased/Referred Care (PRC) Program is integral to providing comprehensive health care services to eligible AI/AN. PRC will always remain a top health care priority because of the constant and underfunded need for: standard, specialized, and emergency care/procedures not provided by our local clinics or if a clinic is unavailable. The need for preventative medical service and program operation must maintain priority to better manage

patient health care for our AI/AN population. Proper funding for the PRC program is essential to assure our patients receive health care services not available at our IHS Unit and/or if a clinic is unavailable for prevention of minor or chronic illnesses from progressing into major complications. Research has shown that prevention helps to reduce overall costs for medical care for both the facilities and the patient. A budget increase in PRC is essential to allow for AI/AN patients to be treated in a timely manner for their current medical conditions and improving their overall health with a lower cost to the health care system.

The PRC Program also administers the Catastrophic Health Emergency Fund (CHEF). CHEF is established to support and supplement PRC programs that experience extraordinary medical costs associated with treatment of victims of disasters or catastrophic illnesses. The CHEF is used to reimburse PRC Programs for high cost cases (e.g., burn victims, motor vehicle crashes, high-risk obstetrics, cardiology, etc.).

PRC is linked to several authorized programs in the Indian Health Care Improvement Act, 25 U.S.C. § 1621r, 1621s, 1621u, 1621y, 1642, and 1646. The PRC supports the IHS Strategic Plan FY 2019-2023, Goal 1 Objective 1.3: Increase access to quality health care services and Goal 2 Objective 2.2: Provide care to better meet the health care needs of AI/AN communities.

Dental Health

Dental is a top ten priority for the Billings Area because of access to Dental Care. We continue to recognize the various health care disparities associated with poor dental health. Dental and Oral Health is underfunded each year as community user populations increase and are in need of dental services. Increasing funding could significantly improve patient's access to care, reduce the need for emergency services and increase preventative care. Multiple factors have been affecting patient access to care in the Billings Area. Shortages of staff being the core problem. The recent additions to Purchase Referred Care (PRC) have been very beneficial to patient care and has helped to increase access to care, but it alone is not enough.

In the Billings Area, our federal service unit dental programs currently have an approximate vacancy rate of 44% in dental assistant positions. Many, if not all of the service units are still having difficulty recruiting and retaining qualified support staff. The support staff positions pay is often below entry level jobs in their communities. This has become a large factor decreasing patient's access to services as most clinics have unfilled assistant positions. The IHS Resource Requirements Methodology (RRM) requires two dental assistants per provider to maximize clinical efficiency and effectiveness. The majority of IHS dental programs do not meet this standard. Pay scale changes have been increased this year and other financial incentives to try and get quality applicants for the current vacancies are being explored. The pilot program with housing subsidies has been effective in retaining employees who were looking for alternate jobs and funding for this should be continued.

As the pandemic has come to an end, patients seeking care has rebounded and a backlog of dental need has built up. In order to help meet the needs of the people we serve we will need significant funding to keep PRC as an option for more complex cases. We also need to continue to fund staffing pay incentives, such as the Housing Subsidy to decrease our support staff vacancies as they are crucial to clinical efficiency and effectiveness. Filling these support staff vacancies would have the single biggest impact on increasing patient access to care.

Billings Area as a whole met all the 2023 GPRA measures for Dental: General Access (Goal: 24.4%, Achieved: 25.1%), Sealants (Goal: 9.9%, Achieved: 15.3%), and Topical Fluoride (Goal: 21.1%, Achieved: 25.7%). However, several service units did not individually meet the GPRA targets. In one recent IHS study, some significant improvements were made in AI/AN adolescents oral health. One study showed a decrease in untreated decay in 13-15 year olds from 64% to 45% from 1999-2019. However, there is still a large disparity between AI/AN adolescents vs the general population (45% vs 14.1%). Even with staffing shortages these improvements have been made. With fully staffed clinics these improved numbers could be even greater and help us accomplish the goals of the IHS mission.

Dental Health is linked to the Indian Health Care Improvement Act, U.S. Code, Title 25, Chapter 18. The Dental Health supports the IHS Strategic Plan FY 2019-2023, Goal 1 Objective 1.3: Increase access to quality health care services and Goal 2 Objective 2.2: Provide care to better meet the health care needs of AI/AN communities.

Special Diabetes Program for Indians

In response to the diabetes epidemic among American Indians and Alaska Natives, Congress established the Special Diabetes Programs for Indians (SDPI) grant programs in 1997. This $150 million ($147 million when applying sequestration) annual grant program, coordinated by IHS Division of Diabetes[113] with guidance from the Tribal Leaders Diabetes Committee,[114] provides funds for diabetes treatment and prevention to IHS, Tribal, and urban Indian health programs across the United States. The Billings Area is the recipient of 15 SDPI grants. The annual Fiscal Year (FY) funding authorization for SDPI expired on September 30, 2023. However, Congress has recently passed continuous resolution (CR) legislation that has extended SDPI funding. This legislation includes a partial funding authorization of $46 million.

Despite this short-term authorization, the IHS has decided to fund all SDPI grant recipients for 6 months (from January 1, 2024 to June 30, 2024) utilizing the CR funding ($46 million) and a portion of unobligated, one-time funding from previous years. These partial 2024 grant awards are currently being processed and were awarded by January 1, 2024, in preparation for year 2 of the current grant cycle. If/When SDPI is fully authorized for 2024, the rest of the annual funding will be awarded.

As part of their required activities, SDPI Community-Directed grantees will implement one SDPI Diabetes Best Practice (also referred to as "Best Practice"). The Best Practices are focused areas for improvement of diabetes prevention and treatment outcomes in communities and clinics. Note that, as in previous years, grantees may use some of their SDPI funds for diabetes-related activities outside of their selected Best Practice.

To assess improvement on outcomes, each Best Practice includes one Required Key Measure (RKM) that programs will track and report on regularly. Grantees will collect data on the RKM for individuals in their Target Group. The Target Group is the carefully selected set of individuals that grant programs can realistically serve. Each Best Practice provides guidance on selecting an appropriate Target Group.

Community Health Representatives

Community Health Representatives (CHR) is a vital program in the Billings Area. Nearly all of the CHR programs are Tribally operated. CHRs are frontline public health workers who are trusted members of the community and serve as a link between the Indian health system, including associated health programs, and AI/AN patients and communities. The aim of the CHR program is to help AI/AN patients and communities achieve an optimal state of well-being by providing health promotion and disease prevention, wellness and injury prevention and education, language translation and interpretation, transportation to medical appointments and delivery of medical supplies and equipment within the Tribal community. Without the CHR program, many patients within the Billings Area would not have access to health care. The CHR provides access to health care on the reservation for the elderly, handicapped and disadvantaged populations. The CHR program needs sustained and increased funding to provide quality health services. CHR's services for mental health, opioids, and chronic illnesses have continued to increase.

The lack of transportation is a barrier for the AI/AN to access quality health care services. Tribal Nations in the Billings Area are located in rural areas and long distances are travelled to access health care services. It is not unusual that CHR's and patients they serve travel up to 6 hours or more to receive professional emergency care.

In 2020, COVID-19 was the leading cause of death among American Indian residents of Montana. (Montana Department of Public Health and Human Services (DPPHS), 2021). During the COVID-19 pandemic, the CHR's were at the front line providing health care services including assisting with testing and vaccination activities as well as contact tracing. CHR's also assisted patients who were isolated or quarantined by providing food, medical equipment and supplies and essential items.

CHR's have not received a budgetary increase to support increased demands for services and to maintain training and education to provide community health services. The CHR's have also experienced COVID-19 fatigue, it is known that health care work can be physically and psychologically draining. More resources are needed for CHR's to provide health care services and COVID-19 cases continue to rise in Montana.

113 https://www.ihs.gov/diabetes/.
114 https://www.ihs.gov/sdpi/tldc/.

CHR is authorized by the Indian Health Care Improvement Act, 25 U.S.C. § 1616. CHR supports the IHS Strategic Plan FY 2019-2023, Goal 2 Objective 2.2: Provide care to better meet the health care needs of American Indian and Alaska Native communities.

Health Education

The need for ongoing health education, especially information on prevention, is integral to the wellbeing of American Indians in the Billings Area. Developing and sharing health education was, and continues to be, particularly crucial during these times of COVID-19. In a Montana Department of Public Health and Human Services (MT DPHHS) publication, it was stated, "There is substantial evidence that COVID-19 had a disproportionate impact on indigenous communities, and Montana has a relatively large American Indian population with seven reservations" (MT DPHHS, 2021, p.1). According to this source, COVID-19 was the number one underlying cause of death among American Indians in Montana in 2020 (MT DPHHS 2021, p.2). Health Education (HE) and health literacy are powerful means of bringing awareness and knowledge to the population we serve. Readable, culturally adapted health information allows those we serve to prevent and protect themselves and their families from COVID-19. The Billings Area Office's (BAO) Health Education (HE) continues to collaborate with the Indian Health Service Headquarters' (HQ's) Health Promotion/Disease Prevention (HPDP) and Health Education (HE) to deliver training in health literacy while also assisting HQ's HE with a review of documents for level of readability and cultural customizing. Once fitted for the American Indian/Alaska Native (AI/AN) population, the adapted health information is disseminated widely across the BAO service area. With the ongoing COVID-19, influenza, and RSV infections, health education is crucial to bringing awareness, protection, and prevention to our region.

COVID-19 has, and continues to; change how health education is delivered. Virtual platforms such as skype, zoom, teams, etc. have become the norm for delivering health education, while also making telehealth/telemedicine much more necessary. Along with the rest of country, BAO quickly implemented virtual options, including telehealth/telemedicine, to stay connected nationally, regionally, and locally. Along with sharing of health education, the BAO shares capacity building information such as funding opportunities to expand broadband in Native American communities so that Tribal communities can stay up-to-date with connective capabilities.

Since in-person programming and training were deemed less safe during the pandemic and also with the continuation of COVID-19 infections, it is safer to utilize virtual and/or hybrid options of sharing HE information. COVID-19 brought the virtual world into practice. For example, in terms of physical activity, the BAO HE has developed and implemented the annual "Healthy Tribes Walk/Run". This coming year, 2024, will be the event's seventh annual year. Once the pandemic hit, this event became the "Healthy Tribes Virtual Challenge." Although the in-person events were successful and significant health and substance recovery education was delivered, adding a virtual option allows more people to partake in this important physical activity event. The BAO HPDP & HE Coordinator sustains membership on the Indian Health Service's Physical Activity Kit (PAK) workgroup, which includes developing a HPDP website and revising the PAK program. A significant amount of the workgroup's duties can be attributed to the utilization of virtual means. Membership on several Indian Health Service national workgroups is part of the BAO HE efforts (PAK, National Public Health Council, Community Cancer Care, Office of Suicide Prevention QPR project, etc.).

In a fact sheet from the MT DPHHS, it was stated, "In Montana, between 2013-2017, the highest rate of suicide is among American Indians (31.3 per 100,000) although they only constitute 6% of the state's population" (MT DPHHS 2020 p.3). Several BAO suicide prevention programs such as Question, Persuade and Refer (QPR), Mental Health First Aid (MHFA), and Zero Suicide continue to utilize on-site trainings while also incorporating virtual and hybrid program options. The BAO Behavioral Health and The BAO HE, and a partnership with the IHS Office of Suicide Prevention and Sister Sky (contractor), has delivered over 1,500 QPR suicide prevention trainings to the BAO service units and some Tribal programs. In 2023, the BA invited all area Tribes to participate in this suicide prevention program. In 2024, the BAO HE, along with the BAO QPR team, will be inviting the Montana urban Native health organizations to participate in this suicide prevention effort. This basic QPR training has been culturally adapted for AI/AN population and is offered directly to each participant (I/T/U), by way of an on-line learning module system (LMS) and delivered through staff/employees own unique email link.

When addressing Community Health Education in the Tribal and urban areas, it is important to understand the potential in these communities. The BAO HE implements both strengths-based and trauma-informed care into their health education and highlights successes. The BAO HE collaborated with Montana State Health Improvement Program (SHIP) to add a "Tribal" tab to their state story map related to nutrition and physical activity resources. Through this collaboration, "success stories" have been developed and embedded into SHIP's story map. This effort will continue into 2024 with a plan to add more Tribal success stories based on promising and evidence-based practices with the hope of transplanting the proven practices from one Tribal or urban community to another.

Cancer was the fourth leading cause of death in 2020 for American Indians in Montana (MT DPHHS 2021, p 2). There is significant health education involved in the prevention of cancer alone, when screening, treatment, and follow up care, are added, cancer health care information is crucial. In partnership with HQ's HPDP, the BAO has utilized cancer prevention trainings such as, "The Sacred Circle of Tobacco," and the "Circle of Life". On a national level, the BAO HE continues to be part of the Indian Health Service's Community Cancer Care initiative and assists in developing a continuum of cancer care.

Along with cancer prevention, and PREVENTION overall, important measures of HE impact are the Government Performance and Results Act (GRPA) ratings of which the BAO HE utilizes as baselines for improvement. The BAO HE was invited to join with the HQ's HPDP to participate in a colorectal cancer screening pilot project in 2020 and continues to monitor and address colorectal health through these efforts. One BAO urban facility and one BAO Service Unit were part of the project. GRPA ratings for colorectal cancer screening were the baseline measure for the project. The BAO consistently uses GPRA ratings as markers because it is a congruent measure of our health care delivery impact. GPRA ratings are also crucial in the area of evaluation. Partnerships are important when planning and implementing the best outreach for health education dissemination. Sharing resources and expertise is a crucial survival strategy for Indian Country and the BAO HE utilizes the same strategy. The BAO HE has collaborated with several entities to further their health education reach. Along with collaborating with IHS HQ's HPDP, BAO Service Units, Tribal and urban centers, other partners include the Native National Network, Montana DPHHS, American Indian Cancer Foundation, Rocky Mountain Tribal Council Leaders, etc. Through these collaborations, HE efforts for the prevention of diabetes, commercial tobacco cessation, obesity, suicide, and cancer preventions continue to be strengthened and sustained. The hope is to see greater positive impact for the communities we serve as more partnerships, virtual platforms, and health education programs are developed.

Continued and increased funding for our BAO HE program(s) is essential to delivering the most impacting, preventative health information, and overall improved health care to the people we serve.

Health Education is linked to several authorized programs on the Indian Health Care Improvement Act, 25 U.S.C. § 1621b, 1621c, 1621h, 1621n, and 1665i. Health Education supports the I.H.S. Strategic Plan F.Y. 2019-2023, Goal 1 Objective 1.2: Build, strengthen, and sustain collaborative relationships, Goal 1 Objective 1.3 Increase access to quality health care services, and Goal 2 Objective 2.2: Provide care to meet better the health care needs of AI/AN communities.

Urban Indian Health

COVID-19 has amplified health inequities in American Indian communities[115] because of underfunded and under-resourced health systems, limited access to health services, poor infrastructure, and underlying health disparities. For example, AI/AN individuals were 3.5 times more likely to be hospitalized for the virus.[116] Chronic underfunding increased AI/ANs vulnerability to the COVID-19 pandemic and resulted in our communities having the highest per capita COVID-19 infection, hospitalization, and death rates. The U.S. Census Bureau reports that in 2020, there were 31,201 American Indian and Alaska Natives living in the catchment areas of the five urban centers, a population increase of 6,074 (22%) from the 2017 census report. The urban AI/AN population represents 31% of the total population of AI/ANs in the Billings Area. Funding levels throughout Indian Health Service for the urban centers is not adequate for the needs the urban population represents.

115 https://www.commonwealthfund.org/blog/2020/challenge-covid-19-and-american-indian-health.
116 https://archive.cdc.gov/#/details?url=https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html.

Hot Issues

PRESERVE MONTANA MEDICAID EXPANSION

BACKGROUND

Montana passed Medicaid Expansion in 2016. Prior to this time Billings Area operated solely at a Level 1 medical priority level. Since this time on a progressive basis, Billings Area SU's were able to move to a Level 4 and approve anything medically beneficial within the Law of PRC Regulation.

Through the enactment of Medicaid Expansion and the Affordable Care Act, Indian Health Service PRC has been able to work in collaboration with Tribes regarding TSHP activity. PRC funds are limited and payer of last resort, through TSHP the Tribes have the ability of purchasing marketplace health insurance plans for eligible Federally Recognized Indians.

RECOMMENDATION

Medicaid expansion in the State of Montana is expected to sunset in June 2025. This will definitely affect the care provided through PRC referrals. It is proven the Billings Area Service Units would not be able to operate at a level 4 and provide the expanded services without the additional dollars and purchasing power of PRC referrals.

TRAUMA TO RESILIENCY

BACKGROUND

There is a long-standing history of trauma imposed on Tribes within the Billings Area, not only historically but also currently, whether in the form of discrimination or chronic underfunding and understaffing of federal programs committed to in treaties between the federal government and Tribes.

A recent example of trauma was the victimization of children in the care of an IHS pediatrician pedophile at the Blackfeet Service Unit in the early 1990s. A case against the physician and the Indian Health Service was filed in 2019 on behalf of one of the victims. This was covered in depth by the news media and therefore won't go into detail about the case in this write up but will note that it was deeply traumatizing for all communities across the area as it surfaced, once again, the abuse and neglect inflicted upon this population for well over a century and generations of families.

The focus of this write up is the further trauma that cases such as the above layers onto existing layers of previous traumas, not only that of the victim but the entire community as well. When the Acting Director of IHS was asked what the plans were to address the trauma, the response was that there was no thought given to it. This response was shocking. As the principle federal agency responsible to provide health care services, including services to address trauma, it is the expectation that funding to address trauma within the Billings Area for Tribes and their members will be provided.

RECOMMENDATION

Billings Area Tribes mark this as a priority and request separate funding to support a multi-year initiative to fund Tribes, working together across the Area, to develop and implement an approach that will support Tribes and their people to recognize specific behaviors and needs they may have because of past or ongoing trauma, including measures to lessen the impacts of trauma. That this approach be specific to recognizing how trauma impacts a person's mental, behavioral, emotional, physical, and spiritual wellbeing. This request should be in addition to the existing priorities allowed for and will not diminish funding in the formulaic approach to identifying top priorities by the Tribes.

TRIBAL DATA SYSTEMS

BACKGROUND

It is said that good decisions cannot be made without good data. Access to Tribal data is riddled with obstacles, the primary one being a lack thereof. Often another entity's system will attempt to capture data, but it is often not easily collected nor readily interpreted as most outside entities don't understand the dynamics, mores, traditions, cultures of Tribal communities.

Managing, strategic planning, budgeting, prioritizing community improvements, to name but a few initiatives and needs, can benefit by analyzed local data. Like any other governmental entity, Tribal government leaders manage a large and diverse array of programs and services for the benefit of their residents and Tribal members. Examples are: Law & Justice, Education, Health Care, Housing, Transportation, Fish and Game, Economic Development, Natural Resources, Cultural Resources, to name but a few. Tribal leadership often oversee twice or thrice this number of programs and services. Attempting to do so without data collected and reported by these programs and services for analysis that will inform the decision makers about that which they manage will often lead to decisions that may not be appropriate or shortsighted.

It is critically important for Tribal leaders to implement data systems at the local level that will capture data from all programs under their oversight. It's not an easy thing to establish these systems but it's critical that this be done for Tribes to identify and advocate for their needs, progress, successes, failures, and gaps as they compete for funding and prioritize the use of funds in the development of their communities. Too often Tribes make requests when data has been captured, usually by federal programs, but the delivery of this data is often too late, inaccurate, and therefore not useful to their need. This issue has been brought forward by Tribes at Federal Tribal Consultation sessions much too often.

RECOMMENDATION

Tribes prioritize this need within Budget Consultations and work locally and regionally to determine the best data elements for each respective program and service, and how best to implement each Tribal system on a regional basis for analytics purposes and to have these reports submitted back to each respective Tribe for their use in decision making.

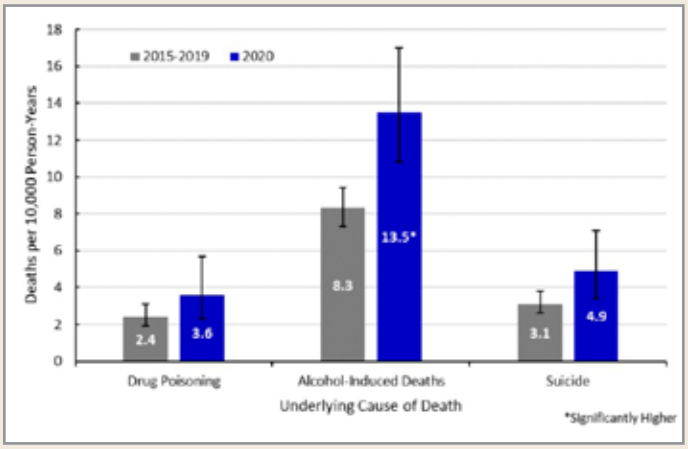
YOUTH REGIONAL TREATMENT CENTERS

BACKGROUND

The Billings Area does not have a Youth Regional Treatment Center (YRTC) to serve the Montana and Wyoming Tribes. The IHS currently provides funding to 12 Tribally and Federally operated YRTC that provides residential substance abuse treatment services for American Indian and Alaska Native (AI/AN) youth. Of the 12 YRTC's, there are no YRTC services in the Billings Area. The closest YRTC is the Healing Lodge of Seven Nations in Spokane, WA. The travel time to Spokane, WA is over eight hours from Billings, MT. Lack of available residential treatment services for youth is challenging. During the FY 2024 Budget Formulation Work Session, the Billings Area Tribes requested to have more treatment centers to serve AI/AN that provide quality, holistic behavioral health care in a residential environment that integrates traditional healing, spiritual values, and cultural identification.

In the "Leading Causes of Death Among American Indian Residents of Montana, 2020 and 2015-2019" report, alcohol-induced deaths and deaths due to drug poisoning were assessed. Among American Indian Montana residents, there was a total of 1,022 deaths in 2020 compared with an average death 676 each year during the previous five years (2015-2019). There was a significant increase among alcohol-induced deaths (Figure). The diseases process that lead to alcohol-related deaths accumulate over several years and treatment services are needed early particularly for youth.

Figure. Age-adjusted mortality rates for drug poisoning , alcohol-induced, and suicide deaths among American Indian Montana residents, 2020 and 2015–2019.[117]



RECOMMENDATION

Lack of alcohol and drug treatment services for youth is a factor and the need for services increased dramatically during the COVID-19 pandemic. Billings Area Tribes request funding for an YRTC to address ongoing issues of substance abuse and co-occurring disorders among AI/AN youth.

117 Montana Department of Public Health and Human Services (DPPHS). (2021, December 21). Leading Causes of Death among American Indian Residents of Montana, 2020 and 2015-2019. Retrieved 12 21, 2021, from https://dphhs.mt.gov/assets/publichealth/CDEpi/DiseasesAtoZ/2019-nCoV/Reports/AI_AN_Leading_Causes_2020.pdf.

California Area

Service Area and Geographic Information



Budget Narrative/Justification

The California Area is submitting a Budget Recommendation at the full funding FY 2027 Recommendation. The California Area Office and California Area Tribal Leaders support funding the California Area's Top 11 Budget Funding Priorities: Behavioral Health, Purchased/ Referred Care, Obesity/Diabetes, Methamphetamines/Suicide/ Domestic Violence, Pharmacy, Indian Health Care Improvement Fund, Dental, Health Information Technology, Community Health Representative, Regional Specialty Centers, and urban.

Budget Increases

Behavioral Health + $8.7B

The lack of behavioral resources is evident in the disproportionate number of suicides, acts of domestic violence, and drug and alcohol addiction in Indian Country. In the California Area, the lack of funding is reflected in the 2023 Government Performance and Results Act (GPRA) Data. Only 38.1% of youth and 43% of adult AI/AN patients were screened for depression at Indian health programs in the California Area. Additionally, over 90% of women were not screened for domestic violence and over 68% of patients were not screened for alcohol use. An increase in funding and subsequent staffing would allow a greater percentage of the population to be screened, seen by behavioral health specialists and most importantly, treated.

Purchased/Referred Care + $8.5B

The California Area recommends that IHS continue increasing funds for Purchased/Referred Care (PRC) and Catastrophic Health Emergency Fund (CHEF) to address the current reported unmet needs represented by the large number of deferrals and denials. There are no Indian Health Service or Tribal hospitals in the California Area, therefore Tribal health care organizations rely heavily upon PRC funding. The majority of Area health programs provide primary care; as a result, the majority of PRC funds are used for specialty referrals, pharmacy services, laboratory testing, and diagnostic studies. PRC funds are rarely adequate to cover Levels of Care beyond Priority II. Few health programs are able to cover inpatient services. This is reflected in the low number of California Area CHEF Cases. The CAO continues to encourage and assist programs to report PRC deferrals and denials. The need in California is greater than the data suggests. In 2023, only 21 of the 28 health programs reported deferred and denied data.

Obesity/Diabetes + $6.9B

The leading cause of death for American Indians/ Alaskan Natives (AI/ANs) is heart disease caused by obesity, diabetes, depression and poverty. The national rate of diabetes for AI/ANs is 15.2%. Tribal and urban Indian health care programs use these funds to offer education, self-management support through professional and community led education, direct clinical and specialty care for AI/AN patient's battling diabetes and obesity. Behavioral health issues are also addressed which contribute to the obesity and diabetes rates of AI/ANs.

Methamphetamines/Suicide/Domestic Violence + $6.6B

Rates of methamphetamine addiction and related crimes, suicide and acts of domestic violence are disproportionately higher among American Indians and Alaskan Natives. According to the CDC, suicide is second leading cause of death among AI/AN between the ages of 10 and 34 and the prevalence of suicidal thoughts was highest amongst AI/AN compared to any other race. An estimated 45% of AI/AN women and 1 in 7 men experience intimate partner violence yet, according to our 2022 Government Performance and Results Act (GPRA) data, over 90% of women at California Tribal health programs were not screened for domestic violence. In 2023, 4 California health programs received IHS Domestic Violence Prevention Initiative funding and 3 received IHS Substance Abuse and Suicide Prevention funding which highlights the need for these programs in California. Increasing funding in these areas will allow Tribal programs to connect more individuals to help through higher rates of screening, outreach and referral processes strengthening and additional trained staffing.

Pharmacy + 4.8B

The net prices for more than 4,200 prescription drugs rose on average 46% faster than inflation between January 2022 to January 2023. High prescription drug prices and high costs of diabetes medical devices create affordability challenges for patients and health care systems. Tribal and urban health care programs can access Federal discounted drug programs such 340B and Veterans Affairs Pharmaceutical Prime Vendor Program (VA PPVP) as a means of affording medications. There are twelve (12) Tribal pharmacies in the California Area that utilize 340B and three (3) Tribal pharmacies that utilize the VA PPVP and 340B. Tribal pharmacies can generate revenue for their respective clinics utilizing 340B, however with Governor Newsome's Executive Order (EO N-01-19), their ability to generate revenue utilizing 340B will be non-existent. Though Tribal and urban health care programs can still access VA PPVP, the VA contract does not allow for resale of medications which would prevent Tribal pharmacies from generating revenue through these means. Despite the ability to purchase medications at discounted costs, Tribal and urban health care centers may still face difficult decisions on how to cover remaining drug costs as their revenue margins decrease substantially.

Indian Health Care Improvement Fund + $4.8B

Congress established an Indian Health Care Improvement Fund (IHCIF) in the Indian Health Care Improvement Act (IHCIA) as one means for addressing resource disparities across the Indian health system. The fund is designed to consider many factors that result in resource gaps among the Indian Health Service (IHS) and Tribal sites or operating unit.

Dental + $4.4B

More than half of AI/AN children and adolescents have experienced tooth decay, and compared to the general population, AI/AN children are twice as likely to have untreated dental caries in their primary teeth and five times more likely to have untreated dental caries in their permanent teeth. California Tribal Leaders recommend increases for better equipment and wellness programs, especially since lack of dental care creates or exacerbates other health problems, particularly in diabetic patients. California Tribal Leaders also recommend funding Dental Therapy and Dental Therapists. This classification would allow Native health care programs to serve more clients.

Health Information Technology + $3.8B

The California Area supports a large investment in health information technology; Tribal and urban Indian health programs require a strong medical records system that is both interoperable and offers modern features, including a public health component. The Resource Patient Management System (RPMS) and medical records interface Electronic Health Record (EHR) comprise a powerful database technology in need of modernization or replacement with a commercial product. The cost of this effort would overwhelm the current IHS budget – a financial commitment similar, but appropriately scaled to the Veterans Administration electronic medical records replacement effort is required.

Community Health Representative + $3.2B

Across IHS, CHR Programs provide essential services for an under resourced, heavily chronic disease-burdened segment of the overall population. Per data obtained through the IHS CHR Data Mart, California Area Tribal and Urban Indian RPMS-using CHR programs provided essential services, including: diabetes, hypertension, injury control, administration and management, and cardiovascular disease. CHR activities including Diabetes; Hypertension; Injury Control, administration and management, and Cardiovascular Disease.

CHRs provide essential services in terms of patient education, health promotion /disease prevention and transportation for members of their communities. It is highly likely that the CHR services in the California Area are not being captured in the CHR Data Mart due to a lack of proper accounting services, since many of the CA Area sites have moved to Non-RPMS systems. IHS does not currently have a method for capturing CHR activity (Services and contacts) from Non-RPMS users, those without access to CHR Reporting Package. Such system challenges are barriers to capturing CHR data from Non-RPMS users and influence attempts to understand the actual impact of CHR work. CHRs often work hand-in-hand with health care professionals to extend services into the community setting, providing invaluable services that bridge coverage gaps by connecting patients with much needed health care and socio-economic services in communities where aging population, high chronic disease burden, and limited resources (funding and staff shortages) may lead to ultimately unacceptably poor health and quality of life outcomes for AI/ANs.

Regional Specialty Centers +$2.1B

California Area is planning to build Regional Specialty Centers to provide specialty health care and ambulatory surgical services to the California AI/AN population. While ample primary care is available to the AI/AN population through more than 40 Tribal and urban Indian health programs spread across the state, secondary health care services including medical and surgical specialty care, specialty dental care, ambulatory surgery, diagnostic imaging, acute care, psychiatry and many other services are only available through Purchased and Referred Care. The construction of two Regional Specialty Centers would make these services available within the Indian health system and would increase the Level of Need Funding (LNF) in California Area from 37.3% to 87.2%. A feasibility study has been completed and more than 40 California Tribes have approved Tribal resolutions in support of the proposal. Initial planning studies are underway. The proposed facilities are estimated to cost about $2 billion for planning, site acquisition, design and construction. Annual operating costs are estimated at $446 million.

Urban + $1.6B

Nearly seven out of every ten American Indians/ Alaska Natives (AI/AN) live on or near cities, and that number is growing. California has more AI/AN than any other state, and just 10% have access to IHS clinical services. Recent studies document poor health status and inadequate health care available and accessible to the Urban AI/AN population living off of their reservations/rancheria's. In California, as in other states, Urban Indians who must move to reservations for health care might have to wait months to reestablish residency, and then might spend even more time on awaiting list before getting treatment. Many become sicker and some even die before reaching the top of the list. Even among the Urban Indian health organizations, not all are able to provide the full spectrum of health services needed by Urban Indians. Urban programs offer behavioral health services and wellness assessments, dental, outreach referral services as well as comprehensive ambulatory health care services. None are connected to a hospital and few are connected to specialty care services. There are ten Urban Indian health care programs in California.

Hot Issues

Broadband

ISSUE

Need to increase broadband or satellite communication to support telehealth and optimize communications in emergency situations.

BACKGROUND

A key requirement of future health care provision for California Tribes will be the availability of broadband in remote areas for the purpose of offering telehealth services. Specifically, The Indian Health Service California Area Office is working with California Tribes to establish consensus around the establishment of Regional Health Centers (RHCs) in the state. These RHCs would be staffed with specialists who could provide clinical services via the internet, depending on the bandwidth capacity of the remote community.

A characteristic of life in California is the persistent threat of wildfire. The California Area Office has engaged in emergency support operations for Tribes numerous times over the last several decades. A key to these operations is optimized communications.

The State of California is currently implementing a statewide network of physical fiber optic infrastructure needed to enable internet connectivity. The intent is to connect community networks ("Last Mile") to the core network that carries high speed internet traffic. This connection – this missing piece – is called the "Middle-Mile". The *Middle-Mile Broadband Initiative* is intended

to assure that all California internet service providers and entities are able to connect to the core backbone of the Internet on equal economic and service terms. While this will be a boost for California communities in general, approximately two thirds of Tribes will not have direct contact on their trust lands with the Middle-Mile Broadband network (MMBN). Those Tribes that are close enough to reach the MMBN will need to undertake a build effort off of trust land to tie back to the MMBN. In addition to the commercial, social and educational benefit that would come with high-speed access to world networks, telemedicine capabilities would be greatly enhanced.

The California Area Office hosted Broadband sessions at the 2023 and 2024 Annual Tribal Consultations. The CAO team joined representatives from California state agencies to discuss broadband technology, infrastructure and funding.

For those Tribes unable to undertake the effort of fiber infrastructure buildout there is the option of establishing connections to low earth orbit (LEO) satellites and private 5G networks (a closed, proprietary set of connections using the same technology that is used by cell towers – it is intended to serve only the community or entity for whom it is built).

LEO satellite connections require commercial contracts, and there is a limit to the internet traffic capacity that can be carried across these connections. LEOS can deliver signal, and private 5G networks can distribute that signal, but capacity constraints limit the number of nodes that can be placed on such a network. Distributed LEO satellite connections may fail to meet the baseline standards of broadband today. Additionally, there are licensing issues that may require a business platform rather than a single destination connection. Similarly, there is a limit to the number of direct connections that an LEO service provider such as Starlink can offer in a given quadrant. In a closely aggregated community of homes, for instance, service from a satellite may degrade if distributed among too many direct connections.
An exception to this analysis is the use case for emergency services. Not only can LEO satellites handle the limited amount of traffic associated with primary emergency response communications, the equipment on the ground that receives signal can be mobile. A scenario in which this equipment is delivered to a Tribe in crisis in the back of a pickup truck and used to stand up an ad hoc communications network in the field is not beyond reach.

The Desert Sage Youth Wellness Center, one of two YRTCS in California, is in a remote area. In the shadow of persistent threat from wildfire and flooding, CAO is currently in the implementation phase of establishing LEO satellite connections for redundancy for the Desert Sage facility.

RECOMMENDATION

As mentioned above, the Indian Health Service California Area Office has engaged in outreach to Tribes with regard to broadband opportunities. It is our recommendation that we continue this outreach. We also recommend that the Indian Health Service offer the contract vehicle that is used to obtain LEO services to Tribal programs for the purpose of standing up emergency response capabilities; and that the area office and field offices are outfitted with mobile ground-based LEO receivers that can be deployed in the event of an emergency in which communications are down or threatened.

Ambulance Service

ISSUE

California Tribal health care programs located in isolated areas are seeking Indian Health Service (IHS) funding to offset their rising operating costs.

BACKGROUND

K'ima:w ambulance service provides critical advanced life support emergency medical services to the Hoopa Valley Tribe and surrounding communities including portions of the Karuk Tribe and Yurok Tribe, responding to approximately 980 calls this past year. The ambulance service started without any funding from the following: IHS, State of California, Humboldt County or the communities near the Hoopa Valley Reservation. In 1983, Hoopa used funds from IHS (Community Health Representative and IHS Headquarters) funds to obtain an ambulance from General Services Administration (GSA). Medicare and Medi-Cal reimbursements in addition to the Hoopa Valley Tribe subsidizing operational costs are not sufficient to sustain the K'ima:w ambulance program. The IHS Emergency Medical Services (EMS) program does not provide operational costs to the IHS affiliated EMS Programs. The IHS does facilitate pre-hospital and out-of- hospital emergency medical training at no cost to IHS-affiliated Tribal EMS programs who have not taken their EMS training shares. Only funding for EMS training is appropriated each year.

Currently Hoopa leases three GSA ambulances (additionally one is owned by the Tribe) through the IHS/GSA Ambulance Shared Cost Program. The IHS subsidizes the cost of the ambulance so Tribal programs lease the ambulance at a reduced cost. The IHS pays for approximately 70 percent of the total cost of the ambulance and GSA pays for 30 percent. The GSA leases the ambulances to IHS affiliated EMS programs at a cost of approximately $383 per month, $75 per month for accessories and $.41 per mile per ambulance.

During the FY 2019 and FY 2020 Budget Formulation sessions, Hoopa requested a line item be created and funded by IHS to assist in the operating costs for ambulance service in rural areas. In addition, Hoopa is requesting Congressional action for funding by their U.S. Representative. The Tribe recommends that if HQ has any additional end-of-year funds, that they be used for the ambulance program. The IHS concurs that Hoopa continue to request additional appropriations through their Congressman; unfortunately, their past Congressional requests have not made it out of the House Committee.

During the FY 2026 Budget Formulation session, additional isolated Tribes requested line items to assist in the operating costs for ambulance services. For example, Tule River Indian Tribe is launching an ambulance service and the Iipay Nation of Santa Ysabel is looking into the logistics of this as well. Without an ambulance service, their PRC dollars are depleting at an alarming rate, and they are not able to provide services in a timely manner.

RECOMMENDATION

The Tribal workgroup believes that the IHS is responsible for funding operational costs for Tribal EMS programs. Currently the IHS is not able to fund these programs in accordance with Line 115 from the IHS Headquarters PSFA Manual of 2002. With the PFSA Manual scheduled to be updated in the near future, the Tribes believe that this could be an opportunity to include funding for EMS programs.

Health Care Facilities Master Plan

ISSUE

Many Tribes and Tribal health programs have expressed interest in establishing new federal IHS health care facilities in California, potentially including hospitals, surgical centers, mental health facilities or expansions of the youth regional treatment centers. There has been growing consensus that regional specialty care centers may be the next priority for health care facilities in California Area.

BACKGROUND

California Area IHS operates two federal health care facilities in the state – the Desert Sage and Sacred Oaks Youth Regional Treatment Centers (YRTC's). Tribal and urban health programs operate all other health care facilities for the American Indian / Alaska Native population in the state. While there are currently no firm plans to develop additional federal health care facilities, there is an opportunity for California Tribal needs to be considered for future funding of health care facilities construction projects.

It is possible that the Health Care Facilities Construction (HCFC) priority list established in 1993 may be fully funded within the next ten years. Once that list is fully funded, the new HCFC priority process will be initiated. IHS is recommending that all areas prepare new health care facilities master plans to develop the priorities that will populate a new HCFC priority list, which will be the basis for funding when the facilities from the 1993 list are completed. This master plan will quantify the unmet health care needs for all Tribal and urban health programs across the state and recommend new or expanded facilities to meet these needs. The last health care facilities master plan for California Area was developed in 2005-2006, so a new plan is needed to qualify for the new HCFC priority list.

RECOMMENDATION

California Area cannot undertake master planning without the support of additional funding from IHS Headquarters. The amount of funding and when it may be available are still unknown, but a new California Area facilities master plan would cost on the order of about $3.5 million, far exceeding the annual budget of the Area's Health Facilities Engineering program. The master plan will require consultation with all Tribal, federal and urban health programs in its execution, so once it is funded, it will likely take a couple of years for it to be completed.

The deliverables of this master plan will be detailed, data-based recommendations for new health care facilities or expansions of existing health care facilities. These needs will be submitted for funding in the new HCFC priority list. This is the necessary first step before California Area could receive funding for a new or expanded federal health care facility through the new HCFC.

Contract Support Costs (CSC) for the third-party-revenue-funded portions of the Tribe's health care program

ISSUE

The panel reversed the district court's dismissal of the San Carlos Apache Tribe's ("the Tribe") claim alleging that federal defendants must cover the "contract support costs" ("CSC") for the third-party-revenue-funded portions of the Tribe's health care program.

BACKGROUND

The Indian Self-Determination and Education Assistance Act ("ISDA") allowed Tribes to run their own health care programs, funded by Indian Health Services ("IHS") in the amount IHS would have spent on a Tribe's health care. Since it was too expensive for the Tribes to run the programs, Congress enacted a fix by requiring IHS to provide Tribes with CSC—the amount of money a Tribe would need to administer its health care programs. In addition, Congress allowed the Tribes to bill outside insurers directly and allowed Tribes to keep the third-party revenue without diminishing their IHS grants, so long as Tribes spent that revenue on health care.

The issue is who pays the CSC for the additional money the Tribe recovers from outside insurers. The Tribe contends that the IHS must cover those additional CSC. The Tribe filed suit to recover the CSC for program years 2011-2013. The parties settled all claims but Claim 2, which alleges that defendants must cover CSC for the third-party-revenue-funded portions of the Tribe's health care program. The panel held that the text of the governing statute, 25 U.S.C. § 5325(a), compelled reversal and remand for additional proceedings.

The federal defendants contended that the language of the contract under which the Tribe operated its health care programs foreclosed the Tribe's claim because the Tribe received the amount of CSC specified by the contract, a properly calculated amount that 25 U.S.C. § 5325(a) did not override. The panel held that this argument ignored the flexibility written into the contract, which allowed those amounts to be adjusted in the event of certain changes. A determination that the Tribe is owed CSC by statute for third-party-revenue-funded portions of its health-care program would fall under this umbrella. Additionally, because the contract incorporated the provisions of the ISDA, if that statute requires payment of the disputed funds, it controlled. The panel concluded that the contract was not dispositive and proceeded to determine whether the Tribe was owed those additional CSC by statute.

The panel started with the CSC provisions of the relevant statute, 25 U.S.C. § 5325(a), and held that Sections (a)(2) and (a)(3)(A)(ii), together, pointed toward requiring the defendants to cover CSC for activities funded by third-party revenues. The panel noted that this conclusion departed from the only other circuit to have considered the issue in Swinomish Indian Tribal Cmty. v. Becerra, 993 F.3d 917, 920 (D.C. Cir. 2021). The panel held that it could not conclude that § 5325(a) unambiguously excluded those third-party-revenue-funded portions of the Tribe's health care program from CSC reimbursement. The plain language of this section appears to include those costs. None of the additional statutory language to which defendants pointed erased this ambiguity.

The Tribe merely needed to demonstrate that the statutory language was ambiguous, and the Tribe met this burden. Since the statutory language was ambiguous, the Indian canon applied, and the language must be construed in favor of the Tribe. The panel held the ISDA required payment of CSC for third-party-funded portions of the Federal health care program operated by the Tribe. The panel found that the Tribe met its burden under Fed. R. Civ. P. 12(b)(6), reversed the dismissal of the claim, and remanded for further proceedings.

RECOMMENDATION

Waiting on guidance from IHS on Supreme Court ruling.

Dialysis Center

ISSUE

Toiyabe Indian Health Project, Inc, a California Tribal health care program, located in a remote area of the Eastern Sierra region, is seeking Indian Health Service (IHS) funding ($2.5M) to offset their rising operating costs in order to continue offering vital hemodialysis (HD) services and to expand services to include peritoneal dialysis (PD).

BACKGROUND

Toiyabe Dialysis Center, located in Bishop, CA provides critical dialysis services to seven (7) Tribes and its surrounding twenty-three (23) communities across Inyo and Mono counties. It is the sole licensed provider of in-center HD services in the Eastern Sierras for both Native and Non-Native patients. The two nearest hospitals, Northern Inyo Hospital and Mammoth Hospital, also send their

stable patients to Toiyabe Dialysis Center. Critical unstable hospitalized patients needing dialysis are flown out. Toiyabe Dialysis Center accepts them if they have also been identified as a clinic patient. Critical unstable hospitalized patients needing dialysis are flown out. Patients can travel over 100 miles one-way to access dialysis services at Toiyabe Dialysis Center. Apart from Toiyabe Dialysis Center, the nearest dialysis centers are located in Ridgecrest, CA and Carson City, NV which are over 2 hours and 3 hours away respectively.

Toiyabe Dialysis Center first started as a modular facility in 1998 on the Bishop Paiute Reservation where it served approximately ten to fifteen patients. Needing more room, the Dialysis Center moved into its current location at 44-B Tu Su Lan in Bishop, CA. At present, it serves forty-five (45) active dialysis patients, sixteen (16) of which are Native American. Approximately fifty percent (50%) of dialysis services are scheduled. However, due to the remote location of Toiyabe Dialysis Center, and the proximity of the location to tourist destinations (e.g. Mammoth Lakes, Yosemite National Park), approximately fifty percent (50%) of patients seen are not scheduled or are unexpected. Toiyabe Dialysis Center does partner with DaVita Kidney Care in Carson City, NV as a back-up dialysis facility for our patients in case of an emergency.

The Toiyabe Dialysis Center is currently operating within a Tribally owned building however, there are plans to move the dialysis center to the main clinic, Toiyabe Indian Health Project, Inc. By consolidating all departments into one building patients can easily access care without having to travel. Currently, Toiyabe Indian Health Project, Inc is undergoing building renovation to convert existing main health space into a dialysis center.

Toiyabe Dialysis Center's 2024-2025 budget of $4.4M allows maintenance of current services six (6) days per week, three (3) shifts per day with twelve (12) chairs. However, current projections show that Toiyabe Dialysis Clinic is operating at a loss of $400,000 for the year which prompted them to request supplemental funds to sustain services but to also invest into improving their infrastructure. With additional funds, Toiyabe Dialysis Center would like to pursue the following:

- Purchase and upgrade ancillary equipment such as: new crash cart, suction machine, intravenous pumps, obtain computer on wheels units (COWS)
- Improve IT infrastructure (includes purchase and installation costs for a new Electronic Medical Record)
- Cover moving and storage expenses for site relocation
- Fund for the maintenance of two (2) active dialysis centers during the certification process of the new dialysis site
- Fund for increased infection control/ sanitation needs (i.e. hiring a new full-time Environmental Service Specialist dedicated to the dialysis center)
- Purchase fourteen (14) new chairs for the new dialysis center of which twelve (12) will be used for regularly scheduled patients, and two (2) will serve as back-up
- Funding to purchase and maintain a vehicle capable of transporting patients in wheelchairs and with limited mobility as well as a dedicated staff member to be the dialysis patient transporter
- Fiscal support to assist in bringing dialysis billing in-house. Currently Toiyabe does not have in-house staff to collect dialysis reimbursement.

Currently, Toiyabe Dialysis Center provides in-center HD. They would like to expand services to include home-based PD. These expanded services would require an additional investment in funds to cover supplies, equipment, and staffing support which they do not have.

Toiyabe Indian Health Project, Inc requests a line item be created and funded by IHS to assist in the operating costs for Dialysis services in remote areas. The Tribes recommend that if HQ has any additional end-of-year funds, that they be used for their dialysis center.

Without a local dialysis service, patients would face undue hardships as they would need to travel great distances to receive care. Additionally, transportation services are infrequent and can cause scheduling difficulties. The development of PD services would improve patient quality of life and Toiyabe Dialysis Center efficiency.

RECOMMENDATION

The Tribal workgroup believes that the IHS is responsible for funding operational costs for a Tribal dialysis clinic. Toiyabe Indian Health Project, Inc is seeking Indian Health Service (IHS) one-time funding of $2.5M to offset their rising operational costs and to expand their current dialysis center to include peritoneal dialysis.

The Tribes recommend that if HQ has any additional end-of-year funds, that they be used for their dialysis center.

Emergency Power and the Green Energy Future

ISSUE

California's commercial power providers, such as PG&E, SoCal Edison and SDG&E, routinely shut off power when there are high wind events that could cause fires. This in turn leaves Tribal communities and clinics without power. Furthermore, weather-related emergencies such as wildfires, flooding and high winds often disrupt commercial power service, sometimes for more than a week. While great progress has been made in funding emergency generators for Tribal clinics, Tribes are now interested in pivoting toward a green energy future, where renewable energy sources can reduce costs and reliance on commercial power generation.

BACKGROUND

In recent years, commercial power utilities have caused multiple fires due to their equipment failing during high wind events. This in turn has caused these utilities to adopt a policy to shut down the power in areas that are affected by these high wind events. This causes problems with our Tribal members and Tribal clinics in the rural areas. Many are without power for days and have medical devices and refrigerators for medicine that will not function without a power source.

Through IHS Emergency Generator funds ($8 million total between FY 21 and 25) and Nonrecurring Expense Funds ($10 million in FY 24), the need for backup power generators for Tribal health facilities has largely been met. There is a program for funding green energy projects for Tribal health facilities: the IHS Green Infrastructure program received $5 million per year over the last several years. There are no dedicated programs for emergency generators or green energy improvements for Sanitation Facilities.

RECOMMENDATION

Though IHS is not aware of any California Area Tribal health facilities that lack emergency generators, we are aware of many health care facilities with undersized generators that are not capable of meeting the full electrical load of the facility. Consequently, we recommend IHS funding continue for Emergency Generators until all such needs are exhausted.

The IHS Green Infrastructure program only provides $5 million per year nationwide for construction projects that make energy and water more sustainable for Tribal health programs (in recent years, these projects have been primarily solar power arrays). This level of funding is far below the demand for these services and should be increased.

For Sanitation Facilities Construction, either a new funding source for green energy should be developed or lack of emergency backup power / need for renewable energy should be allowed as a deficiency that qualifies for funding. Either of these possibilities (which currently do not exist) would allow for funding of emergency generators or green energy projects for Tribal water and wastewater facilities.

Facilities Support Account (FSA) Funding

ISSUE

The California Area Division of Health Facilities Engineering lacks sufficient funding to provide services to 36 Tribal health programs operating nearly 150 clinical facilities across the state.

BACKGROUND

The Facilities Support Account (FSA) funds the expenses for all Area and service unit facility personnel who manage and implement the IHS health care facilities maintenance and improvement program, the health care facilities new and replacement construction program, the biomedical equipment maintenance and repair program, and, in many cases, the real property and health facilities planning program. FSA funds support personnel who operate the physical plant at IHS-owned health care facilities and certain non-personnel related operating costs.

Distribution of FSA funds has typically been based on historic allocations, with increases dedicated to supporting new federal or Joint Venture facilities. They are particularly out of balance between Areas based on health care facility space or user population. No effort has been made to re-balance FSA distributions more fairly or to base them on workload.

CURRENT STATUS

California Rural Indian Health Board (CRIHB) has recently expressed a concern about the lack of FSA funds for California Area. Their concern is rooted in the lack of resources to help Title I and Title V programs to identify deficiencies and find resources to fund solutions. FSA-funded personnel identify

health facility needs and conduct master planning, which leads to further funding increases. Conversely, the lack of FSA-funded personnel leads to an inability to increase funding for health programs. Recent FSA data can be found below:

IHS AREA	Facilities Support Account Funding (FY 22)	FSA per Active Indian Registrant	FSA per Square Meter of ESS
Alaska	$29,318,881	$193.96	$107.66
Albuquerque	$6,583,171	$79.55	$86.14
Bemidji	$2,874,098	$27.41	$19.10
Billings	$6,527,469	$93.12	$88.99
California	$2,784,106	$33.32	$25.25
Great Plains	$21,627,575	$167.41	$150.18
Nashville	$3,003,322	$53.58	$38.62
Navajo	$29,485,248	$123.80	$155.94
Oklahoma City	$37,846,239	$96.60	$127.48
Phoenix	$24,967,385	$140.19	$143.00
Portland	$4,099,350	$36.82	$34.55
Tucson	$2,308,343	$84.69	$97.11

California Area receives $33 in FSA per Active Indian Registrant and $25 per square meter of health facility space. For comparison, Navajo Area receives $124 per patient (4 times more) and $156 per square meter of space (6 times more). California is 11th in per-patient and per-square-meter FSA funding, only ahead of Bemidji Area.

When the two federal facilities operated by California Area IHS (two Youth Regional Treatment Centers) and one joint venture (Lake County Tribal Health) are removed, the FSA funding California Area receives for 34 non-Joint Venture Tribal health programs is only $642,000, a mere $8 per patient or $6 per square meter. This funding is insufficient to serve the facilities needs of 34 Tribal health programs comprising over 100 separate health care facilities and a Native user population of at least 80,000 people.

The subject of equity in distribution of FSA funding was discussed by the IHS Facilities Appropriation Advisory Board (FAAB) during its meeting on June 28-29. Furthermore, with support from CRIHB, the National Indian Health Board (NIHB) has passed a resolution for consideration supporting a fairer distribution of FSA resources.

RECOMMENDATION

California Area recommends a workload-based approach to FSA distribution that properly accounts for the workload required to provide service to Title I and Title V health programs.

Joint Venture Construction Program

ISSUE

Tribes and their respective Tribal health programs have repeatedly expressed concerns of a lack funding support of new or expanded space construction projects for Tribally managed health care facilities.

BACKGROUND

The IHS supports new or expanded space construction projects through several programs including the Health Care Facilities Construction (HCFC) program, the Joint Venture Construction Program (JVCP), and the Small Ambulatory Grants Program (SAP).

Section 818 of the Indian Health Care Improvement Act, P.L. 94-437, authorizes the IHS to establish the JVCP in which Tribes or Tribal organizations acquire, construct, or renovate a health care facility and lease it to the IHS, at no cost, for 20 years. Participants are selected from eligible applicants who agree to provide an appropriate inpatient/outpatient facility to IHS. The Tribe must use Tribal, private or other non-IHS funds to design/construct the facility. Then the IHS will submit requests to Congress to fund staff, operations, and maintenance of the facility per the Joint Venture Agreement.

Each year that the JVCP application process is announced, the CAO ensures distribution of applications to every Tribal health program, serves as a technical advisor to all California applicants throughout the application process, and upon final review, submits the application to IHS Headquarters. Eligibility and final selection is carried out by IHS HQ. Over the last 20 years, CA Area has received 25 pre-applications for JVCP including:

2002 (2): Shingle Springs and Lake County
2007 (11): Bishop Paiute Tribe, California Valley Miwok Tribe, Chapa-de, Santa Clara Valley, Karuk, Northern Valley, Pit River, Redding Rancheria, Round Valley, Santa Ynez, and Tuolumne Me-Wuk
2010 (2): Shingle Springs and Redding
2015 (4): Consolidated (Redwood Valley), Northern Valley, Susanville, and Toiyabe.

2020 (6): Hoopa Valley, Pit River, Riverside San Bernardino, Sonoma County, Southern Indian Health Council, and Tule River

In 2005, the IHS/CAO was successful in receiving a JVCP award in which Lake County Tribal Health Consortium in Clearlake, CA, entered a joint venture project with the IHS.

RECOMMENDATION

The CA Area will continue to support and advocate for CA Area Tribes and their respective Tribal health programs via technical assistance and available IHS resources such as Maintenance, Improvement, and Equipment (MI&E), Tribal General Equipment, and Sustainability funds.

The JVCP scoring criteria changes are needed to make California Tribal applicants more competitive and due consideration is given to their unique service populations, geographic locations, health care facilities, and delivery of appropriate health care services.

Recruitment and Retention

ISSUE

Funding for additional resources to augment recruitment/retention activities due to increasing difficulties in recruiting and retaining critical staff.

BACKGROUND

Personnel vacancy rates in critical health care professions at California Tribal and Urban Indian health care programs are reaching high rates not seen in recent history. This worsening trend is having a significant negative impact on clinic operations, including the ability to address critical quality of care requirements that have recently been announced by the Centers for Medicare and Medicaid services.

Given the increased number of individuals who are now accessing health care in California, the availability of providers does not meet the current demand. Private sector health care organizations have greatly expanded their operations and are paying increasing salaries and bonuses to primary care providers that California Tribal and Urban Indian health care programs are unable to match. In addition, several Tribal programs are having difficulty in hiring and retaining Commissioned Officers due to budgetary constraints and the costs associated with detailing the Commissioned Officers to the program.

RECOMMENDATION

The IHS/CAO, in cooperation with other IHS Area Offices, recommends funding for the following activities:

- Actively participate with other Area Offices at medical conferences that involve primary health care providers
- Visit Family Medicine residency programs in California and participate in various speaking engagements
- Work collaboratively with clinics to develop recruitment materials that inform potential providers of the positive attributes associated with California Tribal and urban Indian clinics, such as no on-call duties, more time with patients, and locations that offer unique amenities in urban or more rural/frontier settings
- Assist clinics in identifying and utilizing more robust advertisement venues for vacancy announcements
- Additional funds are needed for the Tribal health programs to compete with market salaries and bonuses for their physicians and medical staff
- Provide supplemental pay for Commissioned Officers assigned to Tribal health programs
- Streamline application processes between medical schools and Tribal and urban health programs to allow for medical students and residents to do a rotation at a Tribal and urban health program

Sanitation Facilities Construction Program

ISSUE

Tribal leaders have expressed concern if the Sanitation Facilities Construction (SFC) program can meet metrics for project completion given the increased workload from the Infrastructure Investment and Jobs Act (IIJA) projects.

BACKGROUND

Starting in 2022, under the Infrastructure Investment and Jobs Act (IIJA), the Sanitation Facilities Construction (SFC) program nationwide started receiving $700 million per year for SFC projects. This represented a large increase over previous funding levels (FY 2021 SFC project funding was $196 million). While this investment in water, wastewater and solid waste infrastructure in Indian country is quite urgent and long overdue, there are numerous challenges that California Area and IHS as a whole are encountering to complete this work in a timely manner.

Staffing: Funding for SFC staffing has increased by 23% from 2018 to 2022, while funding for SFC

projects has increased by 269% over that same period. In other words, California Area SFC staff need to complete roughly triple the work with a quarter more staff. Coupled with persistent engineering vacancies, the additional workload is beyond the capacity of IHS staff alone.

White House Requirements: The White House is overseeing IIJA project completion and demanding every IIJA project be completed within 4 years or less. Historically, California Area has completed SFC projects in less than 4 years on average, but some large and complex projects take longer due to complex environmental, land easement or design issues. Some projects cannot be completed in 4 years, even with an unlimited amount of funding and engineering assistance, as the timeline depends on the actions of outside parties (e.g. county for obtaining rights-of-way). SFC projects funded in previous years may have to be delayed, despite the wishes of Tribal governments.

Self-Governance: Only one Tribe in California Area has a program for self-governance of the SFC program under a Title V compact. The direct service SFC workload is spread among about 100 federally recognized Tribes served by six (6) separate IHS district and field offices. The funding for self-governance of the program for an individual Tribe varies considerably from year-to-year based on the number and cost of projects funded. With the workload spread out and funding inconsistent, no other Tribes have expressed an interest in self-governance of the SFC program.

CURRENT STATUS

The California Area SFC program has been utilizing a number of different measures to complete projects more efficiently to meet the IIJA project completion goals. These include:

- Tribal procurement of architecture and engineering (A/E) services
- Utilizing federal A/E contracts for project planning and design services
- Improved recruitment and retention incentives to keep engineer positions filled
- Hiring temporary positions to increase engineer capacity
- Exploring partnerships with the Army Corps of Engineers and Bureau of Reclamation to build additional capacity to complete projects

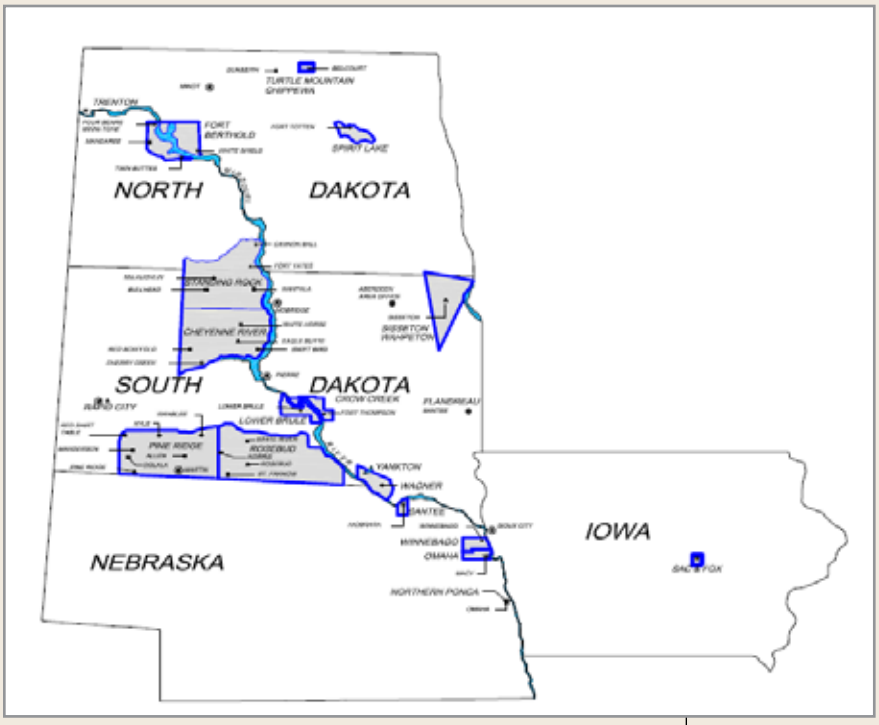
However, even utilizing all these measures at maximum capacity would not allow California Area to complete every IIJA project within 4 years. Managing external A/E contracts still requires a significant amount of work and oversight by IHS engineers. The ability to hire permanent staff is limited by funding and office space. Much of the work requires an in-person presence during planning, design and construction, limiting the ability to utilize full-time remote telework. Partnerships with Tribes, engineering firms and external state and federal partners are being built at every juncture, but it is not sufficient to meet these unrealistic goals.

RECOMMENDATION

IHS should educate the White House on Tribal sovereignty. Some complex IIJA projects require many non-engineering steps, including obtaining rights-of-way, public meetings, and decisions from Tribal leadership. Tribes have a sovereign right to build facilities and follow internal processes that may not meet the White House's ambitious goal of completing an IIJA project within four years. Furthermore, Tribes' priorities to complete previously-funded SFC projects before IIJA-funded projects should be respected.

The target or goal should remain an average project duration less than four years, not requiring every project to be completed within four years. Additional program funding to hire additional staff would not drastically improve the situation, as office space is limited. However, additional projects funding that could be set aside to allow Tribes to hire external engineering firms would help a bit with the challenge.

Great Plains Area



Executive Summary

Tribal leaders representing the Tribes/Tribal organizations, and urban Clinics of the Great Plains Area met virtually on December 12, 2024, to develop the Indian Health Service Great Plains Area FY 2027 Tribal Budget Recommendations.

These federally recognized Tribes have approximately 199,504 enrolled federally recognized Tribal members (Bureau of Indian Affairs, 2010) and cover a four state region that includes 17 federally recognized Tribes and Tribal service areas in North Dakota, South Dakota, Nebraska, and Iowa. This large landmass measures approximately 5,966,279 acres, including trust lands,

American Indians served in the Great Plains Area suffer from among the worst health disparities in the nation. Death rates from preventable causes, including type 2 diabetes, alcoholism, unintentional injuries, suicide, etc., are several-fold greater than the rest of the national IHS population and the general US population. At the same time, the health system designed to serve this population is severely underfunded, and the services provided to address the disparities are not adequate to meet the needs of the Indian population in the Great Plains Area. Direct services funding has not seen an increase in over two funding years. As medical and health care costs increase, the funding is not increasing to meet our needs.

It is the position of the Great Plains Tribes that even if the estimated full funding recommendation is funded, it is inadequate to meet the needs of a growing Tribal community and uphold the trust responsibility outlined in the Indian Health care Improvement Act, to provide the "highest possible health status to Indians and to provided existing Indian health services with all resources necessary to effect that policy."

The Great Plains Area Health and Budget priorities by Tribal consensus is to follow the recommendations of the National Budget Workgroup with increase of additional funding of $55,922,940 for FY 2027 The Great Plains Area would like to continue to focus on the following programs increases in addition to the recommendations made by the National Workgroup.

1. Purchase Referred Care $17,895,340
2. Hospitals & Health Clinics $15,099,193
3. Health Education ..... $ 6,151,524
4. Special Diabetes Program for Indians ..... $ 5,592,294
5. Facilities Support ..... $ 5,033,064
6. Mental Health ..... $ 3,355,377
7. Dental Services ..... $ 2,796,147

Great Plains Budget Justification Narrative

1. Purchase/Referred Care

The Great Plains PRC service area of is comprised of 4 states (North Dakota, South Dakota, Nebraska, and Iowa), with 6 states being included in the Purchased/Referred Care Delivery Areas (North Dakota, South Dakota, Nebraska, Iowa, Minnesota and Montana). A total of 83 counties are included in the Purchased/Referred Care Delivery Area for

the Great Plains Area Tribes. The majority of these counties are extremely rural, which fosters a strong dependence on contracted providers.

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

When a patient does not meet all requirements of priority they are issued a denial of the services are deferred. Typically, only Priority I conditions are covered or approved through PRC in the Great Plains Area. This then leads to a larger public health concern as fewer individuals in Tribal communities are receiving the specialty and preventive care they need before a condition becomes emergent. Preventive health is important because it can reduce disease burden, decrease morbidity and mortality, and improve the quality of life of people. The burden on the health services also reduces, thereby having an impact on the IHS budget.

GPA 2018 Total Estimated Unmet Need

An increase to IHS PRC funds will allow more Tribal members to access private-sector care before the health care condition becomes an emergency, improving and increasing the overall health of the AI/NA population.

2. Hospitals & Clinics

The Great Plains region relies heavily on Direct Care Services. More than half of the Great Plains Area budget is allocated to Hospitals & Clinics. Great Plains Area identifies this as a priority because it provides the base funding for the hospitals, clinics, and health programs that operate on the Area reservations, which are predominately rural.

Increasing H&C funding is necessary to support the following: primary medical care services, impatient care, routine ambulatory care, and medical support services — such as laboratory, pharmacy, medical records, information technology, and other ancillary services. In addition, H&C funds provide the greatest flexibility to support community health initiatives targeting health conditions disproportionately affecting American Indians/Alaska Natives in areas of diabetic, maternal and child health, and communicable diseases including influenza, HIV/AIDS, and hepatitis.

The incidence of leading infectious disease (ID) in the Great Plains is significantly higher among AI/AN than among the white population, especially in the Dakotas, where American Indians experienced substantially higher burden of Syphilis, and other recent outbreaks. The all-cause of mortality rate between 1990 and 2013 among AI/AN in the Great Plains was double that of the white population.

3. Health Education

The Indian Health Service (IHS) Health Education Program has been in existence since 1955 to educate American Indian/Alaska Native (AI/AN) patients, school age children and communities about their health. The program focuses on the importance of educating patients in a manner that empowers them to make positive choices in their lifestyles and how they utilize health services. Accreditation requirements at IHS and Tribal facilities specifically require the provision and documentation of patient education as evidence of the delivery of quality care.

In FY 2022, there was a decrease of 8 percent or 256,059 patient visits from the previous year. In FY 2022 there was 2,747,938 patient education visit, which decreased FY 2021 patient education visits. The decrease in visits was impacted by COVID-19. However, FY 2022 patient education visit exceeded target results.

The Health Education funds provide critical support for direct health care services focused on strengthening the collaborative partnerships among direct care providers, patients, communities, and internal and external stakeholders. Funds are utilized to ensure IHS, Tribal, and Urban Indian health care programs have comprehensive, culturally appropriate services, available and accessible personnel, promotes excellence and quality through implemented quality improvement strategies, and strengthens the IHS program management and operations to address health disparities and raise the health status of AI/AN populations to the highest level possible.

4. Special Diabetes Program for Indians

The Special Diabetes Program for Indians (SDPI) grant program provides funding for diabetes treatment and prevention to 302 Indian Health Service (IHS), Tribal, and Urban (I/T/U) Indian health grant programs. Funds for SDPI were first authorized in FY 1998; as such, FY 2025 would be the 28th year of the SDPI. SDPI is currently authorized through September 30, 2024. The IHS Office of

Clinical and Preventive Services (OCPS) Division of Diabetes Treatment and Prevention (DDTP) provides leadership, programmatic, administrative, and technical oversight to the SDPI grant program.

The mission of the DDTP is to develop, document, and sustain public health efforts to prevent and control diabetes in American Indians and Alaska Natives (AI/ANs) by promoting collaborative strategies through its extensive diabetes network. This mission aligns with Goal 1 of the IHS Strategic Plan, to ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people and Objective 2.2 of the HHS Strategic Plan, Provide care to better meet the health care needs of American Indian and Alaska Native communities. The diabetes network consists of a national program office, Area Diabetes Consultants in each of the 12 IHS Areas, and 302 SDPI grants at I/T/U sites across the country. Target Population: American Indians and Alaska Natives Diabetes and its complications are major contributors to death and disability.

5. Facilities Support

Facilities Support Account (FS) provides funding for Area and Service Unit staff for facilities related management activities, operation and maintenance of real property and building systems, medical equipment technical support, and planning and construction management support for new and replacement health facilities projects.

Facilities operations, maintenance, repair, and improvements address deficiencies/BEMAR and medical equipment, which are complex and involve many variables such as accreditation CJ - 217 standards, health care patient satisfaction, changing health care delivery standards, building codes, old building equipment/system, and medical devices/ equipment plus telemedicine used by health care professionals.

The IHS owns approximately 11,000,000 square feet of facilities (totaling 2,193 buildings) and 1,760 acres of federal and trust land. The nature of space varies from sophisticated medical centers to residential units and utility plants. Facilities range in age from less than one year to more than 170 years, with an average age greater than 40 years. A professional and fully functional workforce is essential to ensure effective and efficient operations. An estimated 600 Federal positions (fulltime equivalents) are funded under this sub-activity. Typical staff functions funded may include:

- Facilities engineers and maintenance staff responsible for ensuring that building systems are operated properly, facilities and grounds are maintained adequately, utilities are managed appropriately, environmental compliance requirements are met, and buildings are safe;
- Specialized clinical engineers and technicians who maintain and service medical equipment;
- Realty staff that manages the real property requirements and quarters; and
- Facilities planning, project management, and construction-monitoring that assist in the planning and construction of projects.

In addition, FS provides partial 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. Accomplishments include supporting health delivery through the attainment of accreditation and the maintenance of the environment of care of buildings, utility systems, life safety systems, and medical equipment.

Adequate facilities/maintenance staffing both at the Area Offices and service units are paramount to maintain accreditation, for the continuity of health services, and ensuring that major building systems function correctly. Workload for the facilities and biomedical staff has continued to increase to meet the Agency's emphasis on accreditation standards and supporting program enhancements/expansion, which is predominately funded with collections.

In consultation with Tribes and the Federal health care sites, IHS is coordinating with and allocating funding to the IHS Area Offices to complete BEMAR projects to make renovations and improvements necessary to support health care delivery in the health care facilities and to modernize the health care facilities and staff quarters to expand access to quality health care services including modern medical equipment.

6. Mental Health

Native Americans with serious mental illness experience high rates of morbidity and mortality. This adversely affects our Tribal members' quality of life and contributes to premature death. Particularly concerning is the rising rate of suicides and suicide attempts in this area. The Great Plains Area (GPA)

suicide rates/behaviors is one of the highest of the 12 IHS service areas. There are several barriers to delivering effective care to those in most need of help. Behavioral Health referrals are often outsourced to professionals who are extreme distances away (90 miles or more) from their home Tribal communities. This has resulted in limited behavioral health care, missed appointments and very poor follow-up care. Our Tribal members are at risk for further isolation due to COVID-19, depression and anxiety.

Housing on the GPA reservations are inadequate to meet the needs of our growing Tribal populations as well as housing for our clinical staff. This significant barrier discourages licensed/credentialed behavioral health and other clinical providers from seeking and accepting employment at our area Tribal sites. Challenges in retaining our clinical professionals also makes it extremely difficult to provide adequate services to our patients.

Native members who have experienced historical trauma often adopt adverse coping skills by self-medicating with alcohol or other substances, which have contributed adversely to the high rates of suicide. Providing these members with more access to behavioral health care is a vital element in averting suicides and lowering substance abuse.

There is still a proportionally high volume of suicides among our native youth, despite the grants available by various states and federal agencies to address this issue. Established intervention and prevention programs have begun to reach our youth, but an unprecedented amount of suicides, suicide attempts and suicide ideations and clusters continue to plague our Tribal members. Better access to behavioral health care is needed. When a youth's life is lost, a piece of our culture and their contribution to our community is no longer with us.

7. Dental Services

Dental Health supports preventive care, base care, and emergency care, with approximately 90 percent of services covering basic and emergency care. Basic services are prioritized over more complex rehabilitation care such as root canals, crowns and bridges, dentures, and surgical extractions. The demand for dental treatment remains high due to a high dental caries rate in American Indian and Alaska Natives (AI/AN) children, however a continuing emphasis on community oral health of AI/AN people.

Within the Great Plains Area dental health, especially prevention remains a high priority. GPA also is in need of additional funding to provide dental implants for Natives who have lost teeth and need replacement.

Across all age groups, AI/ANs suffer disproportionately from dental disease. When compared to other racial or ethnic groups, AI/AN children 2-5 years old have more than double the number of decayed teeth and overall dental caries experience as the next highest ethnic group, U.S. Hispanics, and more than three times that of U.S. white children.1 In the 6-9 year-old age group, 8 out of 10 AI/AN children have a history of dental caries compared with only 45 percent of the general U.S. population, and almost half of AI/AN children have untreated tooth decay.

The Dental Health funds provide critical support for direct health care services focused upon strengthening the collaborative partnerships among direct care providers, patients, communities, and internal and external stakeholders. Funds are utilized to ensure IHS, Tribal, and Urban Indian health organizations have comprehensive, culturally appropriate services and personnel available and accessible, promotes excellence and quality through implemented quality improvement strategies, and strengthens the IHS program management and operations to address health disparities and raise the health status of AI/AN populations to the highest level possible.

Hot Issues

Health Professional Manpower Shortages

ISSUE

Funding to adequately provide for Health Care Professional in the Great Plains Area

BACKGROUND

The Association of American Medical Colleges (AAMC) reported that by 2032 there will be a shortage in the US of up to 122,000 physicians, as there aren't enough people going into the field to replace the number expected to retire in the next dozen years. On top of that, the Bureau of Labor Statistics' Employment Projections 2016-2026 lists Registered Nursing (RN) among the top occupations in terms of growth, with a 15% increase in jobs by 2026, and more than 200,000 new RNs needed each year to fill these positions and replace retiring nurses. "The health care landscape is changing

quickly with a physician workforce that's aging and a number of physicians retiring, which is estimated to be increasing the next few years," says Annette Reboli, MD, dean of Rowan University Medical School and a professor of medicine with a specialty in infectious diseases. "The good news is, the number of nurse practitioners (NPs) and physician assistants (PAs) are increasing. They are part of the solution if they practice to the limit of their licenses and free up physicians to do what only they can do," she says.

Still, the numbers are daunting. Two of every five active physicians will be 65 or older in next 10 years, with 40 percent of the workforce expected to retire during that period. The increasing number of patients being insured, coupled with the growing number of Americans over age 65 and needing more care, make it all the more important to increase the pool of available physicians, highly qualified nurses and other health professionals

The relative **shortage** of **physicians** in **rural areas** of the **United States** is 1 of the few constants in any description of the **US** medical care system. About 20% of the **US** population—more than 50 million people—live in **rural areas**, but only 9% of the nation's **physicians** practice in **rural communities**. (This will continue to increase causing stresses on the current delivery systems). This problem is magnified in our population and reflected in comments to our recruiter of: remote locations, substandard housing, poor schools, little or no extracurricular activities, shopping or entrainment, proximity to airports and ease of travel to a large metro area. Our primary audience for attraction is younger providers recently finishing training who desire basics of financially stable, attractive communities. Our physician population is aging for example 1/3 of ND physicians are over the age of 55. Other states have similar statistics. AAMC is quoted online as saying the aging, retiring, and rural demands will cause a deficit of 54,000 to 139,000 by 2033. *And if "Medicare for all." is passed will accelerate these numbers due to heavier workloads leading to more retirements.

Today, a quick search reveals the FP providers are among the "lowest paid." Many specialists are paid at higher levels; however, our smaller/rural medical units do not support by volume enough patients to justify their specialty salaries (Dermatology, Ophthalmology, and General Surgeons which were a large consumer of out sourced funding this past year at Pine Ridge and Rosebud.)

RECOMMENDATION

Raise salaries/benefits to those levels which will attract providers and meet industry standards.

For example, many nongovernment hospitals are paying above $300,000/yr plus benefits including CME. Somehow our rules must change for increased monies.

Hire formally trained educators to build for the future to implement a post graduate medical program. And utilize these individual in planning and developing superior clinical rotations for students. One per hospital that entertains training is a minimum. These educators might also oversee some of the extender providers (NP, PA), thereby freeing up Primary Care Providers.

Spend monies necessary to adequately market our jobs, benefits, and salaries that exceed the norm.

Purchase modern equipment and new EHR.

Purchased/Referred Care (PRC)

ISSUE

To provide adequate funding to provide coverage for the North Dakota and South Dakota area, settlement of outstanding medical bills, and availability of specialty care for referred patients. The need for itemized funding for kidney transplants, dental implants, and preventive services as a Priority.

BACKGROUND

There are basically 5 categories to the PRC allocation:

- Category 1 ~ The Recurring base – this is the amount we start with every year and is not subject to a formula calculation. This is a historical base established decades ago and cannot be changed as it would impact Tribal shares.

  The recurring base is increased when we have increases in categories 2, 3, and 4. For example, if a service unit's recurring base is $100,000 and we receive a 0.5% ($500) increase. That amount is added to the old recurring base creating a new recurring base of $100,500.
- Category 2 is for maintaining services and is primarily broken into two subcategories – population growth and inflation. This is a fixed percentage that is added to each PRC recurring base, for example we may receive a 0.5% increase in PRC funding to cover population growth

and inflation, so each sites recurring base is increased by 0.5%.
- Category 3 is Congressional earmarks which are distributed as indicated in the appropriation text. These are generally funds for new Tribes.
- Category 4 is for service expansion and this is the category for which we utilize the PRC distribution formula.
- Category 5 is the Catastrophic Health Emergency Funds (CHEF) which are distributed based on actual catastrophic health care costs incurred by our patients.

With the SD Medicaid Expansion becoming effective July 1, 2023 could result is greater purchasing power for the PRC Programs. This savings will allow PRC funding to cover services at a lower level of medical priority and also bring in Specialty Care onsite with the PRC savings.

RECOMMENDATION

Additional Funding will greatly help with increased referrals and provide for specialty care opportunities. With the limited funding it's a challenge to refer patients for specialty care outside of the Indian Health Service hospitals and clinics.

Restructure of the PRC medical priorities plan to maximize the efficiency of resource allocation promoting evidence-based strategies that balance the preventive, mental health, chronic and acute care needs in our service population with the goal of improved patient satisfaction and health concerns.

Mental Health Services and Residential Treatment

ISSUE

Funding to provide Mental Health Services and Residential Treatment.

BACKGROUND

During national lockdowns and civil unrest, our nation experienced soaring rates of anxiety and depression, financial hardships and soaring rates of substance abuse including overdose deaths. This stretched our nation's mental well-being and transformed the way we delivered mental health and substance abuse services in our communities. This also changed the way we viewed physical safety and service delivery to our most vulnerable community members in communities of color and specifically in Indian Country.

Since the onset of the COVID-19 pandemic, we were isolated from our loved ones, did not have a chance to say good bye when they died from COVID-19 and were even restricted from gathering together to honor our loved ones' legacy before sending them on their journey. COVID-19 stretched our safety and mental well-being in America, globally and throughout our native communities.

Native Americans with serious mental illness experience high rates of morbidity and mortality. This adversely affects our Tribal members' quality of life and contributes to premature death. Particularly concerning is the rising rate of suicides and suicide attempts in this area. The Great Plains Area (GPA) suicide rates/behaviors is one of the highest of the 12 IHS service areas. There are several barriers to delivering effective care to those in most need of help. Behavioral Health referrals are often outsourced to professionals who are extreme distances away (90 miles or more) from their home communities. This has resulted in limited behavioral health care, missed appointments and very poor follow-up care. Our Tribal members are at risk for further isolation due to COVID-19, depression and anxiety.

Additionally, native members who have experienced historical trauma often adopt adverse coping skills by self-medicating with alcohol or other substances, which have contributed adversely to the high rates of suicide. Providing these members with more access to behavioral health care is a vital element in averting suicides and lowering substance abuse use. There is still a proportionally high volume of suicides among our native youth. Established intervention and prevention programs have begun to reach our youth, but an unprecedented number of suicides, suicide attempts and suicide ideations and clusters continue to plague our Tribal members. Better access to behavioral health care in local Tribal communities is needed. When a youth's life is lost, a piece of our culture and their contribution to our community is no longer with us.

A mental health crisis can be devastating for individuals, families and communities in Indian Country. Too often service to our relatives are met with delay, due to transportation issues and undue burden on the patient and medical staff. Unfortunately, costs escalate due to an overdependence on restrictive, longer-term hospital stays and hospital readmissions. Substance use and psychiatric inpatient services are over-burdened with referrals that might be best-supported with less intrusive, less expensive services that are offered locally and within their own community.

Great Plains Area has the one of the highest alcohol related deaths and the second highest rate of suicides in the country. The need for additional funding to assist Tribes in developing inpatient and transportation services is greatly needed in order to fully utilize opportunities for Third party reimbursement funding (Medicare, Medicaid, Private Insurance, VA).

The current pathway to crisis care has patients leaving their home communities to engage in SUD and mental health services. Patients must be offered real-time access to culturally relevant services that align with the needs of the person and within the community they reside in. Our relatives are struggling to access care as well as transportation services.

RECOMMENDATION

Budget increase for mental health, substance abuse and transportation services.

Special Diabetes Program for Indians

ISSUE

Direct funding for diabetes prevention and treatment services in a Tribal community.

BACKGROUND

Diabetes is a complex and costly chronic disease that requires tremendous long-term efforts to prevent and treat. Although diabetes is a nationwide public health problem, American Indian/Alaska Native (AI/AN) people are disproportionately affected. In 2019, 14.5 percent of AI/AN people aged 18 years or older had diagnosed diabetes, compared to 7.4 percent of non-Hispanic white people (CDC, 2021). In addition, AI/AN people have higher rates of diabetes-related morbidity and mortality than the general U.S. population (O'Connell, 2010; Cho, 2014).

In response to the diabetes epidemic among AI/AN people, Congress established the Special Diabetes Program for Indians (SDPI) program through the Balanced Budget Act of 1997. This $150 million annual grant program, coordinated by IHS Division of Diabetes with guidance from the Tribal Leaders Diabetes Committee (TLDC), provides funds for diabetes treatment and prevention to IHS, Tribal, and urban Indian health programs across the United States. In 1998 the IHS Director established the TLDC to make recommendations to the IHS Director on broad-based policy and advocacy priorities for diabetes and related chronic conditions as well as recommends a process for the distribution of SDPI funds.

The Special Diabetes Program for Indians is authorized under the Snyder Act, 25 U.S.C. 13; the Transfer Act, 42 U.S.C. 2001(a); and Section 330C of the Public Health Service Act, codified at 42 U.S.C. 254c-3. Cooperative agreements awarded by the Department of Health and Human Services are administered under the same policies as grants. The funding agency, IHS, has substantial programmatic involvement in the project during the entire period of performance. The funding available for competing and subsequent continuation awards is subject to the availability of appropriations and budgetary priorities of the Agency.

RECOMMENDATION

Direct funding for diabetes prevention and treatment services may best fit the local needs of Tribal communities. TLDC is in discussion on an SDPI framework concerning direct diabetes prevention and treatment funding process.

Nashville Area



- 25 Tribally Operated Facilities
  - 10 Compacting
  - 15 Contracting
- 3 Purchased Referred Cares Sites
- 3 Direct Service Facilities
- 2 Urban Indian Health Program
  - 1 serving Baltimore and Boston
  - 1 serving New York
- 1 Youth Regional Treatment Center
- Tribally Operated Adult Treatment Center
- Servicing: 96,000 American Indian and Alaska Natives

Nashville Area Tribes have expressed the critical importance of increases to the IHS budget matching rising levels of inflation. Historically, IHS is not only underfunded, but has not received appropriation increases to minimally keep up with comparable overall rising inflationary costs. The Nashville Area Tribes wholly support a full funding request. However, in the absence of full funding, Tribes emphasize the significance of ensuring the President's Budget maintains levels of national inflation.

Budget Recommendations

The Nashville Area offers the following budget recommendations for FY 2027:

FULLY FUND THE INDIAN HEALTH SERVICE AT $71 BILLION. NASHVILLE AREA TRIBAL NATION'S RECOMMEND DISTRIBUTION OF THE REMAINING OF $55.9 BILLION TO THE FOLLOWING PRIORITIES:

1. Hospitals and Clinics $19.2 billion
2. Purchase Referred Care $15.4 million
3. Mental Health $11.6 billion
4. Dental $5.8 billion
5. Alcohol/Substance Abuse $3.9 billion

Top 5 Budget Increases

1. Hospitals & Clinics +$19.2B

Funding for Hospitals & Clinics (H&C) remains a top Tribal budget priority, as more than half of the IHS H&C budget is transferred under P.L. 93-638 contracts or compacts to the Tribes, who are responsible for approximately 66% of the IHS outpatient workload and 62% of the inpatient workload. H&C funding supports essential personal health services including inpatient care, routine and emergency ambulatory care, and medical support services including laboratory, pharmacy, nutrition, diagnostic imaging, medical records, physical therapy and other services. H&C funds also supports community health initiatives targeting health conditions disproportionately affecting AI/ANs, such as specialized programs for diabetes, maternal and child health, women's health, elder health and disease surveillance.

2. Purchased/Referred Care (PRC) +$15.4B

PRC funding is one of the key budget priorities for the Nashville Area. IHS and the Tribes serve primarily small, rural populations and provide mainly primary care and community health services. Much of the secondary care, and nearly all of the tertiary care needed, must be purchased from non-IHS facilities. PRC funds are used to purchase essential health care services, including inpatient and outpatient care, routine emergency ambulatory care, transportation and medical support services, such as diagnostic imaging, physical therapy, laboratory, nutrition and pharmacy services. These funds are critical to securing the care needed to treat injuries, heart disease, digestive diseases, and cancer, which are among the leading causes of death for AI/ANs.

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

Due to the changes in PRC priority levels, Nashville Area Tribes have identified the need for additional funding to ensure this increased access to care.

3. Mental Health +$11.6B

Mental Health, is also a top Tribal health priority. The high incidence of mental health disorders, suicide, violence, and behavior-related chronic diseases among American Indians and Alaska Natives is well documented. A mental illness regularly disrupts a person's thinking, feeling, mood, ability to relate to others and function, however outcomes can be improved through early intervention and proper support. Lack of access to timely, high-quality treatment is the greatest barrier to healthy Native American individuals and communities. Many IHS, Tribal, and Urban Indian Mental Health programs across the nation offer access to community-based integrated primary care and preventive mental health services that are culturally appropriate and integrated with primary care with options for specialty tele-behavioral services. However, the majority of programs are small and staffed with one provider. To ensure that everyone who seeks treatment is able to receive it, additional resources are required.

4. Dental Health +$5.8B

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

As a result of these disparities in oral disease, the IHS has created national initiatives. The IHS Early Childhood Caries (ECC) Collaborative is focused on preventing tooth decay (ECC) in American Indian/ Alaska Native (AI/AN) children under the age of 71 months. The ECC Collaborative began in 2010 with the goal of reducing ECC in the AI/AN population through a coordinated, nationwide collaborative utilizing not only dental programs but also medical and community partners such as medical providers, public health nurses, community health representatives, pharmacists, Head Start teachers, and more. By the end of the first five years of this

initiative, the IHS had increased access to dental care for AI/AN children under 71 months by 7.9% and significantly increased prevention and early intervention efforts (sealants increased by 65.0%, the number of children receiving fluoride varnish increased by 68.2%, and the number of therapeutic fillings increased by 161.0%), resulting in a net decrease of ECC prevalence from 54.9% in 2010 to 52.6% in 2014. To support this initiative, the IHS conducted a nationwide surveillance of 1-5 year-old AI/AN children through two coordinated efforts of 8,451 children in 2010 and 11,873 in 2014 - the largest oral health surveillance sample size ever of this age group in the AI/AN population.

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

5. Alcohol/Substance Abuse Program (ASAP) +$3.9B

Alcohol has wide-ranging adverse consequences. Identifying the factors that contribute to alcohol-related problems and understanding the fundamental biological, environmental, and developmental factors is key to developing preventive and treatment approaches in a culturally appropriate and community driven context. This is critically important because although Native Americans are less likely to drink than white Americans, those who do drink are more likely to binge drink, have a higher rate of past-year alcohol use disorder compared with other racial and ethnic groups, and are twice as likely to die from alcohol-related causes than the general American public (NIAAA). Increasing ASAP funding to tailor resources for preventing, treating, and facilitating recovery from alcohol problems across the lifespan, including at the embryonic and fetal stages to eliminate fetal alcohol spectrum disorders. The resources must be available for Tribal Nations to adequately address detoxification, inpatient rehabilitation in a culturally appropriate environment, and support for residential treatment as well as sober housing. The increased funding for ASAP is also needed to allow for integrated approaches to address co- occurring substance use and mental health disorders and to reduce health disparities through a comprehensive public health approach.

Standing Area Priorities

Health Care Facilities Construction

While the Nashville Area supports increased funding for Health Care Facilities Construction, the Area has not historically benefited from this program. With the development of a revised Health Care Facilities Construction Priority System and language in the permanently reauthorized Indian Health Care Improvement Act regarding new funding mechanisms for health care facilities construction provided some hope that future funding might be available to replace outdated Nashville Area health care facilities. IHS has yet to approve the revised priority system for implementation or to create an Area Distribution Fund to address Nashville Area facility construction needs. The Nashville Area Tribal Nations request that IHS develop and implement an Area Distribution Fund for the Facilities line item, so that other Area facilities get smaller projects completed while IHS continues to work on the "grandfathered" priority list.

Additionally, SARS-COVID2 the virus that causes COVID 19 is transmitted via respiratory droplets. During the pandemic, Nashville Area found that most facilities' ventilation systems, including protective barriers, could be optimized to mitigate the spread of COVID. The Area also found a lack of negative pressure rooms necessary to isolate positive COVID 19 patients. Environmental engineers that review the systems felt that due to age of the buildings that installation of true negative pressure rooms were not feasible due to lack of ventilation. As a result, facilities found themselves having to improvise with creating negative pressure rooms that were not ideal to prevent the spread of COVID 19. Ventilation system upgrades or improvements can increase the delivery of clean air and dilute potential contaminants. These upgrades are important for control of spread of the infection within all health facilities who were seeing COVID positive patients, or for future pandemic response.

Facilities and Environmental Health

The Facilities Support, Sanitation Facilities Construction and Environmental Health Services programs are funded out of the Facilities and Environmental Health Account. Facilities and Environmental Health support funds are used for the planning, construction and maintenance of hospitals and clinics to provide the highest quality of care in a safe clean environment; to assure new facilities meet or exceed health care accreditation standards; for identifying environmental hazards

and risk factors in Tribal homes, health care facilities, food service establishments, Head Start centers, and many other types of Tribal establishments and proposing control measures to prevent adverse health effects; for monitoring and investigating disease and injury; and to collaborate with AI/AN, other agencies, and IHS programs to prevent unintentional injuries (motor vehicle-related, falls, burns, drowning, poisoning) and intentional injuries (suicide and violence- related) through technical assistance, training, and the Tribal Injury Prevention Cooperative Agreement Program (TIPCAP).

In recent years the Nashville Area has grown to include seven new Tribes and four additional Service Units so additional funding is required to provide needed services. Along with the additional Tribes and Service Units, many of our Tribes are expanding services and building additional facilities such as Elder housing and Domestic Violence Shelters so additional staff is needed to assess new facilities on at least an annual basis.

Over the last four years, there has been a significant increase in M&I funding without a corresponding increase in Facilities Support Account for staffing. Additionally, over the past several years, a number of Tribes have been federally recognized without a corresponding increase in Facilities and Environmental Health Support funds for staffing. The additional funds are used for planning and monitoring health care facility maintenance programs to guarantee public safety, maintain high health care accreditation standards, and maintain a healthy environment for staff and patients. Since many of our facilities are older, some need extensive renovations which adds work to both Facilities and Environmental Health staff in terms of plan review, construction review, and technical assistance.

The Division of Sanitation Facilities Construction (SFC) designs, and supervises the construction of water, wastewater, and solid waste facilities. Engineers also inspect water, wastewater, and solid waste facilities with Division of Environmental Health Services staff in an effort to provide clean, safe water for Area Tribes. In recent years the SFC project budget has doubled without a corresponding increase in staffing dollars, which increases work for SFC certainly, but also increases the need for additional Facilities and Environmental Health staff in regards to increased inspections and technical assistance.

Advance Appropriations

Since Fiscal Year 1998, appropriated funds for the Indian Health Service have been released after the beginning of the new fiscal year. Most often caused by a Congressional failure to enact prompt appropriations legislation, late funding has severely hindered Tribal and IHS health care providers' budgeting, recruitment, retention, provision of services, facility maintenance, and construction efforts. Congress has recognized the difficulties inherent in the provision of direct health care that relies on the appropriations process and traditional funding cycle and has appropriated beginning with FY 2010, advance appropriations for the VA medical care accounts. As the only other federally funded provider of direct health care, IHS should be afforded the same budgetary certainty and protections extended to the VA.

Advance appropriations is a budgetary solution that would protect these services from future lapses in appropriations and ensure they do not count against spending caps. The Indian Health Service (IHS) Advance appropriations is a budgetary solution that would protect these services from future lapses in appropriations and ensure they do not count against spending caps.

Moving federal Indian programs to the advance appropriations process will protect Tribal governments from cash flow problems that regularly occur due to delays in the enactment of annual appropriations legislation. We're appreciative of the approval of advance appropriations for Fiscal Year 2025 but approval for future years is needed to avert budgetary delays and uncertainties for the Indian Health Service.

Special Initiative Funding for New Tribes

The six newly recognized Tribal Nations in Virginia, Chickahominy Indian Tribe, Chickahominy Indian Tribe – Eastern Division, Monacan Nation, Nansemond Indian Tribe, Rappahannock Tribe, and the Upper Mattaponi Tribe, were recognized on January 29, 2018, as well as Pamunkey's recognition in 2016. These Tribal Nations are now eligible for services provided by the Indian Health Service. While the FY 2020 budget request included funding for programs and services, it did not include special initiative funding leaving these Tribes without funding for special initiatives for grant programs, such as Special Diabetes Program for Indians. This became a significant issue for the Nashville Area when the FY2023 SDPI applications were open for

competition, but funding allocated to the Area was not increased with the 7 new applicants approved during the new funding cycle.

Ultimately with final funding decision the newly recognized Tribes were able to receive funding for SDPI, however this issue continues to be important for any additional newly recognized Tribes IHS may receive funding for.

Hepatitis C

Hepatitis C (HCV) infection is the most common blood-borne disease in the United States, disproportionately impacting racial and ethnic minorities, including American Indians and Alaska Natives (AI/AN). In 2015, AI/AN experienced a rate of acute HCV higher than that of other minority populations, with AI/AN women more than 50% likely to die from viral hepatitis compared to their non-Hispanic white counterparts. As a result, the Indian Health Service has increased its focus on HCV Elimination, with the goals of increased HCV screening, prevention of new viral hepatitis infections, and the reduction of viral hepatitis fatalities.

With an increase in initiatives to address opioid abuse in Indian Country, attention to viral hepatitis exposure is critical. Indeed, the highest risk of HCV infection occurs among injection drug users and persons with sexually transmitted infections. Additionally, the co-infection with HIV in those with HCV is estimated between 50% and 90%, with higher HCV viral load, more rapid progression to HCV-related liver disease, and increased risk for cirrhosis and liver cancer. Approximately 1 in 4 people living with HIV are co-infected with HCV.

Intensified education around Hepatitis C is critical to ensuring Tribal and urban Indian communities have the necessary knowledge to protect themselves from infection and/or to access effective antiretroviral therapies. Such efforts would likewise assist in the prevention of HIV and STIs given the parallel risk of exposure. Knowing that risk amplifies where injection drug use is present, it is vital to include this information in any efforts to prevent and treat opioid abuse. A strong health promotion/disease prevention approach could have significant impacts on the health Indian Country.

Project TransAM

The National Defense Authorization Act of 1995, Section 8032 of Public Law 103-335, created Project TransAM for the purpose of acquiring and distributing excess military and government assets, at no cost to IHS and Tribal facilities for the advancement of Tribal public health. In FY2024, Project TransAM transferred over $3.0M in assets to 63 federal and Tribal public health programs across the nation in collaboration with the VHA, FEMA, GSA, and other HHS operating divisions.

Initially conceived and created as a joint IHS-DOD operation, TransAM was allotted $500K in equipment funding. While in partnership, the IHS provided financial and operational management, while DOD provided facilities, equipment, and personnel. The DOD ceased its support for the program in 2007, with the Nashville Area IHS assuming oversight of all facets of the program. Since its inception, Project TransAM has not received an increase in funding. Furthermore, the funds provided cannot legally be used for facility lease or government personnel expenses. Consequently, Project TransAM has relied on intermittent funding from the Nashville Area IHS and IHS HQ to sustain operations. A dedicated funding stream for operations of $600K, as well as an increase in equipment funding to a total of $1.0M would ensure Project TransAM can continue to provide its vital services to Tribal communities.

Hot Issues

1. **Funding for Telehealth Resources**
   Nashville Area Tribal Nations believe that IHS should build out the telehealth program models that are available to health care facilities, urban Indian health programs, and personnel.
2. **Public Health Education**
   Provide increased recurring funding to support public health education professionals and programming.
3. **Funding for Aftercare and Housing Programs**
   Create additional recurring funding opportunities to support aftercare services.
4. **Funding to reduce the Hepatitis C Influx**
   Tribal Nations are recommending that IHS advocate for additional funding to support Hepatitis C prevention programs, promote and provide access to testing, to facilitate access to care and comprehensive care management, and to support those Tribal citizens living with Hepatitis C.

5. **Continued Funding for CHR Programs**
   CHR funding must be increased as CHRs improve access to health services through their training to provide information and create connections between providers and Native people. Work must be done to ensure data supporting the success and need of CHR programs is more accurately captured in the future.
6. **Constitutionality Challenges**
   Indian Country must remain vigilant and continue to challenge and oppose any efforts within the federal government — executive, legislative, and judicial — that seek to undermine the constitutionality of our relationship.
7. **Special Diabetes Program for Indians**
   The Nashville Area Tribal Nations recommend that the IHS ensure special initiative funding, including SDPI, is requested and accounted for when newly recognized Tribes funding is requested.
8. **Modernizing Health Information Technology**
   The current electronic health record has not had the same advancements that some of the commercial off the shelf packages. IHS needs additional funding to meet EHR modernization needs and to ensure a comprehensive implementation and transition across the I/T/U.
9. **Expand Group Payor Authorities for ITUs when Sponsoring Health Care Plans**
   Nashville Area Tribal Nations request that IHS support initiatives that would give parity to ITUs for group payor authorities where needed.
10. **Long Term Services and Support Funding**
    Targeted funds toward identifying need for LTSS in citizenry of the Tribe/Nation and development of a plan, capital costs associated with facilities to meet identified needs, and ongoing costs of delivery of LTSS.
11. **I/T/U Provider and Staffing Recruitment and Retention, including Competition With Private Staffing Companies**
    Increased funding for Recruitment and Retention of clinical providers and team members for the I/T/U system; flexible scheduling and leave authorities; standardized procedures for recruitment and retention.
12. **Continued / Sustained High Pharmaceutical Costs**
    Recommend: increased recurring funding for pharmaceuticals; maximize cost-effectiveness formulary decisions; awareness and strategic planning for the anticipated increases in pharmaceutical costs in the US.
13. **SAP (Small Ambulatory Program) Access**
    Consideration of revision to eligibility requirements such that more T/TO owned health care facilities may participate.
14. **Purchased Referred Care**
    Workforce shortages; internal educational outreach for new and established vendors; provide technical assistance for Tribes with vendor education; provide additional training on undelivered orders and fiduciary intermediary pending reports.
15. **Challenges / Opportunities in the Indian Health Care Improvement Fund (IHCIF)**
    Review and update funding formulas; enhance legislative support; develop strategies to utilize potential increases; consider increasing the level of funding threshold.

ISSUE:
Funding for Telehealth Resources

BACKGROUND

When surveyed, Tribal Nations in the Nashville Area reported a need for significantly increased telehealth resources and opportunities. Nashville Area Tribal Nations and urban sites have requested access to and support for telehealth resources and opportunities for the past 6 or more years. Limited access to telehealth is provided by the IHS Tele behavioral Health Center of Excellence at 3 Nashville Area sites. However, Health Directors have also indicated a need for a wider range of Telehealth services – with emphasis on child tele psychiatry, Nutrition Care, and stress management particularly in the current pandemic.

RECOMMENDATION

Nashville Area Tribal Nations believe that IHS should build out the telehealth program models that are available to health care facilities, urban Indian health programs, and personnel. In addition, with the ongoing COVID19 pandemic, increased funding for telehealth integration into primary care models should be made available in the following priorities:

- Technology: infrastructure updates, including software, wiring telemedicine carts, cameras, portable tablets and high-quality video conferencing systems.
- Staffing: ongoing funding for Telehealth Coordinators and local, regional and national levels.
- Partnerships: Securing various partnerships for increased, discounted broadband services, larger medical centers for specialty care services, etc.

» Connectivity: Access to secure high speed internet/Wi-Fi and integrated telehealth platforms. Lack of connectivity can hinder the implementation and expansion of telehealth programs that require live-video connections between patients and providers. Dropped calls and delays in video feeds can interrupt care delivery and lead to patient dissatisfaction

ISSUE:
Public Health Education

BACKGROUND
Health education is one major focus area within public health work. Health educators serve as an important part of the public health team. By blending knowledge from biological, environmental, psychological, and medical sciences, health education professionals develop, implement, and evaluate programs designed to keep people healthy in their daily lives. Health educators are trained to assess health needs and develop programs as well as communication strategies across environments. Health educators help translate complex health concepts into manageable, community-friendly health programs and information. They help teach others how to incorporate healthy choices into their lifestyle, and they explain health concepts at both the individual and community level. Because health educators specialize in educating the public about health issues, they work with a wide variety of topics and diverse populations. Their role is to help people both understand health information and understand how to apply it to their everyday lives. Health educators can work as part of a team or independently with both communities and individuals. They are a crucial part of health promotion and program planning and are often the voice of public health. In many of our smaller facilities and communities we have experienced a drawdown of services such as health education over the years largely due to financial limitations and competing priorities. Dedicated specialty services such as health education have been diminished greatly or lost all together. This issue has been intensified by the COVID-19 pandemic, demonstrating the critical need for the full funding of these programs to better assist Tribal communities in preparation for future health crises.

RECOMMENDATION
Provide increased recurring funding to support public health education professionals and programming.

ISSUE:
Funding for Aftercare and Housing Programs

BACKGROUND
When surveyed, the Nashville Area Tribal Nations reported the need for additional funding to aid those returning from substance abuse treatment programs, particularly opioid abuse, through detox, rehabilitation and aftercare services. In addition to funding needed to support detox and rehabilitation efforts, Tribes have reported a critical need for aftercare services. Time and time again, Tribal citizens are re-entering the community and reservation without access to professional support services to prevent them from falling into the same crowds and behaviors that led them to past abuse. Additional funding would be directed to support groups, sober-living opportunities, job placement and other resources to encourage a clean and drug-free lifestyle.

RECOMMENDATION
Create additional recurring funding opportunities to support aftercare services.

ISSUE:
Funding to reduce the Hepatitis C Influx

BACKGROUND
Additional funding is needed to ensure that Tribal Nations and their citizens are educated on the prevention of Hepatitis C (HCV) and that all those affected have access to treatment. The prevalence of Hepatitis C (HCV) in the Native American population in the United States is believed to be higher than in the general population. Unfortunately, Tribal Nations lack adequate information regarding Hepatitis C transmission. Community members may engage in behaviors that are assumed to be of low or no risk, but pose significant threat of infection. Promotion of testing for Hepatitis C is critical for early detection and linkage to care for optimal health outcomes. The availability of new prescription medicine makes it possible to cure Hepatitis C in most patients. Additional funding would be directed towards prevention and treatment education, Hepatitis C testing, infectious disease management, medication support teams to promote adherence, and other appropriate ancillary services.

RECOMMENDATION
Tribal Nations are recommending that IHS advocate for additional funding to support Hepatitis C

prevention programs, promote and provide access to testing, to facilitate access to care and comprehensive care management, and to support those Tribal citizens living with Hepatitis C.

ISSUE:
Continued Funding for CHR Programs

BACKGROUND
Community Health Representatives (CHRs) are critical to the Indian Health Delivery System, in their roles, they help to bridge the gap between AI/AN individuals and health care resources through outreach by specially trained community members. The CHR is a trusted member of and/or has an unusually close understanding of the communities served. This trusting relationship enables the worker to serve as a liaison, link, and intermediary between health and social services and the community to facilitate access to and coordination of services which improve the quality and cultural competence of service delivery.

RECOMMENDATION
CHR funding must be increased as CHRs improve access to health services through their training to provide information and create connections between providers and Native people. Work must be done to ensure data supporting the success and need of CHR programs is more accurately captured in the future. Options for different methods to collect supporting data should be explored, as well as adequate training opportunities on how to utilize current systems to track and report CHR program measures.

ISSUE:
Constitutionality Challenges

BACKGROUND
Failure to recognize that AI/ANs have a unique political status within the federal government that is not based on race and, in fact, obligates the federal government with a trust and legal responsibility to ensure the highest possible health status for Tribal Nations. Actions by the previous administration have applied a fundamentally flawed interpretation to the relationship between Tribal Nations and the U.S. government, calling federal Indian programs and accommodations for American Indians and Alaska Natives (AI/AN) "race-based," rather than political in nature. Under familiar principles of Indian law, the Constitution explicitly addresses AI/AN and Tribal Nations based on their underlying political relationship with the United States.

RECOMMENDATION
Indian Country must remain vigilant and continue to challenge and oppose any efforts within the federal government—executive, legislative, and judicial—that seek to undermine the constitutionality of our relationship. The federal government has ample legal authority to provide AI/ANs with accommodations in administering federal programs due to the unique federal trust responsibility to Indians.

ISSUE:
Special Diabetes Program for Indians (SDPI)

BACKGROUND
Increased funding is needed to help ensure SDPI availability to all of Indian Country. Nashville Area is unique in having multiple newly recognized Tribal Nations that were recently deemed eligible for SDPI funding with the new 2023 funding cycle. However, this eligibility came without additional funding to the Area to account for the new SDPI grantees.

RECOMMENDATION
The Nashville Area Tribal Nations recommend that the IHS ensure special initiative funding, including SDPI, is requested and accounted for when newly recognized Tribes funding is requested.

ISSUE:
Modernizing Health Information Technology

BACKGROUND
Additional funding is needed to modernize health information technology. The Indian health care delivery system is supported through a network of 594 health care facilities across the country, including 49 hospitals, 545 ambulatory facilities (231 health centers, five school-based health centers, 133 health stations, and 176 Alaska Native village clinics), including referral services on or near reservations. The Indian health care delivery system offers a broad scope of services consisting of clinical (ambulatory and hospital), public health, and environmental health services. The challenges medical providers face in the Indian health care system are driven by a host of geographic, socio-economic factors, high rates of uninsured or underinsured AI/AN patients, and inadequate funding to modernize "health information technology" (HIT). Additionally, Tribes within the Nashville Area identified the need for further clarity and transparency on how Tribal shares will work

with any new funding to support modernization particularly for fully compacted/contracted Tribes or those who may have transitioned to a new system ahead of IHS, including future technical support available to Tribes who have transitioned.

RECOMMENDATION

The current electronic health record system has not had the same advancements that some of the commercial off the shelf packages. IHS needs additional funding to meet EHR modernization needs and to ensure a comprehensive implementation and transition across the I/T/U. Any changes in implementation requires consultation. Continued communication to Tribes is needed, including additional sessions or correspondence focusing on the common funding and support questions raised.

ISSUE:
Expand Group Payor Authorities for I/T/Us when Sponsoring Health Care Plans

BACKGROUND

Support is needed for parity and inclusion of IHS/Tribes/Urbans in accessing group payor authorities when sponsoring patients in insurance plans. The language in Section 402(b) of the Indian Health Care Improvement Act (IHCIA) provides Tribal Nations with the authority to maximize their health resources through premium sponsorship programs. In spite of the federal trust obligation to provide health care to American Indian and Alaska Native (AI/AN) people, the chronic underfunding of IHS continues to leave many Tribal citizens with woefully inadequate health care. But, through organized Tribal premium sponsorship programs, in which health facilities coordinate and finance the enrollment of eligible Tribal citizens in other federal health care programs, Tribal Nations have begun to close gaps in care for their people. In addition to premium sponsorship through the Affordable Care Act marketplaces, Tribal Nations have also successfully implemented sponsorship programs for Medicare Part B and Part D coverage. Not only do Tribal sponsorship programs dramatically expand access to care for Tribal citizens eligible for various federal health programs, they also provide a critical opportunity for Tribal governments to improve the quality of and access to care for all Tribal citizens through third-party billing. Tribal premium sponsorship programs are an important way for Tribal Nations to maximize health resources, while increasing access to health services and improving health outcomes.

RECOMMENDATION

While Tribally Operated facilities have been sponsoring their citizens through various insurance opportunities successfully for a number of years, being able to pay for premiums directly to the insurance company through group payor authorities hasn't been available for all insurance options. Nashville Area Tribal Nations request that IHS support initiatives that would give parity to ITUs for group payor authorities where needed.

Under current law, CMS has mechanism for 3rd party premiums that are paid for or collected from workplaces or unions, however, Tribal Nations do not have this authority under current law and must go through a cumbersome process to get authorization from CMS to pay monthly Part B premiums for their citizens. This process includes meeting a certain threshold to pay for all enrollees as well as data exchange requirements. Amending the authority for Tribal Nations would also eliminate the required minimum number of enrollees covered by a Tribal Nations or Tribal organizations and would further eliminate required premium deductions from SS paychecks.

ISSUE:
Long Term Services and Support Funding

BACKGROUND

The permanent reauthorization of the IHCIA as part of the PPACA in 2010 gave explicit authority to IHS and Tribal programs operating through self-governance agreements to provide long term care, hospice, assisted living, and home and community-based services. However there have been no new appropriated funds for these services.

In the intervening years, Tribes operating LTSS have included them in their self-governance funding agreements and have continued to develop services as resources allow. For example, the Cherokee Indian Hospital Authority is in process of replacing their current LTC facility (Tsali Care) with a new facility.

IHS Division of Facilities Planning and Construction (DFPC) in the Office of Environmental Health and Engineering (OEHE) is in process of development of Health System Planning (HSP) Software necessary to plan, construct, and support LTC facilities for the agency.

RECOMMENDATION

Appropriations to be targeted toward 1) the costs associated with the work necessary to identify need for LTSS in citizenry of the Tribe/Nation and development of a plan for services to meet those needs, 2) capital costs associated with facility construction or adaptation to meet identified needs, and 3) ongoing costs of delivery of LTSS as a core component of Indian Health.

ISSUE: *I/T/U Provider and Staffing Recruitment and Retention, including competition with private staffing companies*

BACKGROUND

Across the I/T/U system programs face significant difficulties in the recruitment and retention of clinical providers and team members as reflected by turnover and vacancy rates across the agency. Future recruitment of health care workers, including clinical providers, is anticipated to become more competitive in the next 5-10 years with anticipated shortages across many categories including primary care physicians. The IHS faces many competitive disadvantages in recruitment and retention including HR processes, compensation packages, and flexibility with leave and scheduling, as well as geographical isolation of many sites. In particular, flexibility is of increasing importance in recruitment of health care workers. Although Tribally operated sites have more flexibility in compensation packages and process, these programs are also hindered in recruitment and retention efforts due to funding limitations.

Additionally, the VA remains one of IHS' biggest competitors for retention of current health care workers given we both operate within the same Federal benefits structure. The VA currently provides an automatic 8 hours of leave per pay period for its Title 38 employees and has a standardized annual performance bonus for providers. Lack of parity between the IHS and VA decreases our ability to compete for staff.

RECOMMENDATION

Increased funding specifically for Recruitment and Retention of clinical providers and team members to aid the I/T/U system in competing for and retaining critical patient care staff.

Authorize 2087 hour/year scheduling (vs 80 hours per pay period). Outside of timekeeping infrastructure, most likely to be budget neutral. Benefits include increased flexibility in scheduling (better demand/supply matching), better recruitment and retention particularly for inpatient and ER services. This would allow for compressed scheduling which may alleviate some of the difficulty for isolated sites (providers traveling to and from site for work). Compressed scheduling would allow for the recruitment of a distinct pool of clinical providers that we cannot currently recruit (e.g. providers that are already working such as academic clinicians).

Implement 8-hour-leave category for Title 38 employees to match the VA.

Establish a standardized, transparent, and predictable procedure across the agency for recruitment and retention bonuses for clinical teams. Designate work group to include clinical leadership (CD, CMO) and administrative leadership (CEO) to study and recommend to HQ Executive leadership different bonus procedures with analysis of budget and market parity implications

ISSUE: *Continued/Sustained High Pharmaceutical Costs*

BACKGROUND

The Nashville Area Tribal Nations have expressed concerns regarding the continued and sustained high costs of pharmaceuticals. These escalating costs significantly impact their Pharmacy Referred Care (PRC) budget lines. Recent data reveals a concerning trend in the pharmaceutical sector. Over the period from January 2022 to January 2023, more than 4,200 drug products underwent price increases. Alarmingly, 46% of these increases surpassed the rate of inflation. On average, drug prices surged by 15.2%, which translates to an average increase of $590 per drug product. This trend indicates a substantial financial burden for health care providers, including Tribal clinics, which supply medications to their patients at no cost.

RECOMMENDATION

Additional recurring funding opportunities be created to support pharmaceutical services in Tribal clinics. This approach should also explore the feasibility of establishing on-site pharmacies. On-site pharmacies typically have a mechanism to recoup expenses through billing for medications dispensed, including insurance dispensing fees.

Maximize cost-effectiveness in local formulary decisions. Implementing a local formulary that closely aligns with the IHS National Core Formulary, approved by the local Pharmacy and Therapeutics Committee, can help manage costs effectively.

Monitor and prepare for the predicted overall increase in drug expenditures in the U.S., which is expected to rise by 6% to 8% in 2023. This projection is particularly relevant for clinics, which may see an increase in spending between 8% to 10%. Awareness and strategic planning for these increases are crucial for the sustainable management of pharmaceutical services in Tribal clinics

ISSUE:
Small Ambulatory Program (SAP) Access

BACKGROUND
When surveyed, Tribal Nations in the Nashville Area reported a need for increased access to the Small Ambulatory Program. The SAP awards funding on a competitive basis for qualifying projects to construct, expand, or modernize, T/TO owned, small ambulatory health care facilities that serve American Indian and Alaska Natives (AI/AN) and that are operated pursuant to a health care services contract or compact entered into under the Indian Self-Determination and Education Assistance Act, Public Law (P.L.) 93-638. Due to the eligibility requirements, a limited amount of Nashville Area Tribes are eligible to participate.
Specifically, upon completion projects selected must serve 500 eligible Indians annually and be located in a service area containing at least 2,000 eligible Indians. This limitation excludes 14 Tribes in the Nashville Area from potential participation.

RECOMMENDATION
Consideration of revision to eligibility requirements such that more T/TO owned health care facilities may participate.

ISSUE:
Purchased Referred Care

BACKGROUND
Tribal Nations have expressed concerns regarding purchase order issuance, balance billing, payment delays from the Fiduciary Intermediary (FI), and contacting related concerns.

CURRENT CHALLENGE
Staffing: There are currently several recruitment vacancies within PRC. These positions continue to be unfilled with active recruitment initiatives in place.

Research: To ensure payments are made timely, PRC programs need to actively research the undelivered orders (UDO) and the FI pended (Pend) claims reports.

Spenddown: Alternate benefits such as expanded Medicaid have limited the ability to spend allocated funding. There are newly published priority levels that affords an opportunity to approve previously excluded services.

RECOMMENDATION
Develop action plan to address workforce shortages and focus on recruitment/retention for PRC positions.

IHS PRC staff provide internal educational outreach for new and established vendors; provide technical assistance for Tribes with vendor education. IHS PRC staff provide additional training with internal and external PRC programs on researching the UDO and FI Pend Reports in effort to increase payment and reduce UDOs.

ISSUE:
Challenges and Opportunities in the Indian Health Care Improvement Fund (IHCIF) in the IHS Nashville Area

BACKGROUND
Under the authority of 25 U.S. Code § 1621, the Indian Health Care Improvement Fund (IHCIF) is fundamentally designed to provide equitable health care services to American Indians and Alaska Natives (AI/AN). It is a critical instrument in addressing and reducing health disparities within these communities. In the IHS Nashville Area, which covers a vast region encompassing 24 states, the IHCIF's role is especially significant. The fund's commitment to enhancing health care delivery is pivotal in bridging the health gap faced by AI/AN populations across this extensive area. However, the IHCIF, including its implementation in the Nashville Area, faces several challenges that can impact its effectiveness. Addressing these challenges proactively and seizing potential opportunities is vital for improving health outcomes among the AI/AN communities in the Nashville Area.

CURRENT CHALLENGE

Resource Allocation: The IHCIF must navigate the complex task of equitably distributing resources among a diverse array of Tribal communities across the Nashville Area, each with unique health care needs and requirements.

Health Disparities: AI/AN populations in the Nashville Area continue to confront significant health disparities. The IHCIF's capacity to address these disparities is crucial but often challenged by varying resource allocations and evolving health care needs.

Legislative and Funding Fluctuations: The effectiveness of the IHCIF in the Nashville Area is closely tied to federal funding and legislative support. Historical inconsistencies in funding and legislative attention have impacted the IHCIF's ability to meet its objectives in this region.

RECOMMENDATION

Review and Update Funding Formulas: Regularly revise the IHCIF funding formulas to align with the current health care needs of AI/AN populations in the Nashville Area, ensuring equitable resource allocation.

Consider utilizing a fractionalization of the user population for the User Count. Patients may visit multiple facilities were resources are utilized, yet users are only counted for one facility per the user count critiera.

Consider utilizing up-to-date alternate resources data to include Tribal data.

Consider adding in a factor related to Purchased/ Referred Care (PRC) Dependency as it relates to purchase of services outside the heath system in rural areas or areas where the cost of care may be higher than average.

Enhance Legislative Support: Advocate for consistent legislative and federal support to provide stable and adequate funding for the IHCIF, specifically addressing the needs of the Nashville Area.

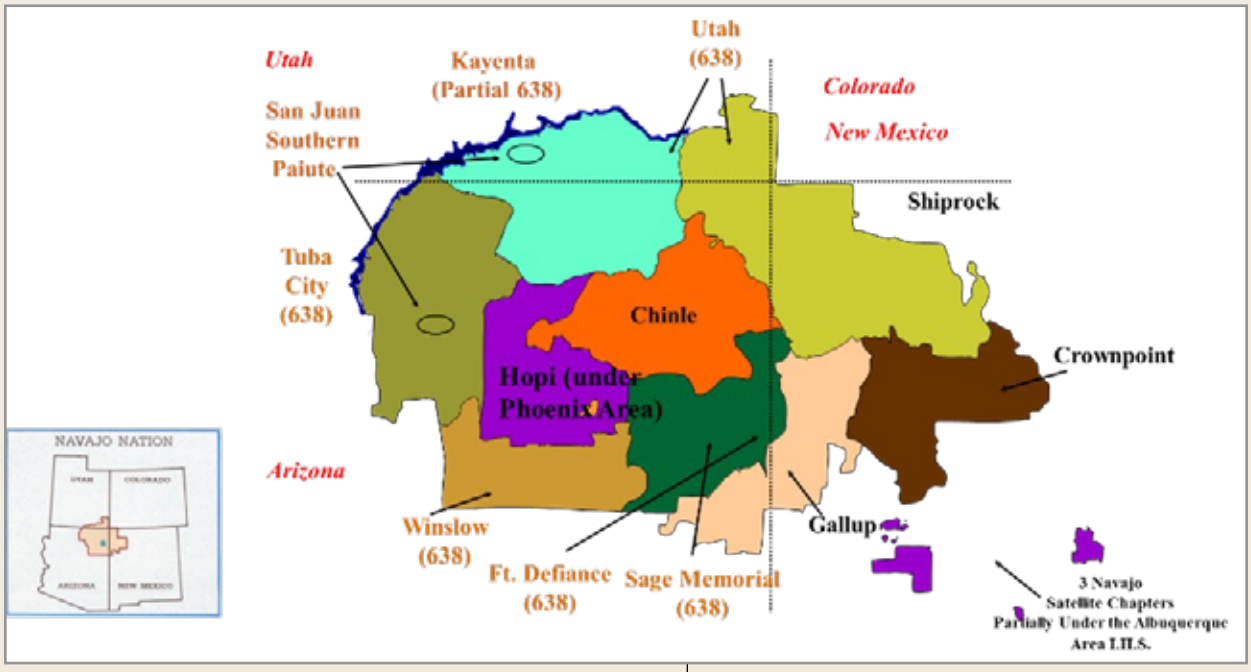
Consider funding the Indian Health Services at 100% Level of Need.

Engage in Regular Tribal Consultations in the Nashville Area: Conduct ongoing consultations with Tribal leaders in the Nashville Area to ensure the IHCIF effectively addresses their communities' unique health care needs and concerns.

Prepare for Future Opportunities: Develop strategies to quickly and effectively utilize potential increases in IHCIF funds, particularly focusing on addressing urgent health care needs in the Nashville Area without delay.

Consider increasing the threshold related to the level of funding to bring all sites up to an adequate level of funding based on the factors described in the formula.

Navajo Area



- 5 Federal Service Unit:
  - Gallup, Crownpoint, Shiprock, Chinle, and Kayenta
- 6 Self-Determination Contractors:
  - FDIHB, NHF/SMH, NTCCTF, HMS, EMS, SJSPT
- 3 Self-Governance Compactors:
  - WIHCC, TCRHCC, UNHS; and
- Urban Indian Health Center: NACA

The Navajo Area IHS service area is comprised of the Navajo Nation and selected adjacent U.S. census tracts outside the reservation boundaries (not shown). Two Tribes are served by the Navajo Area, including the Navajo Nation and the San Juan Southern Paiute Tribe.

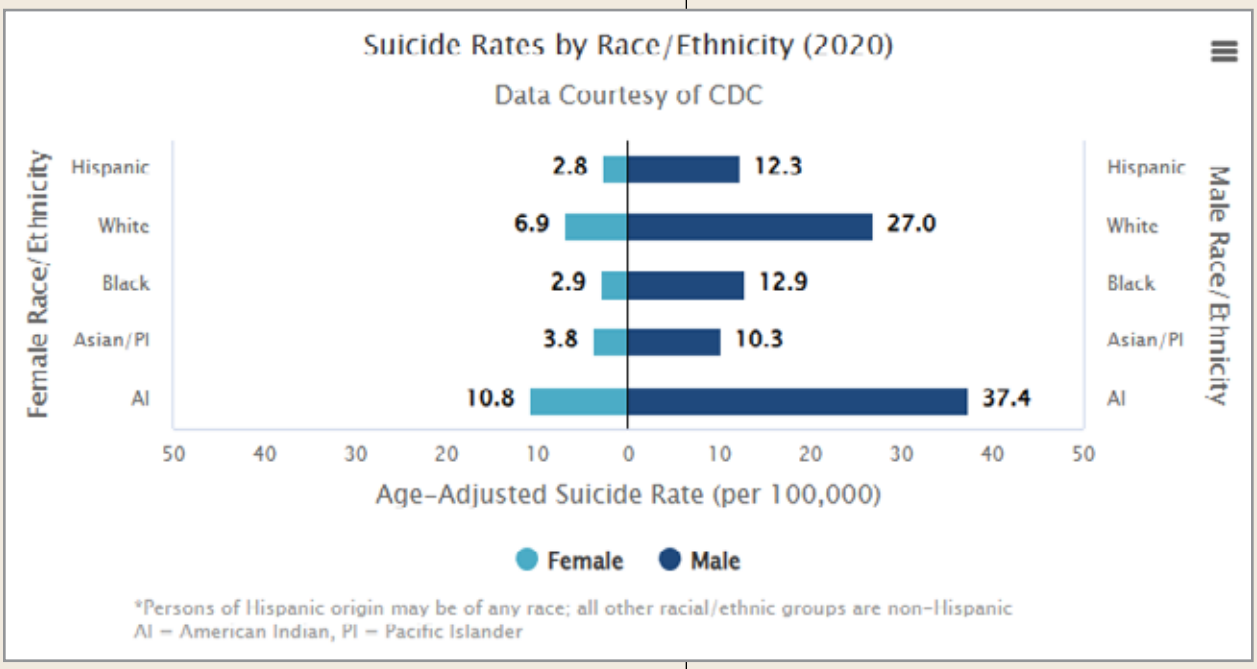
Budget Recommendations

Mental Health

The Navajo Area requests a funding increase to the Mental Health central line accounting category. COVID-19 has been a catalyst for the onset of new psychosis, depression, anxiety, and post-traumatic disorder. Post-COVID-19, social isolation and loneliness continue to have detrimental effects on individuals with Serious Mental Illness (SMI). Suicidal ideation, suicide attempts, and suicide completion rates have all increased among American Indians/Alaska Natives (AI/AN) since the onset of the pandemic. High rates of suicidality among young adults and adolescents are critical areas that require advanced technical knowledge and skill in mental health interventions.

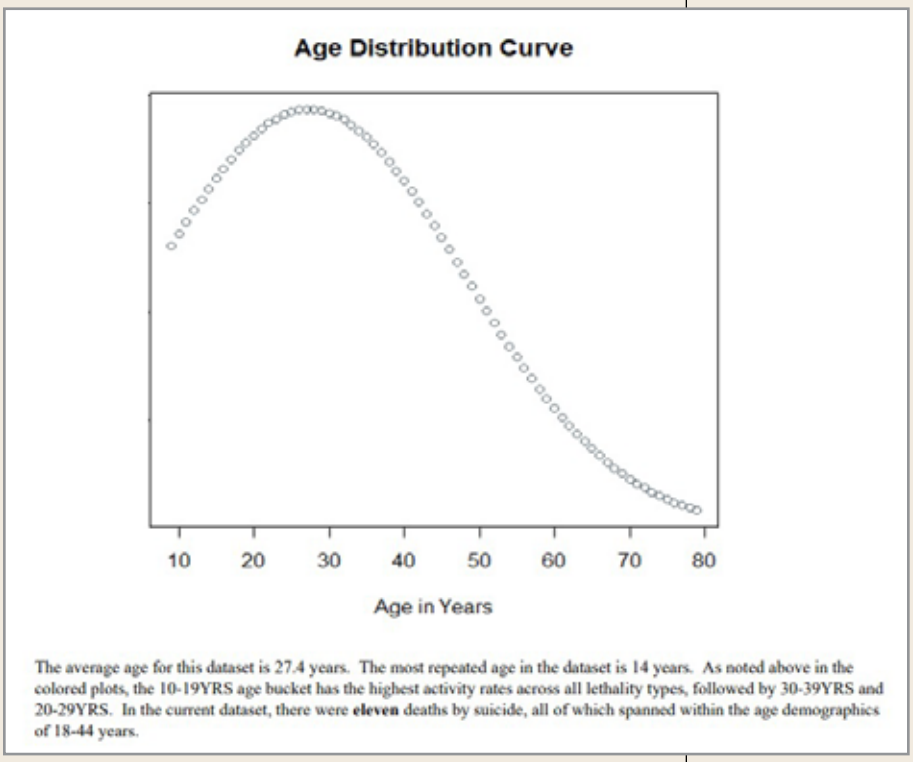
The National Institute on Mental Health (2020) reports that national suicide rates are highest among American Indians (AI) at 10.8 per 100,000 for females and 37.4 per 100,000 for males (see Figure 1).

Figure 1: Suicide Rates by Race/Ethnicity (2020)



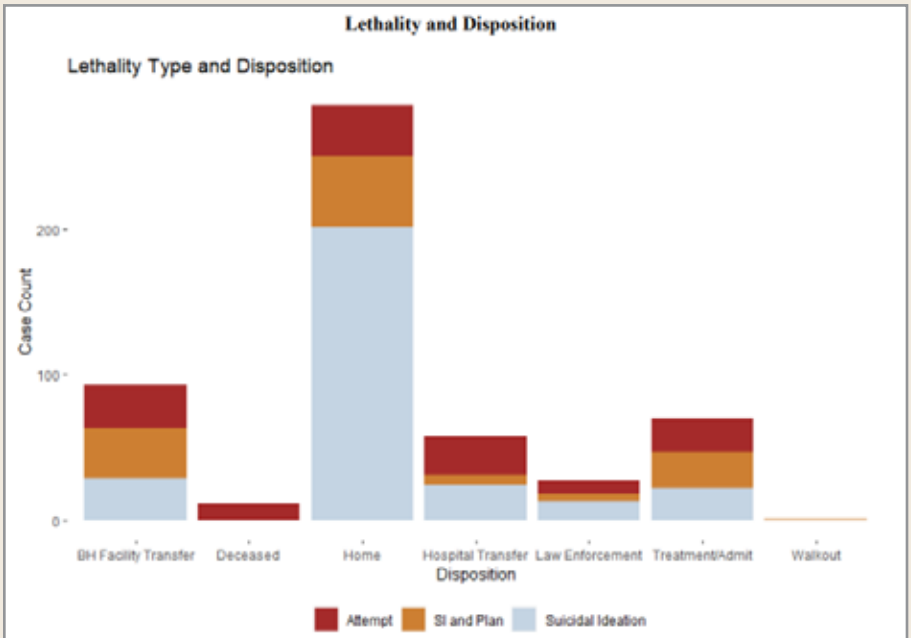
Navajo Area statistical reports for suicide events presenting at hospitals and clinics in 2023 mirror NSDUH findings, as shown in Figure 2 and the accompanying caption.

Figure 2: 2023 Suicide Events in NAIHS Hospital and Clinics.



2023 NAIHS reports that the typical disposition for suicide events is for patients to return home with a safety plan and follow-up appointments, as indicated in Figure 3.

Figure 3: 2023 NAIHS Lethality and Disposition for Suicide Events.

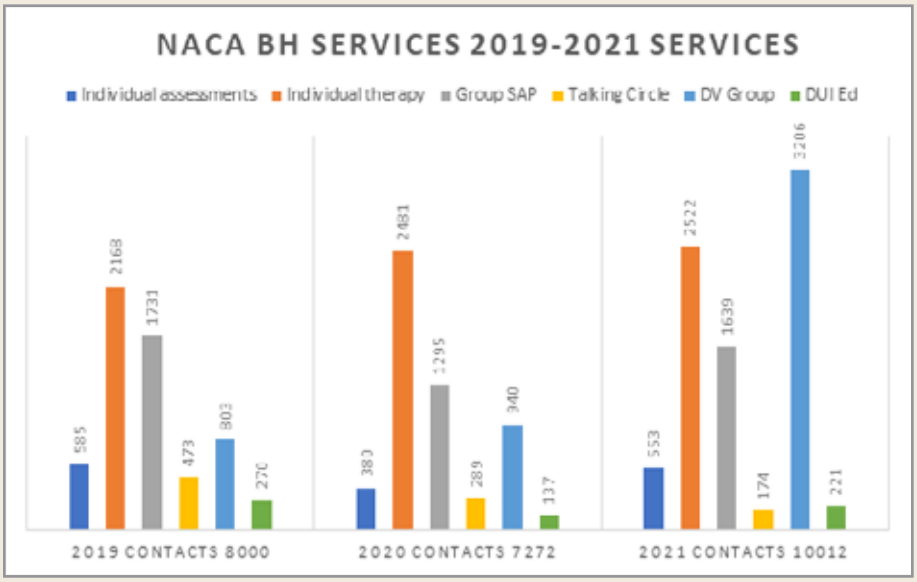


Above noted are the various dispositions following an event. The most common disposition type is releasing the patient back to their homes, most often with a safety plan in place and/or referral to therapy services. The second highest outcome includes a transfer to another Behavioral Health facility followed by admission into the Service Unit for treatment. For variable "Law Enforcement", no information available on if police or prison system presented the patient for care.

Because acute psychiatric care facilities on the Navajo reservation are non-existent, many patients are transferred off the reservation to access critical psychiatric care, which is the second highest outcome for disposition (Figure 3).

Transitional or step-down mental health services are much needed to support independent living for the chronically mentally ill. Limited specialized services are available to address postpartum depression, which is significantly higher among Indigenous populations.

Native Americans for Community Action in Flagstaff, Arizona is one organization that provides mental health services to AI/AN in the Navajo Area. The data in the chart shows the growing need for behavioral health services among this Urban AI/AN population in Flagstaff. The number of contacts rose from 8,000 to 10,012 in two years. The most startling statistic in this chart is the increase in domestic violence contacts, from 803 in 2019 to 3,206 in 2021. Increased mental health funding is necessary to address this significant uptick in demand for mental health services, including virtual mental health services.



Data extracted from RPMS Daisy Barney, Clinical Applications Coordinator. The data set was compiled by Curtis Randolph Ph.D., LPC Director of Behavioral Health, on 1/14/2022. Native Americans for Community Action, Inc. Urban Indian Organization (UIO), Flagstaff, AZ

There is also a tremendous need to strengthen the trauma-informed care due to high rates of early childhood exposure to family violence, sexual abuse, and substance use disorders. The Agency for Health care Research and Quality (AHRQ),

2016, "*Trauma-Informed Care*," explains that "Trauma is a widespread, harmful and costly public health problem." The AHRQ explains that the trauma-informed practice model incorporates the following guidelines:

1. Realize the prevalence of traumatic events and the widespread impact of trauma.
2. Recognize the signs and symptoms of trauma.
3. Respond by integrating knowledge about trauma into policies, procedures, and practices.
4. Resist re-traumatization actively.

Past funding increases have permitted the implementation of the Primary Care Behavioral Health (PCBH) model to support mental health access and care and achieve two GPRA measures for mental health screening. Enhancement and expansion of the PCBH program would directly impact the accessibility to mental health services. Specialty services such as pharmacological care and case management services will increase patient engagement.

APPLICABLE INDIAN HEALTH CARE IMPROVEMENT ACT (IHCIA) PROVISION(S):

25 USC § 1621 (h)-Mental Health Prevention and Treatment Services.

There are two GPRA measures relevant to the mental health budget line item: 1.) Depression and Mood Disorders Screening for children ages 12-17 and 2.) Depression and Mood Disorders Screening for adults aged 18 years and older.

In 2022, screening for ages 12-17 in the Navajo Area did not meet the national target of 33.90 percent, with Navajo Area performance at 32.13 percent. In 2023, the Navajo Area exceeded the national target with a score of 33.992 percent.

In 2022, the Navajo Area achieved a screening score of 37.0 percent for the 18 years and older group. This fell short of the national target of 42.9 percent. In 2023, the national target for this category was 36.40 percent, which the Navajo Area exceeded with a score of 37.38 percent.

The unmet GPRA performance measures for 2022 are due to the onset of the COVID-19 pandemic, which precipitated the closure of some health services, including behavioral health care. Though virtual behavioral health services were activated, many patients could not access computers and phones without local internet connectivity. Increased funding will help improve GPRA scores going forward.

LINK TO IHS SERVICE STRATEGIC PLAN

Increased mental health funding supports the IHS Strategic Plan and IHS mission, which is to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level.

The Strategic Plan details how the IHS will achieve its mission through three strategic goals:

To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people

The trauma of the COVID-19 pandemic has compounded the historical trauma experienced by AI/AN populations. Increased mental health funding will support comprehensive and holistic health care, decrease mental health stigma, and increase access and early intervention. Training and implementation of evidence-based screening and interventions for patients presenting with suicide symptoms in hospital emergency departments will enhance access to the appropriate level of care. Suicide surveillance strategies will assist in the mitigation of suicide rates. The trauma-informed care approach will establish a user-friendly and trustworthy hospital environment. Trauma-focused treatment interventions will enhance reintegration into the community and decrease re-hospitalization for patients with serious mental illness. A collaborative model will reflect the Navajo philosophy of healing and well-being, where the whole person is treated within a network of relationships.

To promote excellence and quality through innovation of the Indian health system into an optimally performing organization

Significant strides have been made to integrate mental health with medical primary care services using the Primary Care Behavioral Health (PCBH) Model. The PCBH Model facilitates the integration of medical and mental health care by including the patient's primary care provider in mental health-related screening and treatment. It is a collaborative framework that supports a holistic approach to care. Increased mental health funding will bolster this team-based model of behavioral health promotion, thereby improving the Navajo Area's efficacy in terms of identifying and treating behavioral health problems.

To strengthen IHS program management and operations

Increased mental health funding will strengthen the Navajo Area's behavioral health programs by enabling the expansion of the PCBH and Trauma-Informed Care models and also by improving patient access to virtual medicine appointments. The advent of the COVID-19 pandemic has forced health care providers to capitalize on digital technology to reach patients. Significant Information Technology infrastructure development will need to occur on Indian reservations and rural areas of America to improve access to care, including behavioral health care.

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Hospitals and Health Clinics

The Navajo Area requests a funding increase to the Hospitals and Clinics (H&C) major line item account. This category funds essential personal health services through medical and surgical inpatient care; emergency, ambulatory, and specialty services; and medical support services such as laboratory, pharmacy, nutrition, diagnostic imaging, electronic health information management, and physical therapy. Personal health care services are integrated with community and public health services, including epidemiology, that target health conditions disproportionately affecting members of the Navajo Nation and San Juan Southern Paiute Tribe. Such health conditions include diabetes, maternal and pediatric illness, and communicable diseases like influenza, human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS), hepatitis, and COVID-19. The five federally-operated Navajo Area Federal Service Units serve 67.8 percent of the Area User Population, and the Tribally-operated health care facilities serve 32 percent of the Area User Population. Resources under the H&C budget category are distributed to all health care delivery stakeholders in the Navajo Area, including P.L. 93-638 Indian self-determination contractors and Tribal self-governance compactors.

Increased funding for the H&C budget category will address a wide range of health care needs at the Navajo Area where a growing population and increasing life expectancy are driving the demand for health care. Increased funding will support post COVID-19 infection rehabilitative care. A COVID-19 infection can result in immediate and delayed health and mental health effects, requiring occupational therapy, physical therapy, respiratory therapy and other medical therapies, along with behavioral health care. Increased funding will support continued efforts to modernize health Information Technology systems and infrastructure across the Navajo Area. Modern Information Technology infrastructure will allow full integration of tele-medicine into routine clinical practice. Increased funding will support a strong public health infrastructure which will enable effective response, recovery, and prevention for the ongoing COVID-19 pandemic and other unforeseeable challenges from infectious disease outbreaks, disasters from climate change, environmental hazards from industrial contamination, and more. Increased funding will develop a centralized epidemiology program that provides uniformity in health data management and reporting, optimize data sharing, and use data analytics for public health, reducing health risks through improved population-based health planning.

Past funding increases allowed a proactive response to the COVID-19 pandemic by directing resources to infection control/surveillance and contact tracing; patient isolation and quarantine; the purchase of personal protective equipment, medical supplies and medicines; and the upgrading and expansion of several computer and telecommunication technologies to support telemedicine and telework. Past funding increases also established COVID-19 testing sites and vaccinations sites, enabled the standing up of the Area and Service Unit-level Emergency Management Operation Centers, and provided funds to pay for overtime and hire of temporary staff. Past funding increases allowed the Navajo Area to meet a significant number of the GPRA performance targets and outcomes, and allowed the Area-wide implementation of the Primary Care Medical Home Model (PCMH), along with the Trauma-informed Care Approach to behavioral health care. Past funding also supported Joint Commission, Centers for Medicaid & Medicare, Accreditation Association for Ambulatory Health

Care (AAAHC), and Critical Access Hospital (CAH) accreditation activities. State certifications for Levels III and IV trauma center designations for three hospitals were also supported by past funding increases.

APPLICABLE INDIAN HEALTH CARE IMPROVEMENT ACT (IHCIA) PROVISION(S)

SUBCHAPTER I-INDIAN HEALTH PROFESSIONAL PERSONNEL

1. 1616b Recruitment activities.
2. 1616c Tribal recruitment and retention program
3. Tribal health program administration.

SUBCHAPTER II-HEALTH SERVICES

4. 1621c. Diabetes prevention, treatment, and control.
5. 1621d. Other authority for provision of services.
6. 1621h. Mental health prevention and treatment services.
7. 1621k. Coverage of screening mammography.
8. 1621m. Epidemiology centers.
9. 1621n. Comprehensive school health education programs.
10. 1621q. Prevention, control, and elimination of communicable and infectious diseases.

SUBCHAPTER III-HEALTH FACILITIES

11. 1638c. Contracts for personal services in Indian Health Service facilities.
12. 1638e. Other funding, equipment, and supplies for facilities.

SUBCHAPTER III A-ACCESS TO HEALTH SERVICES

13. 1647b. Access to Federal insurances.

SUBCHAPTER V-ORGANIZATIONAL IMPROVEMENTS

14. 1662. Automated management information system.

SUBCHAPTER VI-MISCELLANEOUS

15. 1677. Nuclear resources development health hazards.
16. 1680d. Infant and maternal mortality: fetal alcohol syndrome.
17. 1680q. Prescription drug monitoring.

LINK TO GPRA PERFORMANCE TARGETS AND OUTCOMES

During FY 2022, Navajo Area made improvements to meet targets in several GPRA performance measures compared to FY 2021. As the pandemic waned, the Navajo Area recommenced the majority of patient services and continued to address GPRA performance measures.

Below are the GPRA performance measures results for FY 2022.

The Navajo Area has met 0 of the 3 Dental measures.

- Dental General Access: Target: 28.80%; Navajo Area: 20.86%.
- Sealants: Target: 13.70%; Navajo Area: 7.45%.
- Topical Fluoride: 26.80%; Navajo Area: 17.30%.

Navajo Area has met 3 of the 5 Diabetes care measures.

- Controlled blood pressure: Target: 57.00%; Navajo Area: 49.54%
- Nephropathy assessment: Target: 43.70%; Navajo Area: 43.77%.
- Poor glycemic control: Target: 15.60%; Navajo Area: 19.65%.
- Retinopathy exams: Target: 41.20%; Navajo Area: 43.05%.
- Statin therapy: Target: 56.80%; Navajo Area: 63.39%.

The Navajo Area has met 2 of the 4 Immunizations measures.

- Adult Immunizations – all age-appropriate immunizations: Target: 44.40%; Navajo Area: 40.86%.
- Childhood immunizations: Target: 47.80%; Navajo Area: 51.28%.
- Influenza vaccinations for ages 18 and over: Target: 28.00%; Navajo Area: 27.11%.
- Influenza vaccines for ages 6 month to 17 years: Target: 29.70%; Navajo Area: 31.48%.

The Navajo Area has met 7 of the 14 Prevention measures.

- Cervical PAP Screening: Target: BASELINE; Navajo Area: 34.40 %.
- Childhood Weight Control: Target: 22.60%; Navajo Area: 25.92%.
- Colorectal Cancer Screening: Target: BASELINE; Navajo Area: 25.81%.
- Controlling High Blood Pressure (MH): Target: 40.90%; Navajo Area: 41.50%.
- CVD Statin Therapy: Target 40.60%; Navajo Area: 50.77%.
- Depression Screening or Mood Disorder 12 – 17 years old: Target: 33.90%; Navajo Area: 31.07%.
- Depression Screening or Mood Disorder 18 years and older: Target: 42.90%; Navajo Area: 39.02%.
- Breastfeeding at Age 2 Months: Target: 42.00%; Navajo Area: 43.00%.
- HIV Screening Ever: Target: 38.00%; Navajo Area: 46.38%.

- IPV/DV Screening: Target: 36.30%; Navajo Area: 46.38%.
- Mammography Screening: Target: 37.70% %; Navajo Area: 28.52%.
- SBIRT: Target: 13.50%; Navajo Area: 9.71%.
- Tobacco Cessation Counseling, Aid, or Quit: Target: 29.80%; Navajo Area: 15.39%.
- Universal Alcohol Screening: Target: 39.20%; Navajo Area: 39.84%.

LINK TO IHS STRATEGIC PLAN

The mission of the IHS is to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level. Our vision is healthy communities and quality health care systems through strong partnerships and culturally responsive practices. The Strategic Plan details how the IHS will achieve its mission through three strategic goals:

To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people

H&C funds ensure comprehensive, culturally appropriate personal and public health services are available and accessible to patients across the Navajo Area. The Navajo Area uses an interdisciplinary approach to delivering health care, incorporating medical and behavioral therapeutics, traditional healing practices, and public and community health methods to improve health outcomes. One of the factors that drives positive health outcomes is a commitment to increasing access to care. H&C funds facilitate health services availability and the Navajo Area strives to ensure services are relevant, effective, and accessible to patients, families, and communities. The Area has implemented the Primary Care Medical Home model, Primary Care Behavioral Health model, and Trauma-informed Care Approach to support the integration of physical and mental health care. Mental and physical health care is further combined with the Navajo philosophy of healing and well-being. The result is a culturally-appropriate and holistic approach to health.

To promote excellence and quality through innovation of the Indian health system into an optimally performing organization

The Navajo Area's highest priority is sustaining hospital accreditation and certification by The Joint Commission, Centers for Medicare & Medicaid, Accreditation Association for Ambulatory Health Care, and Critical Access Hospitals. Accreditation is a mark of excellence and quality. The Navajo Area is facing numerous challenges including funding shortfalls, competition for professional health care worker recruitment, aging facilities, and more. Yet the Area continues to be innovative in maintaining hospital accreditation/certification, sustaining State certifications for Levels III and IV trauma center designations; implementing Primary Care Medical Home, Primary Care Behavioral Health, and Trauma-informed Care approaches; and keeping aging facilities repaired for patient care services. The people who manage the Navajo Area's health care delivery system – as well as those who deliver health care directly to patients – are to be commended for their dedication.

To strengthen IHS program management and operations

Increased H&C funds will continue to strengthen the Navajo Area's health care delivery system, which depends on reliable recurring funding that keeps abreast of advances in information technologies, biomedical equipment, building codes, competitive salaries and benefits, and advances in population health data collection systems.

Public Health Infrastructure

The Navajo Area is requesting a funding increase to the Hospitals and Health Clinics (H&C) major line item budget account to support Public Health and Preventive Health Services programs. There is not a separate Public Health and Preventive Health Services line item. Instead, these functions are supported by the H&C budget category, which allows for the flexibility to address public health at every level of patient care, including Tribal epidemiology centers. An important priority of the Navajo Area is to strengthen public health programs, community partnerships, collaboration, planning, health promotion, disease prevention, epidemiology, environmental health, and public health emergency preparedness. The requested funding increase will support surveillance, response, recovery, and prevention for both ongoing and emerging health challenges – including infectious disease outbreaks (e.g., hantavirus, HIV/AIDS, syphilis), chronic illnesses (e.g. diabetes, heart disease, cancer, injuries), violence, mental health, behavioral health, and environmental issues like access to safe drinking water, basic utilities, and better roads.

The COVID-19 pandemic illustrated the need for a coordinated, data-driven partnership between Tribal, Federal, and state entities. An important lesson learned during the pandemic was the

importance of adequate public health staffing. Due to staffing shortages, many clinical staff were reassigned to fill gaps within the public health response at the expense of providing ongoing preventive and chronic health care. The long-term effects of decreases in preventive and chronic clinical care is that staff are now having to address the impacts of deferred care. An increase in funding for Public Health Infrastructure will increase the capacity to respond to future public health threats while simultaneously avoiding negative impacts to the delivery of preventive and chronic clinical care.

During the pandemic, federal health facilities, Tribal health facilities, Tribal programs, and the urban health program (Native Americans for Community Action) all participated in public health activities. The overall workforce of the Navajo Area public health system has historically included health care professionals such as public health nurses and community health representatives. However, we are now transitioning into an enhanced system, which includes other public health personnel. An enhanced public health system will involve the following:

- To address real-time public health needs, Navajo Area health care facilities and the Navajo Epidemiology Center must build the capacity to share and report data. At the same time, data must to be managed with respect for Tribal data sovereignty and cultural sensitivity.
- Surveillance of health outcomes requires an information technology platform that is capable of data sharing, data exchange, data security, and data storage. It is vital that the implementation of Health IT modernization addresses all the data needs for a comprehensive public health program.
- Navajo Area and Tribal health programs are updating current data sharing agreements with Arizona Department of Health Services, New Mexico Department of Health, Utah Department of Health. Without agreements in place, surveillance of public health threats such as cancer, suicide, and syphilis is more challenging.
- Public health research has traditionally been conducted through health care facilities, universities, and federal agencies. Going forward, research needs to be shared with the Navajo Nation to more effectively develop and implement public health interventions. The pandemic showed us that collaboration and cooperative problem solving results in improved decision-making and health outcomes.
- As a result of COVID-19, there is renewed focus on public health infrastructure by the Biden/Harris Administration. In the Navajo Area, health facilities and Tribal governments understand the need to encourage Tribal sovereignty by working collaboratively in care coordination and community outreach. With increased funding, the Indian Health Service can better support public health capacity building for the Navajo Nation.
- Leading up to the COVID-19 pandemic, Tribal epidemiology centers had not received an increase in funding for several years. There is a profound need to conduct more community assessments and surveys, which help to steer public health efforts. Examples of assessments include COVID-19 wastewater testing for communities and COVID-19 testing for individual patients. Additional funding for staffing and information technology to assist in collecting, analyzing, and reporting assessment or survey results is still needed.
- Public health professionals continue to respond to COVID-19 by providing vaccines, conducting data analysis, administering boosters, and communicating public health education and messaging to our patients. Public health professionals have been extremely effective in responding to the COVID-19 pandemic. Having the funding to bring in more professionals to prepare for future pandemics is essential for the public health infrastructure in the Navajo Area.
- Public health and prevention programs serving Indigenous communities have historically been under-funded. During the pandemic, many successes were due to emergency funds that allowed for the hiring of temporary staff. In the future, recurring support for public health infrastructure — rather than one-time, crisis-based funding — will be essential to protect families and foster safer and healthier communities.
- Flexible and respectful partnerships between local communities, Tribal programs, non-governmental organizations, and IHS during the COVID-19 pandemic resulted in high levels of vaccination, direct support to thousands of families for the purposes of isolation and quarantine, and systems for epidemiologic data collection and information sharing. Increased funding will enable public health personnel on the Navajo Nation to build upon these successes.

APPLICABLE INDIAN HEALTH CARE IMPROVEMENT ACT (IHCIA) PROVISION(S)

SUBCHAPTER I-INDIAN HEALTH PROFESSIONAL PERSONNEL

18. 1616b Recruitment activities.
19. 1616c Tribal recruitment and retention program.
20. 1616n. Tribal health program administration.

SUBCHAPTER II-HEALTH SERVICES

21. 1621b. Health promotion and disease prevention services.
22. 1621c. Diabetes prevention, treatment, and control.
23. 1621d. Other authority for provision of services.
24. 1621h. Mental health prevention and treatment services.
25. 1621k. Coverage of screening mammography.
26. 1621m. Epidemiology centers.
27. 1621n. Comprehensive school health education programs.
28. 1621q. Prevention, control, and elimination of communicable and infectious diseases.

SUBCHAPTER III-HEALTH FACILITIES

29. 1638c. Contracts for personal services in Indian Health Service facilities.
30. 1638e. Other funding, equipment, and supplies for facilities.

SUBCHAPTER III A-ACCESS TO HEALTH SERVICES

31. 1647b. Access to Federal insurances.

SUBCHAPTER V-ORGANIZATIONAL IMPROVEMENTS

32. 1662. Automated management information system.

SUBCHAPTER VI-MISCELLANEOUS

33. 1677. Nuclear resources development health hazards.
34. 1680d. Infant and maternal mortality: fetal alcohol syndrome.
35. 1680q. Prescription drug monitoring.

LINK TO GPRA PERFORMANCE TARGETS AND OUTCOMES

COVID-19 restrictions and closures negatively affected Navajo Area GPRA measures. This highlights the impact of limited resources being diverted from routine services to emergency public health activities.

Increasing H&C funds for public health purposes will allow the Navajo Area to better meet its annual GPRA performance targets by building permanent public health personnel capacity and public health infrastructure.

The Navajo Area plans to utilize Public Health Aides to support our health centers and clinics in the future. Public Health Aides will call patients, document preventive screenings, schedule preventative appointments, and encourage patients to complete preventive screenings like the home screening test for colorectal cancer, tobacco cessation, and home STI testing.

Below are the GPRA performance measures results for FY2023:

The Navajo Area has met 2 of the 3 Dental measures.

- Dental General Access: Target: 24.40%; Navajo Area: 23.70%.
- Sealants: Target: 9.90%; Navajo Area: 10.14%.
- Topical Fluoride: 21.10%; Navajo Area: 23.38%.

Navajo Area has met 1 of the 5 Diabetes care measures.

- Controlled blood pressure: Target: 52.40%; Navajo Area: 51.71%
- Nephropathy assessment: Target: 45.10%; Navajo Area: 43.37%.
- Poor glycemic control: Target: 14.40%; Navajo Area: 19.21%.
- Retinopathy exams: Target: 44.70%; Navajo Area: 47.85%.
- Statin therapy: Target: 54.50%; Navajo Area: 53.09%.

The Navajo Area has met 4 of the 4 Immunizations measures.

- Adult Immunizations – all age-appropriate immunizations: Target: BASELINE; Navajo Area: 43.49%.
- Childhood immunizations: Target: 40.90%; Navajo Area: 52.40%.
- Influenza vaccinations for ages 18 and over: Target: 19.70%; Navajo Area: 28.28%.
- Influenza vaccines for ages 6 month to 17 years: Target: 19.80%; Navajo Area: 30.39%.

The Navajo Area has met 11 of the 14 Prevention measures.

- Cervical PAP Screening: Target: 33.20%; Navajo Area: 35.11 %.
- Childhood Weight Control: Target: 22.60%; Navajo Area: 23.33%.
- Colorectal Cancer Screening: Target: 23.70%; Navajo Area: 25.59%.
- Controlling High Blood Pressure (MH): Target: 45.80%; Navajo Area: 43.02%.
- CVD Statin Therapy: Target 37.80%; Navajo Area: 40.61%.

- Depression Screening or Mood Disorder 12 – 17 years old: Target: 29.50%; Navajo Area: 33.07%.
- Depression Screening or Mood Disorder 18 years and older: Target: 36.40%; Navajo Area: 39.03%.
- Breastfeeding at Age 2 Months: Target: 42.60%; Navajo Area: 46.24%.
- HIV Screening Ever: Target: 38.90%; Navajo Area: 48.97%.
- IPV/DV Screening: Target: 29.60%; Navajo Area: 34.94%.
- Mammography Screening: Target: 28.70%; Navajo Area: 40.52%.
- SBIRT: Target: BASELINE; Navajo Area: 11.66%.
- Tobacco Cessation Counseling, Aid, or Quit: Target: 24.40%; Navajo Area: 15.74%.
- Universal Alcohol Screening: Target: 32.20%; Navajo Area: 40.54%.

LINK TO IHS STRATEGIC PLAN

Increasing H&C funding to support Public Health and Preventive Health Services programs is a budget priority which is in line with the IHS mission to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level.

The IHS Strategic Plan details how the IHS will achieve its mission through three strategic goals:

To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people
Additional H&C funds ensure comprehensive, culturally-appropriate personal and public health services are available and accessible to AI/AN. The Navajo Area uses an interdisciplinary approach to delivering health care, using medical and behavioral therapeutics, traditional healing practices, and public and community health methods to achieve positive health outcomes. One of the factors that drives positive health outcomes is improving access to care. H&C funds facilitate Public Health and Preventive Health Services availability, and the Navajo Area strives to ensure services are relevant and effective to patients, families, and communities.

To promote excellence and quality through innovation of the Navajo Area Indian health system into an optimally performing organization
H&C funds support and promote Public Health and Preventive Services excellence and quality through innovative initiatives that support population health management and healthy communities. Additional H&C funds would help the Navajo Area hire and retain qualified public health care professionals, extend disease surveillance projects, implement more preventative programs, and increase GPRA screenings.

To strengthen IHS program management and operations
H&C funds strengthen IHS program management and operations by supporting the employment of qualified subject matter experts who have a passion for excellence, compassion for underserved populations, dedication to advancing Navajo Area health care, and respect for Diné Fundamental Law and Values.

Information Technology Infrastructure

The Navajo Area is requesting an increase in funding for Information Technology (IT) Infrastructure, which includes network equipment, computers, servers, and software. The funding to support the IT Program is located under the Hospitals & Health Clinics (H&C) budget account. Because there is not a designated line item for IT, when there are competing needs and priorities, IT becomes secondary until a failure or immediate threat materializes. Previous H&C funding increases that were specifically earmarked for IT modernization and maintenance have been used successfully. In 2024, patient care requires the interfacing of medical equipment and electronic health records using up-to-date technology. Unfortunately, the current funding appropriations for H&C does not meet the need for IT initiatives. The H&C line item should be increased with funds earmarked specifically for the advancement and maintenance of IT infrastructure and security.

The Navajo Area is working to update the IT needs assessment and the 5-year IT plan. The plan details IT needs/priorities, including associated annual costs to keep current with advancements in technology and medicine. IT modernization is an intentional investment to keep pace with the latest health care technology by upgrading and replacing equipment and systems. The modernization plan has a strong focus on IT Security compliance and a 4-year life cycle replacement of IT equipment, periodic software upgrades, and 2 to 3-year upgrades to network systems to keep abreast of advancing security requirements and to protect against damages and threats. Over the years, organizational information has become more valuable and vulnerable. Therefore, accessibility, integrity, and confidentiality of information must be protected.

During the COVID-19 Pandemic, the Navajo Area expanded the use of telemedicine and tele-behavioral health technologies to prevent disruption to patient care services, focusing especially on high-risk and elderly populations. With the growth of tele-medicine, each health care facilities' bandwidth, transmission speeds and accessibility to information require annual quality, risk and cost evaluations. In a digital environment, internet connection with ample bandwidth is considered crucial.

Post-pandemic, telemedicine is here to stay. However, the current funding level for IT is not sufficient to cover the costly upgrades necessary to meet the needs of Navajo Area health care facilities. The Navajo Area's IT Modernization Plan targets the next 3 years in core health care infrastructure development and maintenance: Patient Care Medical Home (PCMH) model, cloud computing, Wide Local Area Network (WLAN), wireless voice and radio services. IT infrastructure must be able to support the mandatory PCMH initiative – a patient care model that supports access to care, case management, and transition of care.

The full development of a robust PCMH model requires a reliable IT infrastructure that links a patient's electronic health records to a network of providers for real-time and near real-time medical information accessibility. As the digital environment evolves, hybrid and cloud services will progress to a comprehensive delivery of computing services over the internet. Health care information computing will be part of this advancement, and health care facilities will need to be prepared to use this platform as part of their daily business practices. Telemedicine usage is expected to double in the next two years, becoming a mainstay of a providers' clinical practice.

In the wake of the COVID-19 pandemic and the threat of possible future pandemics, health care facilities need to be prepared to fully leverage their WLAN, wireless voice, and radio services with local partners such as counties, states, Tribes, federal agencies and others. Delivery of electronic health information to the point of care and across networks of partners is highly dependent on a reliable IT infrastructure.

The Information Technology Disaster Recovery Plan (ITDRP) and Continuing of Operations Planning (COOP) are fundamental for any IT infrastructure. Both the Gallup Service Unit and the Navajo Area Office have experienced outages over the last several years that proved problematic. Getting IT Services back up immediately is paramount, as delays impact direct patient care with providers having to spend long hours on workarounds. Navajo IT is responsible for delivering a sound ITDRP and COOP that will work in conjunction with OIT to assist at the service units across Navajo Area.

To maximize bandwidth and onsite support, the Navajo Area is proposing to change internet service providers from Frontier to Navajo Tribal Utility Authority (NTUA). The Navajo Area is also looking to upgrade much of its obsolete hardware and software, and possibly looking to replace the outdated uninterruptible power supply and cooling systems.

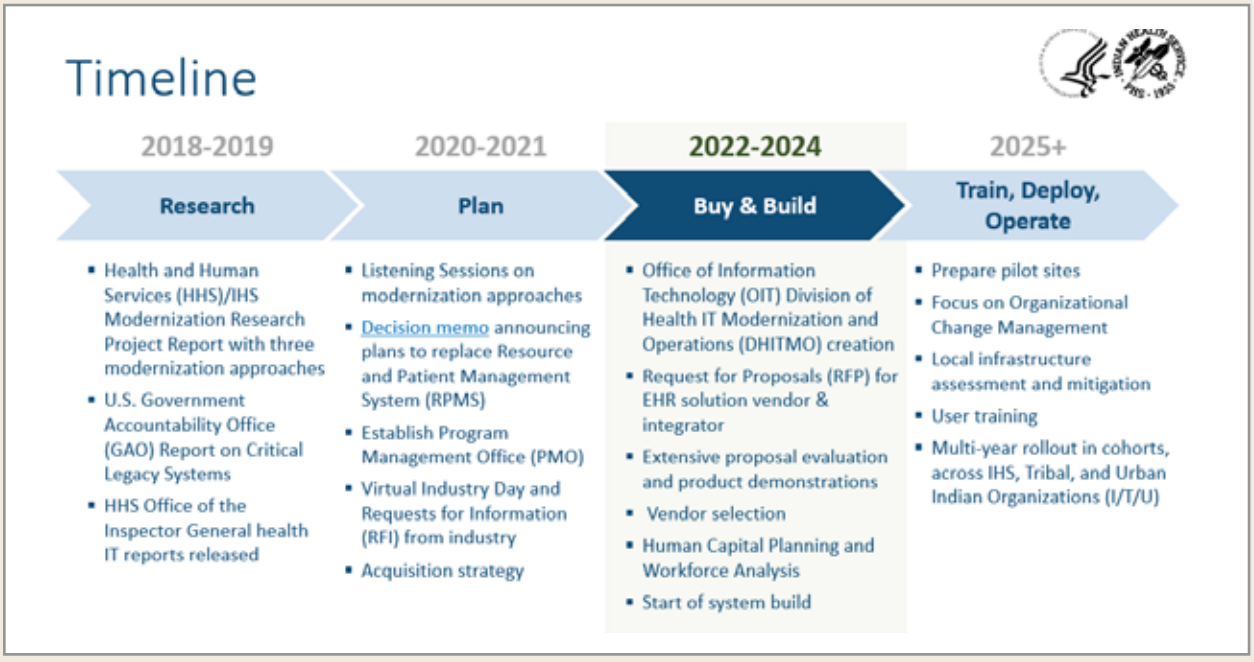
Finally, the Navajo Area is moving towards a viable offsite Disaster Recovery (DR) location. Currently we are in discussions with NTUA, OIT, and the BIA datacenter.

The following table shows Navajo Area's annual IT infrastructure needs for Fiscal Years 2024, 2025, 2026, 2027 and 2028.

SUMMARY OF SPENDING	FY2024 PLANNED TOTAL COST	FY2025 PLANNED TOTAL COST	FY2026 PLANNED TOTAL COST	FY2027 PLANNED TOTAL COST	FY2027 PLANNED TOTAL COST	FY2028 PLANNED TOTAL COST
FTE & Contract Costs Total	$8,979,022.94	$9,248,393.63	$9,490,753.86	$9,688,158.90	$9,688,158.90	$ 9,978,803.67
Hardware Replacement Total	$12,734,158.00	$7,647,922.00	$8,389,974.00	$8,850,814.00	$8,850,814.00	$ 9,116,338.42
Software Total	$7,081,647.04	$7,081,647.04	$7,081,647.04	$7,081,647.04	$7,081,647.04	$ 7,294,096.45
Planned Project Total	$6,962,381.00	$3,965,059.00	$5,106,822.00	$5,062,980.00	$5,062,980.00	$ 5,214,869.40
Planned Cloud Projects Total	$0.00	$8,500.00	$0.00	$470,000.00	$470,000.00	$ 484,100.00
Total Area IT Spending	**$35,757,208.98**	**$27,951,521.67**	**$30,069,196.90**	**$31,153,599.94**	**$31,153,599.94**	**$ 32,088,207.94**

IHS HIT MODERNIZATION EFFORT

The IHS' current health IT suite, the Resource and Patient Management System (RPMS), is nearly 40 years old. As such, RPMS is based on outdated technology and is increasingly challenging to sustain. Through extensive research, as well as discussions with Tribal and urban partners, IHS has determined that RPMS must be replaced with a modern solution that will enable its users to deliver comprehensive, accessible health care across all IHS sites and provide consistent patient management. On November 8, 2023, IHS announced its selection of General Dynamics Information Technology, Inc. (GDIT) to build, configure, and maintain a new IHS enterprise Electronic Health Record system. The modern EHR will support an organization's full continuum of care all in one system that houses an organization's clinical, medical, operational, financial, and engagement software. This makes information instantly and securely available to patients, providers, and other authorized users. The enterprise EHR will be available for all Tribal and urban organizations should they choose to adopt GDIT.



APPLICABLE INDIAN HEALTH CARE IMPROVEMENT ACT (IHCIA) PROVISION(S)

SUBCHAPTER I-INDIAN HEALTH PROFESSIONAL PERSONNEL

36. 1616b Recruitment activities.
37. 1616c Tribal recruitment and retention program
38. Tribal health program administration.

SUBCHAPTER II-HEALTH SERVICES

39. 1621c. Diabetes prevention, treatment, and control.
40. 1621d. Other authority for provision of services.
41. 1621h. Mental health prevention and treatment services.
42. 1621k. Coverage of screening mammography.
43. 1621m. Epidemiology centers.
44. 1621n. Comprehensive school health education programs.
45. 1621q. Prevention, control, and elimination of communicable and infectious diseases.

SUBCHAPTER III-HEALTH FACILITIES

46. 1638c. Contracts for personal services in Indian Health Service facilities.
47. 1638e. Other funding, equipment, and supplies for facilities.

SUBCHAPTER V-ORGANIZATIONAL IMPROVEMENTS

48. 1662. Automated management information system.

LINK TO GPRA PERFORMANCE TARGETS AND OUTCOMES

The data entry, collection, and profiling of GPRA data is entirely dependent on a modern IT and electronic health records system.

LINK TO IHS STRATEGIC PLAN

The IT budget priority is in line with federal IT initiatives and with the IHS mission to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level. Our vision is healthy communities and quality health care systems through strong partnerships and culturally responsive practices.

The Strategic Plan details how the IHS will achieve its mission through three strategic goals:

To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people

The modernization of IT infrastructure across the Navajo Area will assure recruitment and retention of staff, availability of the latest technology for patient care and training, and the use of tele-medicine technology in clinical practice. Maximum integration of tele-medicine technology into clinical practice will increase access to care.

To promote excellence and quality through innovation of the Indian health system into an optimally performing organization

Obsolete and outdated IT systems will be replaced with current technologies that support organizational excellence and quality, and foster innovation.

To strengthen IHS program management and operations

To strengthen IHS programs management and operations, IT infrastructure must be advanced and reliable in order to handle the volume and complexity of a digital work environment, while also protecting patient privacy. The technology should be seamlessly integrated with appropriate medical and non-clinical equipment, health devices, work computers, and digital platforms. The technology should also be user-friendly, efficient and dependable to prevent disruptions to patient flow and health care. A modern Information Technology program is central to health accreditation standards, quality improvement initiatives, population health data management, and cyber security.

Navajo Area IT strives to develop a sound IT DRP in conjunction with a viable dependable business continuity plan that incorporates IHS Navajo Area initiatives, priorities, and recovery time objectives.

Prevention Programs (CHR, PHN, & Health Education)

According to the Navajo Nation Epidemiology Center, the population of the Navajo Nation is projected to increase in the coming years. To ensure that the Navajo Nation, San Juan Southern Paiute Tribe, and Navajo Area IHS are prepared to meet the growing demand for preventive and public health care needs, it is essential to increase funding for preventive health care services. Additional resources will bridge health promotion, disease prevention, and public health efforts to bring about a holistic approach to care and treatment.

More specifically, the Navajo Area recommends increases to the Community Health Representative (CHR), Public Health Nursing (PHN), and Health Education (HE) budget line items. These activities are currently contracted by the Navajo Nation,

San Juan Southern Paiute Tribe, and authorized Tribal Organizations under a Public Law 93-638 (638) agreements. Increased funding will improve recruitment and retention of personnel, and allow expanded training in health promotion, disease prevention, and public health.

The CHR Program administers health services throughout the Navajo Nation. CHRs are frontline public health workers who are trusted members of a care team that provide culturally competent care to Tribal members. CHRs also collaborate with federal IHS facilities and 638 Tribal organizations, serving as advocates for Navajo and San Juan Southern Paiute patients, families, and communities. As such, CHRs understand and respect traditional healing practices, traditional philosophies of well-being and sickness, and the value of kinship networks in restoring Hozho.

PHNs are Registered Nurses who provide an array of services, including in-home treatments, connecting patients with community resources, Diné translation, and health education. Furthermore, PHNs assist public health care teams with community assessments, public health planning, and preparation for crises such as natural disasters. The Navajo Nation, Indian Health Service, and 638 PHN programs provide excellent public health nursing care in homes, worksites, educational institutions, chapter houses, and senior citizen centers.

The Navajo Nation Health Education Program serves 110 Navajo communities across Arizona, New Mexico and Utah. Since July 1981, the Health Educators (HEs) have been in the vanguard of public health response, promulgating information related to disease and injury prevention. Increased funding will help expand existing HE's knowledge and skills through training. Additional funding will also aid in the recruitment and retention of additional HEs, and in the improvement of digital communications.

APPLICABLE INDIAN HEALTH CARE IMPROVEMENT ACT (IHCIA) PROVISION(S)

The FY 2023 budget request is aligned with the provisions of the IHCIA as follow:
25 U.S.C. § 1601. Chapter 18-Indian Health Care.
SUBCHAPTER II-HEALTH SERVICES

49. 1616f. Tribal culture and history.
50. 1616p. Health professional chronic shortage demonstration programs.
51. 1621c. Diabetes prevention, treatment, and control.
52. 1621b. Health promotion and disease prevention services.
53. 1621d. Other authority for provision of services.
54. 1621h. Mental health prevention and treatment services.
55. 1621k. Coverage of screening mammography.
56. 1621m. Epidemiology centers.
57. 1621n. Comprehensive school health education programs.
58. 1621q. Prevention, control, and elimination of communicable and infectious diseases

LINK GPRA PERFORMANCE TARGETS AND OUTCOMES

The accomplishments of the CHR, PHN, and HE programs are demonstrated by the IHS GPRA Performance measures. These invaluable prevention-oriented programs provide outreach in Tribal congregated settings such as schools, senior citizen centers, workplaces, and chapter houses in addition to providing home visits. One important example of the sorts of services that these programs provide is immunizations that are administered outside hospitals and clinics in chapter houses, homes, and schools. While the Navajo Area has many GPRA successes, there is always room for improvement. Increased funding for CHR, PHN, and HE will aid in boosting GPRA scores.

Below are the GPRA performance measures results for FY2023:

The Navajo Area has met 2 of the 3 Dental measures.

- Dental General Access: Target: 24.40%; Navajo Area: 23.70%.
- Sealants: Target: 9.90%; Navajo Area: 10.14%.
- Topical Fluoride: 21.10%; Navajo Area: 23.38%.

Navajo Area has met 1 of the 5 Diabetes care measures.

- Controlled blood pressure: Target: 52.40%; Navajo Area: 51.71%
- Nephropathy assessment: Target: 45.10%; Navajo Area: 43.37%.
- Poor glycemic control: Target: 14.40%; Navajo Area: 19.21%.
- Retinopathy exams: Target: 44.70%; Navajo Area: 47.85%.
- Statin therapy: Target: 54.50%; Navajo Area: 53.09%.

The Navajo Area has met 4 of the 4 Immunizations measures

- Adult Immunizations – all age-appropriate immunizations: Target: BASELINE; Navajo Area: 43.49%.
- Childhood immunizations: Target: 40.90%; Navajo Area: 52.40%.
- Influenza vaccinations for ages 18 and over: Target: 19.70%; Navajo Area: 28.28%.
- Influenza vaccines for ages 6 month to 17 years: Target: 19.80%; Navajo Area: 30.39%.

The Navajo Area has met 11 of the 14 Prevention measures

- Cervical PAP Screening: Target: 33.20%; Navajo Area: 35.11 %.
- Childhood Weight Control: Target: 22.60%; Navajo Area: 23.33%.
- Colorectal Cancer Screening: Target: 23.70%; Navajo Area: 25.59%.
- Controlling High Blood Pressure (MH): Target: 45.80%; Navajo Area: 43.02%.
- CVD Statin Therapy: Target 37.80%; Navajo Area: 40.61%.
- Depression Screening or Mood Disorder 12 – 17 years old: Target: 29.50%; Navajo Area: 33.07%.
- Depression Screening or Mood Disorder 18 years and older: Target: 36.40%; Navajo Area: 39.03%.
- Breastfeeding at Age 2 Months: Target: 42.60%; Navajo Area: 46.24%.
- HIV Screening Ever: Target: 38.90%; Navajo Area: 48.97%.
- IPV/DV Screening: Target: 29.60%; Navajo Area: 34.94%.
- Mammography Screening: Target: 28.70%; Navajo Area: 40.52%.
- SBIRT: Target: BASELINE; Navajo Area: 11.66%.
- Tobacco Cessation Counseling, Aid, or Quit: Target: 24.40%; Navajo Area: 15.74%.
- Universal Alcohol Screening: Target: 32.20%; Navajo Area: 40.54%.

LINK TO IHS STRATEGIC PLAN

CHR, PHN and HE activities contribute to the IHS Strategic Plan by ensuring access to high quality, culturally appropriate personal and public health services, and by strengthening the local Navajo Area Indian health care delivery system's management and operations to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level possible with the goal to reach Hozho'.

Maintenance & Improvement

The Navajo Area is requesting an increase to the Maintenance & Improvement (M&I) program major line item budget account. Previous increases in funds were used by IHS and 638 organizations to support the operation of health care facilities. Specific activities supported by funding increases included the maintenance, repair, and improvement of buildings, utility systems, clinical equipment, grounds, roads, and parking lots. Additionally, M&I funding has supported engineering and planning-related activities, including assessing structures, utilities, and equipment; designing modifications; preparing engineering drawings and specifications for repairs and improvements; and troubleshooting major components and system failures. M&I funds are also responsible for the realty and facilities environmental programs that support patient care activities.

The Indian Health Service (IHS) maintains government owned/leased buildings whether these buildings are operated by the Indian Health Service (IHS) or by Tribal health programs operating under the provisions of the Indian Self Determination and Education Assistance Act (P.L. 93-638, as amended). IHS also provides funding to Tribally owned/leased buildings.

Going forward, increased M&I funds will be used to enhance the M&I Program objectives as follows: providing routine maintenance for facilities, achieving compliance with buildings and grounds accreditation standards of The Joint Commission (TJC) and other applicable accreditation bodies, providing improved facilities for patient care, ensuring that health care facilities meet building codes and standards, and ensuring compliance with Executive Orders and public laws relative to building requirements, e.g., energy conservation, seismic, environmental, handicapped accessibility and security. Increased funding is essential to ensure that health care facilities are functional, meet building/life safety codes, conform to laws and regulations, and satisfy accreditation standards.

Historically, the M&I appropriation has been underfunded with the amount of funding adequate only to sustain buildings in their current condition without any upgrades. (Navajo Area health care facilities range in age from 7 to 63 years old. The oldest facility is also the largest -- the Gallup Indian Medical Center). However, for FY 2024, the IHS received $170.95 million M&I funding, which is beyond the amount required for mere sustainment.

The Navajo Area requests that these higher funding levels be maintained going forward to address the Backlog of Essential Maintenance, Alternation, and Repair (BEMAR), which now totals $1,476,894,779 for the entire Agency.

The BEMAR need for the Navajo Area alone is $294,783,140. Included in this need is $80,673,467 of mechanical BEMAR, which includes HVAC systems. Generally speaking, the current HAVC systems in our health facilities are old and in need of replacement. The COVID-19 pandemic brought to the forefront the importance of HVAC. For instance, data shows that improving indoor ventilation can reduce the risk of virus transmission. Unfortunately, the Navajo Area has not been able to modify or expand HVAC systems to meet the American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) requirements. Increased funding will help with vital HVAC upgrades.

Increased M&I funds will improve IHS' capability to meet both facility sustainment and facility improvement objectives. Though IHS has received increased M&I funding, more appropriations are needed to adequately cover the growing need.

APPLICABLE INDIAN HEALTH CARE IMPROVEMENT ACT (IHCIA) PROVISION(S)

CAPTER 18 – INDIAN HEALTH CARE GENERAL PROVISIONS SEC.

59. § 1602. Declaration of national Indian health policy

SUBCHAPTER II – HEALTH SERVICES

60. § 1621. Indian Health Care Improvement Fund
61. Use of funds
62. (J) Maintenance and Improvement
63. § 1638a. Tribal management of federally owned quarters
64. § 1638f. Indian country modular component facilities demonstration program
65. § 1638g. Mobile health stations demonstration program

SUBCHAPTER IV – HEALTH SERVICES FOR URBAN INDIANS

66. § 1656. Other contract and grant requirements
67. § 1659. Facilities renovation.
68. § 1660g. Use of federal government facilities and sources of supply

SUBCHAPTER V – ORGANIZATIONAL IMPROVEMENTS

69. § 1661. Establishment of the Indian Health Service as an agency of the Public Health Service

SUBCHAPTER VI - MISCELLANEOUS

70. § 1674. Leases with Indian Tribes
71. § 1680a. Contract health facilities
72. § 1680h. Demonstration projects for Tribal management of health care services

LINK TO GPRA PERFORMANCE TARGETS AND OUTCOMES

IHS, Tribes and Tribal Organizations require well-maintained facilities to serve American Indian and Alaska Native people and achieve GPRA performance targets. Given that there are few opportunities to replace health care facilities, maintaining current facilities is imperative. An increase of M&I dollars will allow the IHS to keep existing health care facilities operational. It will also allow IHS to continue meeting facilities-related Accreditation standards.

LINK TO IHS STRATEGIC PLAN

The Strategic Plan details how the IHS will achieve its mission through three strategic goals:

To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people

To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible, staff must have a safe place to work. Moreover, staff require buildings, utility systems, and medical equipment that are well-maintained and reliable. Funding increases for the M&I will support the operation of health care facilities, including the maintenance, repair, and improvement of buildings, utility systems, clinical equipment, grounds, roads and parking lots, and building service equipment systems.

To promote excellence and quality through innovation of the Indian health system into an optimally performing organization

Health care excellence and quality require safe and well-functioning buildings, utility systems, grounds, roads, parking lots, and clinical equipment. The Navajo Area's highest priority is assuring that hospitals and clinics are accredited. Accreditation ensures quality and safe patient care. Increased funding for M&I will not only support compliance

with accreditation standards; it will also decrease the Backlog of Essential Maintenance, Alternation, and Repair (BEMAR). Decreasing the BEMAR allows IHS and 638 staff to emphasize innovating projects planning and prevention activities over simply reacting to facilities and equipment breakdowns. Such breakdowns disrupt health care delivery, cause frustration among patients and staff, and impede innovation.

To strengthen IHS program management and operations
Increased funding for M&I is critical to strengthening program management and operations, as many of Navajo Area's hospitals and freestanding ambulatory facilities are either aged or aging. Indeed, with an average age of 48 years, many Navajo Area facilities and building systems are obsolete and have long surpassed their useful lives. Aging building systems make maintenance more time and funding-intensive. Routine maintenance is more expensive, and repairs more frequent. Much clinical equipment is likewise aged, yet it continues be used due to a lack of alternatives. Decreased availability of replacement parts for aged equipment and infrastructure ultimately disrupts medical services and puts a strain on budgets. System failures deplete designated M&I funds and require the use of third party collections that would otherwise be used for direct patient care. The strength of a health care system requires reliable buildings, mechanical infrastructure, and clinical equipment.

Health Facilities Construction

The Navajo Area is requesting an increase in funding for the Health Facilities Construction Program major line item account to support the construction of new inpatient, outpatient, and small ambulatory facilities. The Navajo Area is also requesting increased funding for staff quarters, green infrastructure, demonstration projects, and the Joint Venture Construction Program.

The Navajo Area continues to maintain Pueblo Pintado, Bodaway-Gap and the Gallup Indian Medical Center replacement facility as high priority projects, and urges congress to consider additional appropriations in the amount of $1.2 billion for Navajo health facilities that remain on the IHS Construction Priority List. The completion of projects on the list will eliminate the risks posed by continued use of outdated facilities. It will also elevate the quality of care delivered, increase access to care, and improve the health of the Navajo Nation, San Juan Southern Paiute Tribe and other American Indians/Alaska Natives that will be served by these facilities. The Navajo Area further urges Congress to acknowledge additional health care facility needs for future health care facilities, treatment centers, and specialty care facilities.

Many existing facilities in the Navajo Area are obsolete and have long surpassed their useful lives. Some facilities are undersized for the identified user populations, which has created crowded conditions. In many cases, existing services are relocated outside the main health facility to modular office units in order to provide additional space for primary and specialty care services.

As existing health facilities age, associated building equipment and infrastructure can deteriorate to the point of failure. Reduced availability of replacement parts for dated equipment and infrastructure ultimately disrupts medical services. For example, systems that provide potable water for health services frequently fail, requiring extended shut downs. This often results in discontinuation of patient care until repairs are completed. The rural and isolated nature of many Navajo Area health facilities complicates repairs, and system failures deplete designated maintenance and improvement funds, requiring the expenditure of third party collections or other funding that would otherwise be used for direct patient care.

In terms of medical, IT, and laboratory equipment, the Navajo Area makes every attempt to keep pace with technological advancements. Unfortunately, due to limited equipment funds, Navajo Area health facilities typically use equipment well beyond its expected useful life. The construction of new health facilities will alleviate many of the problems associated with failing building systems and equipment, while simultaneously modernizing medical, laboratory, and IT equipment.

Previous increases in Health Facilities Construction have allowed for the completion of planning documents for the Pueblo Pintado Health Center and the Bodaway/Gap Health Center. The design for the Pueblo Pintado Health Center is now complete, with a construction contract projected to be awarded in September of 2024. The Pueblo Pintado staff quarters design-build contract is also projected to be awarded in September of 2024. Meanwhile, a Title V Construction Project Agreement (TVCPA) was awarded to the Tuba City Regional Health Care Corporation on August 18, 2022 for the design of the Bodaway/Gap Health Center, which was completed

on December 13, 2023. Construction will commence for the Bodaway/Gap (Echo Cliffs) Health Center on February 20, 2024.

The new Gallup Indian Medical Center is nearing completion of the planning phase, which is anticipated to be concluded in March 2024. The design phase is projected to start in early FY 2025.

APPLICABLE INDIAN HEALTH CARE IMPROVEMENT ACT (IHCIA) PROVISION(S)

The budget request is aligned with provisions of the Indian Health Care Improvement Act (IHICA) (25 U.S.C., SUBCHAPTER III---HEALTH FACILITIES) to improve quality and access to care by making available modern health facility square footage, facility infrastructure, and modern medical and information technologies. Aligning with the IHCIA is the IHS Health Care Priority System that identifies priority Health Facilities Construction projects. Increased funding will help to eliminate deficiencies in health resources, reduce backlogs in the provision of health care services, and meet health care needs in an efficient and equitable manner.

LINK TO GPRA PERFORMANCE TARGETS AND OUTCOMES

Increased funding for health care facilities construction and renovation support efforts to address complications resulting from diabetes and other serious illnesses. Modern health care facilities also support injury and disease prevention. As a result, increased funding for health care facilities construction will serve to boost GPRA scores in the Navajo Area.

LINK TO IHS STRATEGIC PLAN

The mission of the IHS is to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level. Our vision is healthy communities and quality health care systems through strong partnerships and culturally responsive practices.

The Strategic Plan details how the IHS will achieve its mission through three strategic goals:

To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people
The construction of new health care facilities will help in the recruitment and retention of essential staff, which will ensure that services are available to AI/AN beneficiaries.

To promote excellence and quality through innovation of the Indian health system into an optimally performing organization
Assuring that IHS hospitals and clinics are accredited is a high priority for IHS. Meeting Medicare standards allows IHS facilities to be reimbursed for all eligible Medicare and Medicaid services. The IHS is working to strengthen organizational capacity to meet and maintain accreditation of IHS direct service facilities, align service delivery processes to improve the patient experience, ensure patient safety, establish agency-wide patient wait time standards, improve processes, and strengthen communication for early identification of risks.

Within the Indian health care system, quality is also impacted by rising costs from medical inflation, population growth, increased rates of chronic diseases, and aging facilities and equipment. These challenges are heightened at facilities located in remote locations.

The construction of new hospitals and ambulatory facilities will help to address these issues and ensure access to care.

To strengthen IHS program management and operations
Increased facilities construction spending will strengthen IHS program management and operations by building modern hospitals and ambulatory facilities. Many of the existing IHS and Tribal health care facilities are operating at or beyond capacity. Information Technology also continues to be a concern with rising costs and increased security threats. The construction of new facilities across IHS will help to alleviate these issues.

Alcohol and Substance Abuse Programs

The Navajo Area requests a funding increase to the Alcohol and Substance Abuse major line-item budget category. Alcohol use disorder is a major public health concern on the Navajo Nation and San Juan Southern Paiute reservation. American Indians/Alaska Natives (AI/AN) continue to experience relatively higher rates of substance-related disorders among the United States population. According to the Substance Abuse Mental Health Services Administration (SAMHSA) 2022 National Survey on Drugs Use and Health, 24.0 percent of AI/AN ages 12 and older report some sort of substance use disorder, with 10.4 percent reporting alcohol use disorder, 17.3 percent reporting drug use disorder, and 11.0 percent reporting marijuana use disorder. (See Table 1.)

Table 1: Alcohol Use among AI/ANs:

Table B.14B Substance Use Disorder, Alcohol Use Disorder, Drug Use Disorder, or Marijuana Use Disorder in the Past Year: Among People Aged 12 or Older; by Race/Ethnicity, 2022

Characteristic	Substance Use Disorder		Alcohol Use Disorder		Drug Use Disorder		Marijuana Use Disorder	
TOTAL	17.3	(0.27)	10.5	(0.22)	9.7	(0.22)	6.7	(0.17)
HISPANIC ORIGIN AND RACE								
Not Hispanic or Latino	17.2	(0.30)	10.4	(0.23)	9.6	(0.23)	6.6	(0.18)
American Indian or Alaska Native	24.0	(3.15)	10.5	(1.64)	17.3	(2.97)	11.0	(1.80)
Asian	9.0	(1.02)	5.6	(0.79)	4.9	(0.89)	3.3	(0.80)
Black or African American	18.4	(0.78)	10.5	(0.59)	11.5	(0.64)	8.0	(0.47)
Native Hawaiian or Other Pacific Islander	*	(*)	*	(*)	*	(*)	8.9	(3.00)
White	17.6	(0.34)	10.9	(0.29)	9.4	(0.26)	6.4	(0.20)
Multiracial[1]	21.8	(1.78)	10.4	(1.25)	15.7	(1.60)	12.6	(1.32)
Hispanic or Latino[2]	17.4	(0.70)	10.8	(0.59)	9.9	(0.55)	7.2	(0.45)

* Low precision; no estimate reported.

NOTE: Estimates shown are percentages with standard errors included in parentheses.

NOTE: Additional estimates may be found in *Results from the 2022 National Survey on Drug Use and Health: Detailed Tables* at https://www.samhsa.gov/data/report/2022-nsduh-detailed-tables. Measures and terms are defined in Appendix A of the 2022 Detailed Tables.

NOTE: Substance use disorder estimates are based on criteria from the *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition.

[1] Multiracial refers to people not of Hispanic or Latino ethnicity who reported two or more races.

[2] People who reported Hispanic or Latino ethnicity could be of any race.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2022.

SAMHSA (2022) reports also indicate that AI/ANs have the highest opioid use disorder rate of any demographic. (See Table 2.)

Table 2: Opioid Use Disorders AI/ANs

Table B.15B Prescription Pain Reliever Use Disorder, Opioid Use Disorder, or Central Nervous System Stimulant Use Disorder in the Past Year: Among People Aged 12 or Older; by Race/Ethnicity, 2022

Characteristic	Prescription Pain Reliever Use Disorder		Opioid Use Disorder[1]		Central Nervous System Stimulant Use Disorder	
TOTAL	2.0	(0.11)	2.2	(0.12)	1.6	(0.09)
HISPANIC ORIGIN AND RACE						
Not Hispanic or Latino	2.0	(0.12)	2.2	(0.13)	1.6	(0.10)
American Indian or Alaska Native	6.2	(2.72)	6.6	(2.73)	2.1	(0.57)
Asian	1.1	(0.35)	1.2	(0.36)	0.8	(0.32)
Black or African American	2.6	(0.36)	3.0	(0.40)	1.2	(0.22)
Native Hawaiian or Other Pacific Islander	4.2	(2.28)	5.3	(2.54)	*	(*)
White	1.9	(0.13)	2.0	(0.14)	1.7	(0.11)
Multiracial[2]	2.7	(0.98)	3.0	(0.99)	2.3	(0.50)
Hispanic or Latino[3]	2.0	(0.29)	2.0	(0.30)	1.6	(0.24)

The Navajo Nation Division of Behavioral and Mental Health Services (DBMHS) is committed to increasing the capacity of residential, detox, and transitional housing facilities in Navajo Area to address substance use, mental health, and co-occurring problems.

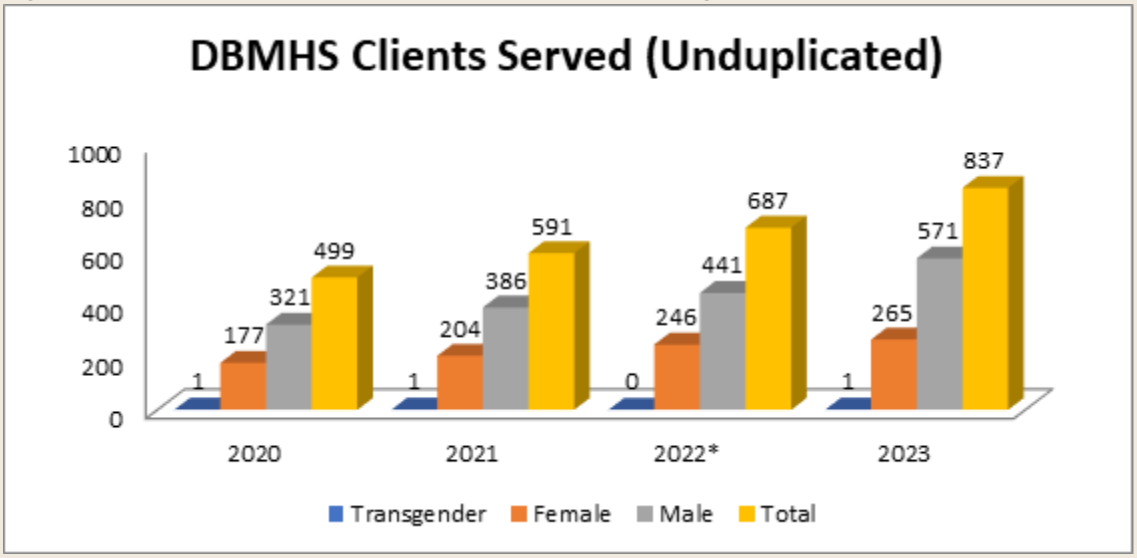
DBMHS has seen a rise in substance use referrals and enrollments from 2021 to 2023 for persons seeking outpatient and residential substance use disorder treatment services. (See Table 3.)

Table 3: DBMHS Referrals, Enrollments.

Navajo Division of Behavioral and Mental Health Services					
	Referrals	Active Start	Enrollments	Discharges	Active End
2021	890	614	618	946	286
2022	957	286	644	561	369
2023	872	369	713	616	466

The services provided by DBMHS during the COVID-19 pandemic significantly declined due to the implementation of public health safety measures that limited in-person care. On May 6, 2023, Navajo Nation President, Dr. Buu Nygren, lifted COVID-19 restrictions, which increased in-person contacts. As shown in Figure 1, 499 individuals were served in 2020. This number has steadily increased to 837 individuals served in 2023. Increased funding will enable DBMHS to serve more clients as demand continues to grow.

Figure 1: Unduplicated count of services provided through DBMHS.



Limited substance abuse education, outpatient services, and inpatient residential services are significant barriers to addressing substance use issues on the Navajo Nation and San Juan Southern Paiute reservation. Both relapse and new onset substance use have led to a substantial influx of patients presenting to emergency departments. This negatively impacts the availability of resources for medical emergencies that are not related to substance use.

There are many other deficiencies on the Navajo Area when it comes to substance use treatment. Currently, there are no residential treatment facilities in the Navajo Area that are able to meet the needs of individuals suffering from methamphetamine and opioid addiction. All inpatient facilities for substance use disorders are located off-reservation. Step-down and transitional care is not available for substance use disorder patients either. Treatment services to address comorbidity are limited due to a low number of qualified specialty providers. Tele-psychiatry and tele-behavioral health services are also limited because broadband internet services are not always available in remote areas. Additional funding will help address gaps.

APPLICABLE INDIAN HEALTH CARE IMPROVEMENT ACT (IHCIA) PROVISION(S)

25 USC § 1655 (a) Behavioral health prevention and treatment services.

LINK TO GPRA PERFORMANCE TARGETS AND OUTCOMES

Two GPRA measures are relevant to the substance abuse budget line item: 1) Universal alcohol screening and other substance use disorders for ages 9-95. and 2) Screening Brief Intervention Referral for Treatment (SBIRT) for all ages.

In 2022, with a score of 33.20 percent, the Navajo Area did not meet the Universal Alcohol Screening target of 39.20 percent. However, with an SBIRT score of 14.32 percent, the national target of 13.50 percent was surpassed.

In 2023, the Navajo Area surpassed the Alcohol Screening target of 32.20 percent with a score of 34.15 percent. In 2023, the Navajo Area SBIRT score was 14.74 percent, while the national target was 12.20 percent. During the COVID-19 pandemic in 2020 and 2022, completing the GPRA targets became a challenge due to the closures of health clinics.

LINK TO IHS STRATEGIC PLAN

In the past, increased funding has allowed the Navajo Area to meet the Universal Alcohol Screening targets, which aligns with the IHS' Strategic Plan and Mission.

The Strategic Plan details how the IHS will achieve its mission through three strategic goals:

To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people

Increased funding supports the Navajo Area in meeting GPRA targets for Universal Alcohol Screening. It also supports culturally appropriate screening and treatment. The Navajo philosophy of healing and well-being has been incorporated into counseling, interventions, and treatments. A hallmark of this philosophy an emphasis on treating the whole person within a network of relationships. In addition, Navajo Area providers utilize evidence-based tools such as screening and SBIRT in primary care clinics and the emergency departments. Moreover, the Navajo Area uses the Primary Care Behavioral Health model and Trauma-informed Care Approach. Both have significantly contributed to culturally oriented personal care. Telehealth increased dramatically during the COVID-19 pandemic to ensure patient access to care.

To promote excellence and quality through innovation of the Indian health system into an optimally performing organization

Significant strides have been made to integrate mental health with medical primary care services using the Primary Care Behavioral Health (PCBH) Model. The PCBH Model facilitates the integration of medical and mental health care by including the patient's primary care provider in mental health-related screening and treatment. It is a collaborative framework that supports a holistic approach to care. Increased alcohol and substance abuse funding will bolster this team-based model of behavioral health promotion, thereby improving the Navajo Area's efficacy in terms of identifying and treating substance use problems.

To strengthen IHS program management and operations

Increased funding will strengthen the Navajo Area's substance use programs by enabling the expansion of the PCBH and Trauma-Informed Care models and also by improving patient access to virtual medical appoints. The advent of the COVID-19 pandemic has forced health care providers to capitalize on digital technology to reach patients. Significant Information Technology infrastructure development will need to occur on Indian reservations and rural areas of the United States to improve access to care, including behavioral health care.

NAVAJO DBMHS FUTURE GOALS AND PLANS

DBMHS has a plan for facility construction projects for detox and residential treatment centers, as well as for transitional sober housing. This plan includes constructing a residential and detox treatment center in Tuba City, AZ, and a transitional sober housing facility in Crownpoint, NM. Both projects require additional funding, not only for construction but also for staffing.

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Professionals Recruitment and Retention

The Indian Health Service (IHS), Tribal health care facilities, and Tribal health programs continue to experience critical nursing, dental, behavioral health, and other provider shortages. In fact, these shortages are growing at an increasing rate for IHS and Tribal health care facilities. If critical staffing shortages continue, closures of beds and service reductions will follow, hindering the ability of IHS and Tribal health care facilities to provide quality health care for Native American communities. Already, many patients are transferred to urban hospitals, which can result in financial hardship for patients and their families.

BACKGROUND

According to the American Association of Colleges of Nursing, the shortage of Registered Nurses (RNs) in the United States is expected to intensify as Baby Boomers age and the demand for health care grows (Rosseter, 2022). In March 2022, the American Nurses Foundation and the American Nurses Association released the results of its COVID-19 Impact Assessment Survey, which found that 52 percent of nurses are considering leaving their current positions due primarily to insufficient staffing, work negatively affecting health and well-being, and an inability to deliver quality care. In addition, 60 percent of acute care nurses report feeling burnt out, and 75 percent report feeling stressed, frustrated, and exhausted. Since the 1970s, the United States has had steady numbers of registered nurses going to college, but numbers have plateaued and even declined in some parts of the country, contributing to the shortage of staff serving in Indian Country. In August 2018, the Government Accountability Office (GAO) published a report, "Indian Health Service: Agency Faces Ongoing Challenges Filling Provider Vacancies," which found overall vacancy rates at federal/IHS sites for physicians, nurses, nurse practitioners, certified nurse anesthetists, certified nurse midwives, physician assistants, dentists, and pharmacists to be around 25 percent. According to a reevaluation of registered nurse (RN) supply and demand by Zhang et al. (2018), the shortage of registered nurses is projected to spread countrywide between 2016 and 2030, with the RN shortage most severe in southern and western regions of the United States. Navajo Area IHS is experiencing an overall nursing vacancy rate of 50 percent (412 vacancies in FY 2023). Tuba City Regional Health Care Corporation (TCRHCC) had a RN vacancy rate of 44 percent with an average of two to three nurses leaving per month.

Contributing factors impacting the nursing shortage include (American Association of Colleges of Nursing [AACN], 2020):

- An aging nursing workforce – significant portion of the nursing workforce is nearing retirement age.
- Changing demographics – an aging population and increased need for health care population-wide.
- Insufficient staffing resulting in increased stress levels, negative impacts on job satisfaction, decreased quality of patient care, decreased time nurses spend with patients.
- Shortage of nursing school faculty which restricts nursing program enrollments.

The COVID-19 pandemic has also escalated provider shortages. Many professionals stepped away from the bedside in early 2020 at the beginning of the COVID-19 pandemic, and greater numbers are retiring or leaving the profession post-pandemic. Additionally, many professionals opt to apply for positions with less than full-time patient care duties. Since 2021, the nursing shortage has been worsening, prompting the American Nurses Association to ask the US Department of Health and Human Services to declare a national crisis (American Nurses Association, 2021).

In an effort to address these critical issues in the Navajo Area, the Winslow Indian Health Care Center Board of Directors drafted a resolution that called upon the leadership of the Navajo Nation Council to bring attention to the nursing shortage in October of 2021. For its part, in the Summer of 2022, Tuba City Regional Health Care Corporation (TCRHCC) entered into a Memorandum of Agreement (MOA) with Northern Arizona University to provide a classroom and SIM lab for American Indian Nurses within the School of Nursing. The primary goal of this five-year agreement is to increase the number of American Indian nurses working in Indian Country. In November 2022, TCRHCC expanded the MOA to include Coconino County Community College in Flagstaff, AZ, and Diné College in Tsaile, AZ.

One important aspect to consider when attempting to address the nursing shortage is the remoteness of Tribal lands. Multiple studies have been done looking at attracting nursing to rural areas. One such study from 2021 entitled, "The Rural Nursing Workforce Hierarchy of Needs: Decision-Making Concerning Future Rural Health care Employment," identified several reasons why nurses choose rural nursing. These elements included easy access to education, a livable wage with affordable housing, the ability to provide high quality care, and a supportive work environment (Terry et al., 2021). Recommendations outlined in the next section were generated these elements in mind.

Multiple studies (AACN, 2018) have demonstrated positive impacts on patient care if there are adequate levels of RN staffing. For every 10 percent increase in bachelor's degree-level nurses, there is a 7 percent decrease in patient mortality. Moreover, higher nurse staffing levels were associated with lower mortality rates, lower failure-to-rescue incidents, lower rates of infection, shorter hospital stays, and decreased nurse burnout.

RECOMMENDATION

In order to address the critical nursing shortage, it is recommended to increase funding for nursing recruitment and retention activities. These activities will include the following:

- Establishing additional nurse residency programs for new nurse graduates.
- Working with Navajo Nation schools, school boards, regional colleges, and universities to strongly promote health field studies for students of all ages.
- Increasing the availability of IHS scholarships, IHS loan repayment, National Health Service Corps Loan Repayment, Nurse Corps Loan Repayment, and Faculty Loan Repayment.
- Establishing a college of nursing at Dine College and Navajo Technical University.
- Furthering Navajo Nation MOAs with surrounding colleges and universities to increase Native American enrollment in nursing programs.
- Increasing facilities budgets for hospitals and universities to create classrooms and SIM labs.
- Increasing access to housing by working with the Navajo Housing Authority to build rent-to-own homes near Tuba City, Winslow, and Dilkon health facilities.
- Increasing aid to defray housing costs for nursing students.
- Expanding ongoing training and skill-building opportunities, so staff can keep up with the latest developments in health care.
- Increasing flexibility for IHS and Tribal health care facilities with respect to salaries and benefits in order to recruit and retain a competent and skilled professional workforce.

The same factors inhibiting the recruitment and retention of nurses are also inhibiting the recruitment and retention of higher-level providers such as physicians and dentists. Increased recruitment and retention funding under the H&C budget line item will fund initiatives that will help make working the Navajo Area more attractive to medical providers of all levels.

Water & Sanitation

The Navajo Nation has more than 2,600 homes that lack adequate water and sewer service. It has been documented that as the number of homes using safe, piped water has increased, the incidence of illness and death due to intestinal disease in childhood has fallen. (See Graph 1 below.) To continue to improve health outcomes, that Navajo Area requests increased funding to address the remaining deficit in sanitation facilities.

The provision of sanitation facilities is an extension of primary health care delivery. The availability of essential sanitation facilities can be a major factor in breaking the chain of waterborne communicable disease episodes, and efforts by other public health workers are much more effective when safe water and adequate wastewater disposal systems are in place.

Data shows that patients admitted to the hospital have longer lengths of stay when there is a lack of sanitation infrastructure in patients' homes. For example, an elderly patient recovering from a broken hip will not be discharged when they normally would be because they have no indoor water and sewer facilities and only have an outhouse located a long distance from the home. Many of these patients end up being admitted to nursing homes where exposure to nosocomial infections may worsen the chance of good outcome and return home.

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

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

APPLICABLE INDIAN HEALTH CARE IMPROVEMENT AC PROVISION(S)

Provision of safe water and sanitary waste disposal facilities is referenced in 25 U.S.C. § 1632.

LINK TO GPRA PERFORMANCE TARGETS AND OUTCOMES

The FY 2022 Government Performance and Results Act (GPRA) measure for providing new or improved water, wastewater, and solid waste facilities to new and existing homes for the Navajo Area is 10,081 homes. Increased water and sewer (P.L. 86-121) funding will allow IHS to provide facilities to even more homes, thus improving the quality and access to health care as described below.

While 1 percent of the U.S. general population lacks access to safe water, 9 percent of Indian homes lack access to safe water.

There is a large national backlog of needed sanitation facilities construction projects in Indian Country. With inflation, new environmental requirements, and population growth, current sanitation appropriations are struggling to keep pace with the backlog.

LINK TO THE IHS STRATEGIC PLAN

The IHS Strategic Plan includes sanitation facility construction improvements. There are two measures linked to this goal: The number of homes provided with sanitation facilities, and the average project duration. Increased funding will provide essential sanitation facilities to homes and secure the workforce needed to reduce the amount of time it takes to complete projects. In Calendar Year 2022, Navajo Area's project duration was 4.99 years, which exceeded the national goal of less than 4.0 years.

2019 – 2023 GOAL 3: TO STRENGTHEN IHS PROGRAM MANAGEMENT AND OPERATIONS

Currently, staffing is the bottleneck to serving more homeowners. It is anticipated that in the short term (0 to 3 years) to medium term (3 to 6 years), project duration will increase due to the large numbers of projects funded through the Bipartisan Infrastructure Law (BIL). Funding for staffing at the Navajo Area is currently available (The Office of Environmental Health and Engineering Program funding is currently >$30,000,000 and growing daily). It is anticipated that as staffing is brought on, the Navajo Area's project duration will decrease. However, the BIL funding will cease after FY 2026. After that time, it will be critical to continue to support Sanitation Facilities Construction (SFC) staffing in order to complete the backlog of BIL projects funded and to reduce the average project duration within the Navajo Area SFC program.

Staff Quarters

Existing facilities need new staff quarters to provide housing for both the recruitment of new employees and the retention current employees. Increased funding for staff quarters has the potential to significantly improve health care delivery in the Navajo Area by attracting new staff to remote hospitals and clinics.

BACKGROUND

The Indian Health Service builds new health care facilities in accordance with the Indian Health Service Annual Facilities Plan. This document outlines an array of facilities-related projects, including the construction of new inpatient and outpatient facilities, green infrastructure initiatives, and staff quarters activities. Unfortunately, dollars for new quarters are only allocated for new facilities, not for facilities that exist already.

In theory, new quarters could be built with Quarters Return (QR) dollars, which are derived from rents collected from tenants living in existing quarters. In practice, however, this revenue is very limited — sufficient only to cover salaries for maintenance personnel, trash collection fees, and utilities for unoccupied quarters. QR funds are not sufficient to renovate or upgrade the existing quarters, make significant repairs, or replace appliances or furnishings.

RECOMMENDATION

Annual quarters funding needs to be augmented in order to carry out the following initiatives:

1. Construction of short-term stay units, which will be fully-furnished. These units will be made available to contract employees and on-call personnel.
2. Construction of RV parks for contract employees, who have their own travel trailers.
3. Construction of multi-family units to house a variety of family sizes.
4. Renovation of existing quarters.
5. Repair-by-replacement of existing quarters.
6. Addition of playgrounds and other amenities to quarters.

Dental

Good oral health plays an important role in people's overall well-being and quality of life. Research has shown that oral disease can cause pain, infection and debilitation that can lead to lost time at school and work. Poor oral health is also associated with other medical conditions such as heart disease, cancer, stroke and diabetes. The nature of dental disease requires timely clinical intervention to stop the progress of pathology that leads to these potential conditions.

American Indian and Alaskan Natives (AI/AN) suffer disproportionately from dental diseases. In the 1-5 year-old age group, AI/AN children experience approximately four times as much tooth decay as the general U.S. population (43 percent vs. 10 percent), causing significant consequences such as delayed speech development, poor self-esteem, and high costs to repair.[118]AI/AN Children ages 6-9

118 Phipps, Kathy R. Ricks, Timothy L. Mork, Nathan P. Lozon, Timothy L. "The Oral Health of American Indian and Alaska Native Children Aged 1-5" *Indian Health Service Data Brief.* April 2019, https://www.ihs.gov/doh/index.cfm?fuseaction=home.databriefs

suffer almost twice as much decay as the general U.S. population (90 percent vs. 42 percent), resulting in increased missed school days, poorer school performance, and pain.[119] AI/AN children ages 13-15 have three times the tooth decay prevalence as the general U.S. population (45 percent vs. 14 percent).[120] The disparity in dental disease continues into adulthood for American Indians and Alaskan Natives. AI/AN adults over the age of 45 have two times the prevalence of severe periodontal disease as the general U.S. population (20 percent vs. 10 percent), leading to premature tooth loss and possible medical conditions previously mentioned.[121]

A comprehensive oral health program must have several components to be effective in preventing and treating dental disease. Clinical care is provided in dental clinics located in and adjacent to the Navajo Nation, and includes diagnostic services such as exams and radiographs. The clinical programs also provide emergency dental care, cleanings, extractions, and routine restorations for children and adults. Preventive care includes topical fluoride and sealants to help prevent cavities, as well as oral hygiene education for children and adults. Oral health care education has proven to be effective in preventing dental diseases such as caries and periodontal disease, thus reducing the need for extensive operative dental procedures and improving the quality of life for patients.

Higher levels of dental care, such as tooth replacement (bridges, implants and removable prosthetics), periodontal (gum) surgery, endodontic (root canal) therapy and complex oral surgery are not typically provided due to the cost, time and expertise required for these treatments. Most clinical time is spent treating emergency conditions and providing basic preventive and restorative care.

The following Indian Health Care Improvement Act (IHCIA) provisions are referenced in this request:
1616(a) – Indian Health Service Loan Repayment Program
1616(l) – Community Health Aide Program

Government Performance and Results Act (GPRA) – All of the Navajo Area Federal and at least one of the Tribal Dental Programs provide GPRA information through the RPMS system. This information is used to help determine Congressional appropriations for the Indian Health Service. There are three oral health indicators that are used to measure the effectiveness of IHS dental services.

Target thresholds have been established for these indicators, which have been adjusted downward due to the impact that the COVID-19 pandemic has had on the provision of dental services since 2020.

GPRA INDICATOR	TARGET GOAL	ACHIEVED 2023	MET/NOT MET
Access to Care	24.4%	23.7%	Not Met
Dental Sealants	9.9%	10.14%	Met
Topical Fluoride	21.1%	23.38%	Met

Corporately, Navajo Area Dental Programs are meeting the Topical Fluoride and the Dental Sealant targets, but not the Access to Care target for 2023. Improvement for each of these measures requires a dedicated workforce with the resources to provide preventive and clinical services.

In order to provide more dental services to the Navajo Area, additional staff will need to be recruited and retained. Clinical and community care requires trained individuals to serve in the Tribal and Federal dental programs. There are currently multiple vacancies for dentists, dental hygienists, dental specialists and dental assistants at the dental programs serving the Navajo Area. The following proposals will improve the recruitment, retention and development of dental health care professionals providing services to the Navajo Nation, as well as update the infection control systems used to insure safe patient care. Specialized dental equipment is also needed to support higher levels of dental care, and funding is needed to support community prevention activities:

1. Dentist Pay – The Indian Health Service needs funding for dentist salaries to ensure that a competitive pay and benefits package is offered to prospective candidates. The Civil Service Title 38 pay plan provides a framework to develop a competitive pay structure, but all positions need to be fully funded to ensure Dental Programs can be fully staffed.
2. Dental Specialists – Dental specialists can provide a higher level of care not ordinarily provided by the general

119 Ibid.
120 Ibid.
121 Ibid.

dentists. Dental Programs have had some success hiring Pediatric Dentists, Oral Surgeons, Endodontists, Periodontists and Prosthodontists, but there have often been long lapses of services when these specialists transfer or leave employment. Support for training currently-employed general dentists to become clinical dental specialists has proven to be an effective program to provide specialty care in the clinics in the past. Unfortunately, lack of funding for these training positions has reduced the number of dental specialists available to provide care. The Indian Health Service needs funding to sponsor salaries and benefits for three positions per year to send current general dentists to specialty training.

3. Loan Repayment – Many dentists graduate from professional school with very high student loan debt. According to the Education Data Initiative, the average debt per dental school graduate in 2022 was $293,900.[116] This high debt load can create a financial hardship for new dentists, who may have monthly payments of $4,000 just to pay off student loans. The Indian Health Service Loan Repayment Program currently offers loan repayment to dentists serving in hard-to-recruit locations in the Navajo Area. The loan repayment award per year is $25,000 (with additional money to pay for taxes on the loan repayment award). The Indian Health Care Improvement Act (IHCIA, 1616(a)) authorizes up to $35,000 per year, with additional funding to pay for taxes. The Indian Health Service needs sufficient funding to pay $35,000 per year in loan repayment to all eligible loan repayment recipients.
4. Dental Assistant Pay – Recruitment and retention of qualified dental assistants has become increasingly difficult. Workforce shortages in the dental assistant specialty has created a supply deficit. Additionally, dental assistants in the private sector can make significantly higher salaries. The Indian Health Service is developing a plan to utilize the Civil Service Title 38 pay plan to offer competitive salaries to dental assistants at all pay scales, but the Indian Health Service needs additional funding to support the pay increases necessary to retain dental assistants.
5. Dental Assistant Training – Dental assistants require technical training to be able perform as part of a dental care team. Dental assistants support dentists and dental hygienists in the provision of care, providing prevention activities such as sealants and topical fluoride. When trained, dental assistants can even place complex fillings. The Indian Health Service has developed a plan to train dental assistants on-site through a certified on-line didactic program and clinical training program. This program is an excellent opportunity for local students to be trained in the dental assistant profession. The Indian Health Service needs funding to hire entry-level dental assistant students and to purchase licenses for this certified dental assistant training program.
6. Infection Control Clinic Updates – Because of the nature of the care provided in dental clinics, there are multiple systems in place to ensure infection control. Dental care requires adherence to strict disinfection and sterilization procedures. Recent accrediting surveys have focused on dental instrument processing, and many of the clinics serving the Navajo Area have had to make significant changes in processing and sterilization procedures. The COVID-19 pandemic further highlighted the need to update infection control systems in the dental clinics, including isolation of rooms and re-engineering of air handling to generate proper air flow, negative pressure and higher air exchange rates. Funding is required to re-engineer instrument processing, air handling and isolation requirements in the dental programs.
7. Specialty Equipment – Higher levels of dental care require not only personnel but specialty equipment to allow the dental team to provide the highest quality of care. Equipment such as operating microscopes, surgical headpieces, dental cone beam computed tomography (CBCT) x-ray units and CAD/CAM dental milling machines would provide state-of-the-art diagnostic and treatment modalities to patients served by the dental programs serving the Navajo Area. These instruments can be used by both general dentists and dental specialists in the provision of care. Funding is requested to equip and update the dental programs with this equipment.
8. Dental Health Aide Therapists – Dental Health Aide Therapists (DHAT) is a relatively new position created to provide limited dental care as part of Tribal Dental Programs.

DHATs are trained as mid-level providers who can provide basic extraction and restorative services under the general supervision of a dentist, thus extending the care that can be offered to patients. The DHAT training curriculum is two years in length, followed by a 400-hour practicum precepted by a dentist. DHATs can then be deployed to practice to provide care to underserved communities. Funding is requested to support students while in training and to support full-time positions as dental providers.

9. Community Dental Outreach Program – A comprehensive prevention program focusing on oral health would significantly reduce the dental disease burden of the population. A community outreach program would target specific age groups such as children and elders, and provide both educational and interventional services. These services would be provided by dental hygienists and dental assistants in locations such as schools, Chapter Houses and nursing homes. Funding is requested to support positions and to purchase portable dental equipment, dental supplies and educational materials.

All of these proposed budget requests will support proven oral health activities, and improve access to dental care. Through increased access to preventive and clinical care, the quality of life and overall health of patients receiving care in the Navajo Area will improve significantly.

Purchased/Referred Care for Transports

The Purchased/Referred Care (PRC) program provides funds for care that cannot be provided at local IHS or Tribal health facilities. It ensures patients have access to health care for standard, specialized, and emergency care and procedures that are not available locally. However, current PRC funding meets only part of the identified need for PRC services. Rural facilities are challenged with limited services related to provider shortages; increased referrals for specialized care such as cancer care, cardiology, or gastroenterology; and long travel distances to tertiary care centers. The geographic distances that patients are required to travel to access the care they need comes with financial cost to patients, their families; and, to the health care facilities that may have to send them emergently. An increase in PRC funding is needed to help defray these transportation costs.

BACKGROUND

Health care for Native Americans lags behind other groups. The United States Government has a legal obligation to provide health care for American Indians and Alaska Natives, yet funding remains a limiting factor in its ability to close the health care gap.

According to the IHS "Disparities" Fact Sheet, American Indians and Alaska Natives (AI/ANs) born today have a life expectancy that is 5.5 years lower than that of the United States' general population. AI/ANs also die at rates higher than other Americans from conditions such as chronic liver disease, diabetes, and chronic lower respiratory diseases. Given the lower life expectancy of the AI/AN population, higher rates of mortality, and preponderance of largely preventable disease processes, it is crucial that there be increased funding to promote health equity for Native citizens.

The Navajo Nation requests PRC funding increases to improve access to specialized services such as oncology care. Cancer is a disease that, if diagnosed and treated early, can result in more positive outcomes. Unfortunately, oncology care is costly, requiring recurring visits to specialists that are often hundreds of miles away. This high cost can be a barrier for many AI/AN patients and their families.

Estimated funding needs:

PROJECT	ESTIMATED COSTS
Emergency Ground Transports	$30 million
Air Transports	$50 million
Non-Emergency Ground	$20 million

EMS is a lifeline for rural hospitals when it comes to transportation. Because many rural hospitals, specifically in AI/AN communities, lack the specialty services available at larger, more urban hospitals, rural hospitals must transfer patients needing critical or specialty care to distant facilities when patient needs exceed local capabilities. Given the long distances, such transports involve significant turn-around time, adding to EMS call volumes and straining resources. When hospitals are unable to transfer patients, emergency rooms, clinics, and inpatient units become overcrowded, which reduces the timeliness and quality of care provided to other patients who present for care. To ensure reliable and timely patient transport, EMS agencies must be sufficiently funded not only for 911 calls, but also for transportation and care of patients in

the inter-hospital and post-hospital settings. The estimated workload at this time for Navajo Area Indian Health Service is between 250-500 transports per month, with a ratio of 2:1 ALS to BLS transports.

The mission of the IHS is to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level. Our vision is healthy communities and quality health care systems through strong partnerships and culturally responsive practices. In the Navajo Area the distance required to obtain needed medical services creates difficulties for staff and patients, and increases wait times. This results in numerous inefficiencies within the https://www.finance.senate.gov/hearings/open-executive-session-consider-favorably-reporting-the-nomination-of-the-honorable-michael-faulkender-of-maryland-to-be-deputy-secretary-of-the-treasuryhealth care system, delaying care. Increased PRC funding for patient transportation will enable IHS to more fully realize its stated mission.

RECOMMENDATION

The Navajo Area requests increased funding for PRC to cover patient transportation costs and thereby ensure access to care that is not available locally. When calculating the PRC funding increase, it is imperative to consider the great distances that many AI/AN patients have to travel.

Hot Issues

Urban Indian Services

ISSUE

In 2024, most American Indians and Alaska Natives (AI/ANs) live off-reservation in towns and cities. There are 41 Urban Indian Organizations around the country whose mission is to serve this population. However, in order to adequately serve the 70 percent of AI/ANs who do not live on a reservation, more funding is needed.

BACKGROUND

Native Americans for Community Action, Inc. (NACA) is an Urban Indian Organization located in Flagstaff, AZ on the border of the largest American Indian reservation in the United States – the Navajo Nation. NACA's mission is to provide preventive wellness services, to empower those who utilize NACA's services, and to advocate for Native peoples with the ultimate goal of creating a healthy community based on Harmony, Respect, and Indigenous values. NACA has served the greater Flagstaff area since 1971 in the capacities of community building, health care, economic development, and more around Northern Arizona. Since its inception, NACA has gained a reputation as a leader and innovator in providing an array of services to beneficiaries.

The term "Urban Indian" refers to AI/AN persons who do not live on a reservation – whether due to the federal government's historical forced relocation policies or due to lack of economic opportunity in rural reservation settings. While many American Indians and Alaska Natives (AI/AN) do live on reservations such as the Navajo Nation, most do not. In fact, Urban AI/ANs now make up more than 70 percent of the AI/AN population. Because of this transition from reservation to urban living, there are now many AI/ANs who live within NACA's service area. Today, NACA provides services such as primary care, behavioral health, alcohol and substance abuse care, and economic development to approximately 7,000 AI/ANs.

RECOMMENDATION

Increased funding for Urban Indian programs will help organizations like NACA improve and expand the health and wellness services they provide to AI/AN populations living off-reservation.

Urgent Need for Long-Term Care Facilities and Elder Care

ISSUE

The issue of long-term and elderly care on the Navajo Nation encapsulates a complex web of challenges deeply rooted in both historical disparities and contemporary struggles. Navajo elders, revered as pillars of cultural wisdom, face obstacles in accessing adequate health care services due to geographical isolation, socioeconomic barriers, and a shortage of culturally competent facilities. Currently, there is only one elderly care facility in the Navajo Area, which is located in Chinle, AZ. Unfortunately, insufficient funding limits the development of additional care facilities tailored to the unique needs of Navajo and San Juan Southern Paiute Tribal members. Recognizing the urgency of this deficiency is crucial for finding a solution that respects and preserves the rich cultural heritage of the Diné while ensuring the well-being of beneficiaries. Addressing these challenges will require a multi-pronged effort that includes establishing a long-term and elderly care budget line item, annual appropriations that grow each year, targeted health care infrastructure development, and the creation of cultural programming tailored to the Navajo community's distinct needs.

BACKGROUND

The lack of IHS for long-term care and elderly care facilities represents a critical gap in health care services for Native American communities. Despite the pressing and unique health care needs of aging individuals within these communities, the lack of specific funding or an earmark for long-term care facilities leaves elders without sufficient access to culturally sensitive and age-appropriate care. This gap not only perpetuates existing health disparities but also undermines the preservation of cultural traditions, as well as the holistic philosophy of well-being held by indigenous communities.

RECOMMENDATION

In order for IHS and Tribes to be able to adequately support long-term care facilities and elderly care, we request that appropriators consider the following recommendations:

1. Dedicated Funding Allocation: Advocate for the establishment of a specific budget category within the IHS budget that is earmarked for long-term care and elderly care. This dedicated funding should be sufficient to cover infrastructure development, operational costs, staff training, and community engagement initiatives.
2. Collaborative Funding Partnerships: Foster partnerships between IHS, Tribal governments, and other relevant stakeholders to pool resources for long-term care and elderly care initiatives. This collaborative approach can leverage diverse funding streams, including federal, state, and private funding sources.
3. Policy Reforms: Work towards policy reforms that prioritize long-term care and elderly care for Native Americans broader framework of IHS. This may involve advocating for legislative changes to ensure the allocation of specific funds for long-term care and elderly services.
4. Grant Programs: Establish and expand grant programs that specifically focus on supporting long-term care facilities within Native American communities. These grants should be designed to encourage innovation, cultural competency, and community engagement in the development and operation of elder care services.
5. Workforce Development: Allocate funds for specialized training programs aimed at enhancing the cultural competency of health care professionals working with Native American elders. This investment ensures that the workforce is equipped to provide sensitive and effective care tailored to the unique needs of the elderly population.
6. Telehealth Initiatives: Invest in telehealth infrastructure to improve access to health care services for remote Tribal areas. This can be a cost-effective solution to overcome geographic barriers and provide elders with timely medical consultations and support.
7. Research and Needs Assessment: Allocate funds for research initiatives and comprehensive needs assessments to better understand the specific health care needs of Native American elders. This data-driven approach can inform targeted interventions and resource allocation strategies.
8. Community Engagement Programs: Set aside funding for community-driven initiatives that actively involve Tribal communities in the planning, development, and decision-making processes related to long-term care facilities. This ensures that facilities align with cultural values and preferences.

By implementing these budget recommendations and actions, there is a greater likelihood of overcoming the challenges associated with the lack of funding for long-term care facilities and elderly care within the IHS system. This multifaceted approach strives to create sustainable solutions that address the unique health care needs of Native American elders while respecting their cultural heritage.

CONCLUSION

Addressing the urgent need for Native American long-term care facilities and elder care requires a comprehensive and culturally sensitive approach. By acknowledging the historical context, understanding current challenges, and implementing targeted budget recommendations, we can honor the wisdom of Native American elders and provide them with the care and respect they deserve. Through collaborative efforts, we can bridge the gaps in health care access and contribute to the well-being of these vital members of our nation's rich cultural mosaic.

Specialty Care Reimbursement

ISSUE

Indian Health Service (IHS) and Tribal health care facilities operating under Indian Self-Determination and Education Assistance Act agreements bill Medicaid and Medicare based on the IHS All-Inclusive or Encounter rates (IHS AIR),

which are reviewed and approved by the Office of Management and Budget and published in the Federal Register on an annual basis.

Unfortunately, IHS AIR do not accurately reflect the Medicare share of costs for some specialty drugs and services. Providing a drug or service that costs a facility more than the payment rate reflected in the IHS AIR is not financially feasible, challenging the facility's ability to continue to provide that specialty service.

BACKGROUND

In 2019, Tuba City Regional Health Care Corporation (TCRHCC) opened a Tribally operated oncology clinic to address the high levels of cancer on the Navajo Nation. Before the center was opened, cancer patients and their families had to travel off the reservation to get the care they needed. This oncology program was created to allow access to cancer care closer to where many patients live.

However, IHS AIR do not sufficiently cover the cost of the infusions that the cancer patients need. For instance, oncology infusions can cost greater than $1000, yet the IHS AIR reimbursement value for FY 2023 was only $620.00. When you consider the multiple treatments required, the facility providing the service incurs a significant cost under this regime.

There are also other specialty drugs and services in addition to high-cost oncology drugs that are not included in the IHS AIR because they are not generally provided by the IHS and therefore not included in the relevant cost reports. There is a need for IHS and Tribal health care facilities to expand services to include specialty care. To be financially feasible it is important that facilities be fairly reimbursed for these services.

RECOMMENDATION

Increased reimbursement for specialty care will allow the IHS and Tribal facilities to improve access to specialty services in the communities we serve. Ultimately, specialty care reimbursement would allow IHS, Tribes and Tribal Organizations to expand the scope of services they provide and thereby improve the health and well-being of American Indians and Alaska Natives.

Homelessness

ISSUE

The Navajo Area requires additional funding to address homelessness, which is a serious public health issue

BACKGROUND

The Navajo Nation does not have a homeless shelter or emergency housing for unsheltered Tribal members. As a result, many individuals will make their way to reservation border towns and hospitals to seek help, especially during adverse weather conditions.

RECOMMENDATION

1. The Navajo Area needs additional funding for to build and operate shelters and emergency housing.
2. With additional funding, the Navajo Treatment Center for Children & Their Families (NTCCF) can help bridge the gap between border towns and the Navajo Nation by providing social services, counseling, and traditional services.
3. The Navajo Nation also needs additional funding for detox centers and more adult treatment centers within its boundaries. Currently, Tribal members much be sent off-reservation for detox services to locations such as Flagstaff, AZ or Albuquerque, NM. This causes financial hardship for individuals and their families.
4. Finally, the Navajo Nation needs funding for family-based in-patient treatment centers. Family-based treatment will aid in family healing.

Medical Equipment Replacement

ISSUE

The provision of quality health care requires the use of an array of medical equipment to diagnose and treat patients. These complex instruments and devices must be replaced periodically to insure that they function reliably and provide state-of-the-art-care. The Navajo Area requests more funding for medical equipment purchases.

BACKGROUND

All medical equipment has a limited life-span, which is determined by manufacturer specifications and the availability of replacement parts. Newer medical equipment tends to be more reliable. It also incorporates updated technology. Both of these factors positively contribute to the quality and efficiency of patient care.

Medical equipment in the Navajo Area is inventoried and assigned an end-of-life date. However, due to funding constraints, medical equipment is often kept in service well beyond this timeframe.

RECOMMENDATION

The Navajo Area requests additional funding to support medical equipment needs. These needs include:

1. Funding to replace all medical equipment and devices that have reached end-of-life per manufacture's recommendations.
2. Funding to purchase or lease any new medical equipment deemed necessary to provide standard of care diagnostic and treatment.
3. Funding to purchase additional laboratory diagnostic testing equipment for in-house testing.

Staffing

ISSUE

Indian Health Service (IHS) and Tribal health care organizations experience significant challenges in recruiting and retaining clinical support personnel such as dental assistants, and laboratory and radiology technicians. Qualified health care personnel have many employment opportunities, and recruitment in rural health care is challenging. Many existing staff are being recruited to higher paying positions in urban areas with more amenities. This loss of vital health care staff leads to reduction in clinical services for Native Americans, leading to negative impacts on health and quality of life.

BACKGROUND

The rural and remote setting of the Navajo Area complicates recruitment and retention of clinical staff. There is a lack of job opportunities for spouses or other family members. There are also very limited school options for their children in most locations. Many of the facilities located on the Navajo Nation are far from amenities such as shopping, and home ownership for professional staff is not possible locally. Road conditions can become hazardous in inclement weather, and airports are located several hours away.

Employment opportunities outside of federal service often offer better pay than current civil service employment. Graduates of health care professional programs often have significant educational debt, which makes pursuing higher salaries and/or better loan repayment options necessary.

Training Navajo students in health care roles not only supports development and employment of Tribal individuals, but also improves recruitment and retention for critical health care positions. Navajo professionals will be more likely to return to the Navajo Nation to provide care to their relatives.

RECOMMENDATION

1. Increase funding and availability for the IHS Scholarship Program and IHS Loan Repayment Program for clinical support staff (i.e., dental assistants, radiology and laboratory technicians).
2. Support review of current civil service pay scales and increase pay based on market review for clinical support technicians. Any recommended increases should be fully funded.
3. Develop and fund formal accredited on-site training programs in conjunction with educational institutions for dental assistants, and laboratory and radiology technicians.
4. Increase funding for ongoing training and skill advancement for all existing staff to maintain quality health care and to keep up with advances in health science, health technology, and health systems. Support cross-training of existing staff to maximize abilities of each individual and to provide depth of service to each health care organization.

Medical Transport Infrastructure

ISSUE

Emergency transport of patients from hospitals and clinics located in the Navajo Area to a higher level of care is vital. Patients may need a higher level of care than can be provided at the Indian Health Service (IHS) or Tribal health care facility, and prompt transport is necessary for provision of required specialty care. Response time is often the critical factor is preservation of health and life.

BACKGROUND

The IHS and Tribal health care facilities serving the Navajo Nation are all considered medically remote. Patients requiring higher level of specialty medical care for urgent and emergent conditions must be transported to tertiary care centers. Transportation by air is ideal, as air transport will get the patient to definitive care quickly, but many of the hospitals and clinics do not have adequate landing facilities for medical transport helicopters and/or airplanes.

Medical transport is further complicated by adverse weather conditions. Flights can be grounded by high winds, thunderstorms, snow and fog, which often significantly delays transport of patients with critical medical needs. Ground medical transportation

can often transport critical patients in inclement weather, thus ensuring the patient will receive appropriate specialty care. Ground transportation can also provide inter-facility transfer for patients with less urgent needs, freeing up air transportation for patient requiring emergent specialty medical care.

RECOMMENDATION

Funding is requested to develop and enhance the following emergency medical infrastructure needs:

1. Construct or update dedicated medical transport helipads at all IHS and Tribal health care hospitals and clinics.
2. Repair and upgrade existing landing strips located on the Navajo Nation to ensure safe facilities for fixed-wing medical transport.
3. Expand Navajo Nation and IHS hospital ground transport to ensure every health care facility is able to provide inter-facility transport. Provide funding for ambulances, positions, and EMT and paramedic training/certification.

Long COVID

ISSUE

The Navajo Area continues to see severe and widespread impacts from COVID-19. Not only do people continue to experience acute infection, but many are also reporting lingering symptoms for weeks, months, and even years after acute infections resolve. This is known as "Long COVID," and the Navajo Area requests additional resources to address it.

BACKGROUND

American Indians and Alaska Natives (AI/AN) experienced the steepest decline in life expectancy of any racial or ethnic group -- from 71.8 to 65.2 years of age -- between 2019 and 2021 (National Center for Health Statistics, 2022). Moreover, a significant proportion of AI/ANs have reported Long COVID symptoms.

Previous work by Johns Hopkins Center for Indigenous Health in partnership with the Navajo Nation found that among 210 adults who participated in a long-term follow-up study, 41.4 percent of those infected with COVID-19 had lingering signs and symptoms 6 months post-infection. Meanwhile, 24.3 percent of study participants reported persistent symptoms at two or more consecutive visits over the course of an entire year. The most commonly reported symptoms were cough, joint or muscle pain, and fatigue. Many reported moderate to severe impairment in at least one domain. In addition, some scores for anxiety, depression, fatigue, and physical function/mobility worsened over time.

The lack of evidence-based interventions for Long COVID, along with the disproportionate impact of the pandemic on AI/AN populations, make it imperative for Congress to appropriate additional funds to IHS, Tribes, and Tribal Organizations so they can better address this problem. Although symptom relief is important, the development of treatments for the underlying causes of Long COVID is critical. Emotional support is also critical, as chronic diseases may be worsened by mental health sequelae. Coping resources, including family support and cultural involvement, have been found to buffer the damaging impacts of stressors for other conditions. We posit that the same will be true for Long COVID.

RECOMMENDATION

While the darkest days of the pandemic are behind us, significant impacts remain. People continue to get sick, and some have never fully recovered from their COVID illness. The Navajo Area requests increased funding to support the following initiatives:

1. Development of evidence-based, culturally-tailored, holistic, and home-centered interventions to support individuals living with Long COVID.
2. Piloting of interventions to support individuals living with Long COVID. Interventions found to be effective could be scaled up for delivery by community health workers (or others) and could be adapted for use with other chronic conditions.
3. Improved access to COVID-19 testing for elders and other key groups by training and empowering community health workers to assist with the distribution and use of self-tests.
4. Promotion of vaccines by understanding facilitators and barriers to uptake.

Infectious Diseases – STIs

ISSUE

HIV and Sexually Transmitted Infections (STIs) are a growing public health challenge in the Navajo Area.

BACKGROUND

The 2018 Centers for Disease Control and Prevention (CDC) Summary Health Statistics for U.S. Adults

reported that American Indians and Alaska Natives (AI/ANs) have over twice the rate of HIV infection compared to their white counterparts. AI/ANs are also more likely to die from HIV infection.[122] Since 1987, the Navajo Nation has seen a steady increase in new cases of HIV infections with the NAIHS, reporting 575 persons living with HIV/AIDS. At the end of 2021, the NAIHS (2023) reported that there were 26 new individuals enrolled in care at NAIHS and 638 facilities for a calculated HIV/AIDS incidence of 10.9 per 100, 000.[123] Evidence suggests that depressed socioeconomic status and poorer health place American Indians at greater risk for contracting HIV.

According to the CDC, reported cases of other sexually transmitted infections (STIs) such as chlamydia, gonorrhea, and syphilis all increased during 2020 and 2021, reaching a total of 2.5 million reported cases nationwide.[124] In the United States, the overall rate of reported chlamydia cases among AI/AN was 3.7 times the rate among the Whites.[125] As for gonorrhea cases among AI/AN, the rate of reported cases was 4.6 times the rate among Whites.

IMPACT

HIV/AIDS in the Navajo Area continues in a steady growth pattern. This is concerning, especially considering the challenges that AI/ANs experience in accessing testing services and care in Tribal communities due to social stigma and confidentiality concerns. In 2014, the CDC reported rate for AI/ANs living with undiagnosed HIV hovers around 18 percent, while the national undiagnosed rate is estimated to be 13 percent. These findings suggest that AI/AN are frequently unaware of their HIV status and do not routinely get tested for HIV. The CDC also reported in 2014 that AI/ANs had the lowest survival rate after an AIDS diagnosis of any demographic in the United States.

The Navajo Area saw 14 deaths among HIV-infected persons in 2021; 2 of those deaths were related to COVID-19.

In terms of STIs more generally, the Navajo Department of Health identified a total of 708 chlamydia cases, 469 gonorrhea cases, and 1,027 syphilis cases across the Navajo Area in 2023. Overall, the total number of diagnoses for chlamydia, gonorrhea, and syphilis were highest (885 cases) among the user population of Tuba City Service Unit in comparison to the lowest number of cases among user population of the Crownpoint Service Unit (32 cases).

RECOMMENDATION

In order to mitigate the impact of rising HIV and STI infections, the Navajo Area requests additional funding for the following:

- The Navajo Nation requests CDC to directly fund the Navajo Nation HIV Prevention Program for the purposes of implementing prevention approaches.
- Health Educators need funding for up-to-date outreach strategies, including harm reduction; PrEP; hepatitis C testing, treatment and prevention; and general STI testing, treatment, and prevention.
- Additional emphasis on women of childbearing age and young men who have sex with men in prevention and screening efforts.
- The Navajo Nation requests that OHAP work with CDC to fund HIV-related capacity building to assist Tribes and Native community-based organizations with the implementation of public health strategies and evidence-based prevention.
- Expand current HIV screening to include rapid screening for hepatitis C and syphilis.
- Funding is needed to develop Teen PrEP Clinics to meet the needs of high-risk Navajo teenagers.
- Increased funding for youth-based prevention activities, including youth-specific health educators, is needed to oversee school health programs and the development of summer education programs.
- Expansion of online HIV and STI education and outreach to include advertisements on smart phones, social media sites, and dating apps.
- Funding is needed to purchase personal protective equipment (PPE), disinfectant products, and custodial services.
- Health educators need funding for electronic devices to perform telehealth appointments for HIV screening, testing, treatment, and counseling.

122 Centers for Disease Control and Prevention. HIV Surveillance Report 2019 (cdc.gov).

123 Navajo Area Indian Health Service (2023). Navajo Area Indian Health Service (NAIHS) 2021 Annual HIV/AIDS Report.

124 Centers for Disease Control and Prevention. (U.S. Department of Health and Human Services 2023). Retrieved from https://www.cdc.gov/nchhstp/newsroom/2023/STD-Surveillance-Report-2021-media-statement.html.

125 Centers for Disease Control and Prevention. (U.S. Department of Health and Human Services 2020). Retrieved from https://www.cdc.gov/nchhstp/healthdisparities/americanindians.html#:~:text=Overall%2C%20the%20rate%20of%20reported,times%20the%20rate%20among%20Whites.&text=In%202018%2C%20the%20rate%20of%20reported%20gonorrhea%20cases%20among%20AI,times%20the%20rate%20among%20Whites.

- Making STI testing and treatment more accessible in rural communities, including the development and approval of rapid test and self-tests.
- Expanding and sustaining local public health services that offer STI testing and treatment programs.
- Enhancing the referral system between different STI prevention and surveillance programs at the federal, Tribal, state, and local levels.

The Navajo Area also requests that 1.) The Secretary of Health and Human Services and the Office of HIV/AIDS Policy (OHAP) convene an annual discussion on HIV prevention in Tribal communities, and 2.) That the DHHS/IHS Behavior Health Services collaborate with Tribal correctional departments and health education programs to conduct alcohol counseling, HIV/STD testing, as alcohol use disorder continues to be a major barrier to HIV care and survival.

Telehealth

ISSUE

The Navajo Area requests additional funding for telehealth to improve the physical, mental, social, and spiritual well-being of American Indians and Alaska Natives (AI/ANs) living in the region's most isolated communities.

BACKGROUND

Telehealth is defined as the use of electronic communications technologies to support clinical health care, health-related education, public health, and health administration (Health Resources and Services Administration – HRSA).

Increasing access to health care for AI/AN patients must include enhancing the infrastructure necessary access care virtually. In many Tribal communities, the nearest hospital or clinic can be more than 100 miles away. Roads are often unpaved and can be impassable during inclement weather.

Virtual care is an attractive alternative to long-distance travel to health care facilities. The Indian Health Service and Tribal partners find telemedicine to be one of the best ways to provide health care to hard-to-reach populations. IHS collaborates with Tribal partners to deploy telemedicine services that respond to patient and community needs. Availability varies by location, but telehealth may facilitate the delivery of specialty services such as behavioral health, dermatology, endocrinology, wound management, and rheumatology.

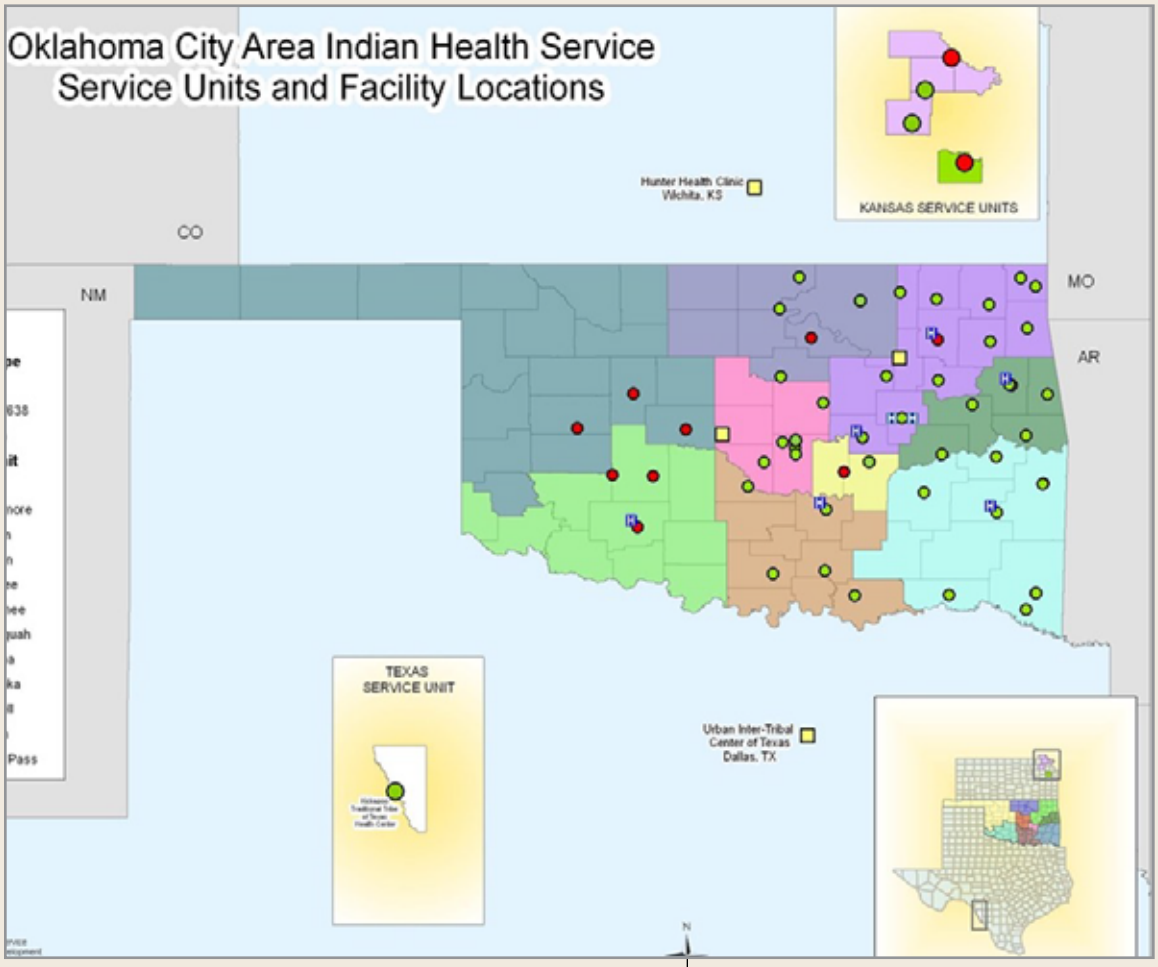
Unfortunately, many of the remote Tribal communities that would most benefit from telehealth services also lack access to broadband internet, which is a prerequisite for video consultations. To fully realize telehealth's potential, a major investment is needed to ensure that all Tribal communities have universal access to broadband internet.

RECOMMENDATION

The Navajo Area requests additional telehealth funding to achieve the following:

1. Improve telehealth access and broadband connectivity.
2. Improve telehealth access for patients with limited access to the internet.
3. Improve telehealth access for people with disabilities.
4. Improve telehealth for patients with limited English proficiency.
5. Improve telehealth for older patients.
6. Improve telehealth for patients with limited digital literacy.

Oklahoma City Area



On November 8, 2023, the Oklahoma City Area Indian Health Service (IHS) convened a meeting with Oklahoma City Area (OCA) Tribal leaders and representatives from Indian Health Service, Tribal, and Urban (I/T/U) health systems to discuss the FY 2026 Budget Formulation process and development of budget recommendations for the National Budget work session.

Two OCA budget formulation representatives were selected. The primary representative is President Terri Parton, Wichita and Affiliated Tribes, and the alternate is Melanie Fourkiller, delegated by Chief Gary Batton, Choctaw Nation. Technical representatives are: Melissa Gower, Chickasaw Nation; Kasie Nichols, Citizen Potawatomi Nation; Nicholas Barton, Southern Plains Tribal Health Board, Terra Branson, Muscogee Nation; Bruce Pratt, Pawnee Nation; Emily Christie, Cherokee Nation; David James, Osage Nation; Ron Grinnell, Iowa Nation; and Kirk Shaw, Osage Nation.

Profile of the Oklahoma City Area

The OCAIHS serves the states of Oklahoma, Kansas, a portion of Texas, and Richardson County, Nebraska. Forty-three federally recognized Tribes are represented within the Area with 38 in Oklahoma, 4 in Kansas, and one in Texas. In FY 2023, the OCA user population was 420,385 the largest user population in IHS. The OCA is the lowest funded IHS Area per capita. The I/T/U health systems within the Area manage nine hospitals, 64 health centers (which includes 5 health clinics in urban locations) and one regional youth alcohol and substance abuse treatment center. The large number of Tribal health care facilities and programs is a strong reflection of the partnership and cooperation within the OCA to fulfill the existing health care needs of our community.

According to the 2022 American Community Survey 5-year report, there are 1,124,412 individuals that identified as either American Indians and Alaska Natives (AI/ANs) alone and/or in combination with one or more other races in the OCA. This represents the potential users for our Area's I/T/U health system that reside within the states of Oklahoma, Kansas and Texas who could potentially be eligible for Indian health services.

The goal is to improve the overall health status of our patients. One challenge is overcoming health disparities such as a higher mortality rate in proportion to the general population. According to the Oklahoma State Department of Health-Vital Statistics, the top ten causes of death for the AI/ANs in Oklahoma with a comparison to All Races combined, shown below. The age-adjusted rate of Deaths due to Diabetes, Accidents, Covid-19, and Chronic liver disease-cirrhosis are at higher rates for AI/ANs compared to all other races for the same period.

TOP 10 RANKABLE CAUSES OF DEATH-ICD10 (STATE OF OKLAHOMA)

AMERICAN INDIAN/ALASKA NATIVES	ALL RACES COMBINED
1 Diseases of heart	**1** Diseases of heart
2 Malignant Neoplasms (C00-C97)	**2** Malignant Neoplasms (C00-C97)
3 Accidents (unintentional injuries) 81.6 per 100,000	**3** Accidents (unintentional injuries) 67.2 per 100,000
4 Diabetes mellitus (E10-E14)	**4** Chronic lower respiratory diseases
5 Chronic lower respiratory diseases	**5** COVID-19 (U07.1) 41.5 per 100,000
6 COVID-19 (U07.1) 53.1 per 100,000	**6** Cerebrovascular diseases
7 Chronic liver disease cirrhosis (K70, K73-74)	**7** Alzheimer's disease (G30)
8 Cerebrovascular diseases	**8** Diabetes Mellitus (E10-E14)
9 Alzheimer's disease (G30)	**9** Intentional self-harm, suicide (X60-X84, Y87.0)
10 Intentional self-harm, suicide (X60-X84, Y87.0)	**10** Chronic liver disease cirrhosis (K70, K73-74)

Source: Oklahoma State Department of Health (OSDH), Center for Health Statistics, Health Care Information, Vital Statistics 2022-2023 on Oklahoma Statistics on Health Available for Everyone (OK2SHARE). Ranking based on Age Adjusted Death Rate.

Budget Recommendations

Indian Health Care Improvement Fund (Hospitals and Health Services)

The Indian health system faces significant funding disparities when compared to other Federal health care programs. The historic allocations of resources appropriated to the IHS have created significant inconsistencies throughout the system. Over the years, allocation methodologies have created a disparity of available resources by line items when reflected in a per capita amount. While youth trauma, suicide, and substance abuse treatment are priorities, so are elders with heart disease and dementia, children who need vaccinations or suffer a routine infection, as well as adults with type 2 diabetes or bipolar disorder. In short, quality health services remain a priority for all our Tribal citizens. The OCA has historically had the lowest funding per capita amongst the twelve areas in overall IHS funding, in FY 2023 the OCA per capita amount is $2,318.

The Indian Health Care Improvement Act (IHCIA) established the Indian Health Care Improvement Fund (IHCIF) to eliminate the deficiencies and inequities in health status and health resources in Indian Country. Despite significant AI/AN health disparities and a legislative mechanism to address resource deficiencies and inequities, only $258.8 million has been distributed to IHS Service Units, Indian Tribes, or Tribal organizations through the IHCIF via the Level of Need (LNF) formula since adopted in 2001. While Tribes are appreciative of the 2018 allocation of $72.28 million, the IHCIF was not allotted additional funding in FY2019, FY2020, FY2021, FY2022 or FY2023. Given that user population is increasing year over year, inflation continues to increase, and health disparities continue to grow, steady consistent funding is necessary to achieve the goals of the IHCIF. Unfortunately, gains in parity also have been negated by rescissions and sequestration. All the Indian health system is underfunded, however the most underfunded units require immediate attention.

In FY 2027, the OCA requests a substantial increase for the IHCIF. In 2018, the joint Tribal/Federal workgroup issued an interim report that included an initial set of recommendations, referred to as Phase I recommendations and conducted their Phase II work from August 2018 to March 2019. The final report of the Indian Health Service (IHS) Indian Health Care Improvement Fund (IHCIF)

Workgroup was completed and submitted on July 15, 2023 and provides the final conclusions and recommendations of the Workgroup, including a description of critical points determined to be notable to any discussion of Indian health care system funding needs but tangential to the Workgroup charge, which was focused solely on the formula used to allocate appropriations increases for the IHCIF. The OCA strongly suggest the IHS:

1. Utilize the final report's recommendations on any new allocation of funds for the IHCIF;
2. Communicate the new allocation methodology for the IHCIF to all Tribes;
3. Update the data in the IHCIF allocation methodology and release to all Tribes annually;
4. Identify and train new permanent statistical/technical staff as point of contact for future IHCIF need calculations; and
5. Reduce per capita disparities for the most underfunded as the top priority to promote greater equity in health care funding.

Any major increases in funding for the Indian health system should be distributed through the IHCIF formula to ensure all increases are equitable and fair which will ensure greater access to high quality, culturally appropriate care and services across the I/T/U system for the ever-increasing user population.

Maintenance and Improvement

Maintenance and improvement (M&I) funds are the primary source for maintenance, repair, and improvements for IHS and Tribal health care facilities. Funding infrastructure maintenance is central to the delivery of and access to quality health care services. Recent Congressional increases to M&I provided for routine maintenance and some major repairs. Persistent underfunding and delayed facility replacement, however, generate exponential growth in need.

The average age of IHS health care facilities is 42 years, with only limited recapitalization in the plant due to a growing Backlog of Essential Maintenance, Alteration, and Repair (BEMAR). Comparatively, the average age, including recapitalization and reinvestment, of U.S. private sector hospitals is approximately 11 years. Failure to fully fund BEMAR exacerbates the overall quality of and access to care across the entire IHS Health System. New facility construction is similarly underfunded and physical plants are not being replaced. Therefore, sustainable funding is essential to ensure functional health care facilities that meet building and life safety codes, conform to laws and regulations and satisfy accreditation standards.

Given the underfunded situation, IHS and Tribes have been forced into a deferred maintenance scenario which is the practice of postponing maintenance activities in order to postpone costs, meet budget funding levels, or realign available funding. The failure to complete needed repairs will lead to asset deterioration resulting in higher costs, asset failure, and health and safety implications. Geaslin's Inverse-Square Rule for Deferred Maintenance says that maintenance deferred until failure will cost 15-fold the repair value or the original value squared. The OCAIHS is concerned that unless a substantial infusion of M&I funds is provided in the FY 2026 budget cycle, that the Area will not be able to perform many required maintenance and improvement projects and this will cause irreparable harm to many IHS and Tribal facilities. Current BEMAR total need as of June 2021 is approximately $945 million. The OCAIHS recommends a significant increase to maintain existing IHS and Tribal facilities. Further, the Area requests that any increases are committed to BEMAR related projects.

Purchased and Referred Care (PRC)

Purchased Referred Care is health care purchased by an Indian health care provider from non-Indian health care providers and facilities when direct health care services are not available.

The OCAIHS ranks last of the twelve IHS Areas in funding available for PRC services based on active patients. The level of funding in OCA was $302.06 per person for FY 2023. As a result, the IHS is not able to purchase needed care from specialists and must prioritize its expenditures for only the most serious and life-threatening care. Historical data indicates a majority of the current base PRC funding is used for Priority I (life and limb threatening) services, which impacts the ability of IHS to meet its Mission of raising the health status of the AI/AN people to the highest possible level.

The sheer volume of OCA PRC denials/deferrals illustrates the need for additional funding. In FY 2023, the numbers of PRC denied cases were 24,635 and deferred cases totaled 25,126 for those facilities reporting. Of the deferred cases, over 95% were for acute and chronic care. In FY 2023, OCA Catastrophic Health Emergency Fund (CHEF)

reimbursed cases was approximately $4.3 million. Furthermore, in the last five years (2018-2023), the OCA averaged over 16% of funded CHEF cases nationally but was funded at only at 10% on average for the PRC program when compared to all other IHS Areas combined.

Again, the OCA does not have adequate funding for specialists, such as cardiologists, oncologists and specialized surgeons, readily available. OCA does not have tertiary hospitals and must utilize PRC to provide that aspect of specialty care. The cost of providing such services is disproportionately burdensome on all PRC resources. The existence of IHS/Tribal hospitals in OCA does not mean there are specialty services available, which must be purchased, nor timely access to direct services, due to waiting times for appointments.

The lack of appropriations leaves many without access to primary health care services and even more to specialty and referred care. Other barriers also exist, such as, distance from an IHS/Tribal facility, overburdened health care facilities due to lack of resources, and services not provided due to lack of resources.

Due to the lack of PRC resources available per patient, IHS-eligible individuals are routinely denied access to needed care until the situation is grave enough to threaten life or limb. Routinely denied and deferred services consist of orthopedic diagnostics and treatment, which often prevents AI/ANs from being in the workplace. Other services, such as sophisticated diagnostic procedures, are also often denied or deferred due to medical priority.

The OCA recommends continuing increased funds for PRC by making it a high national priority. The OCA also recommends that distribution continue to be primarily based upon the patient population to be served with PRC.

Although the positive impact of Medicaid expansion has been profound on a national level, the IHS has noted that Oklahoma City Area remains one of the few IHS Areas that still only fund Priority Level 1 services for PRC, which is borne out by the numbers of denied and deferred cases described above, as well as the increase in CHEF requests from OCA. In its 2019 report, numbered GAO-19-612, the Government Accountability Office found that from 2013 through 2018, most IHS-administered PRC programs moved from covering only the most acute and emergent cases (referred to as Priority 1) to funding nearly all types of care covered by the PRC program.

Prioritization of PRC directly contributes to access to care described in Goal 1 of the IHS Strategic Plan, which states:

Access: Many facilities operated by the IHS and Tribes are located in rural or remote settings and may be unable to provide comprehensive health care services and/or acute and specialty care services. To help meet the health care needs, the PRC program purchases services from private health care providers for eligible patients. Although PRC funding may meet the full patient need in some IHS areas, funding may not be sufficient to meet the need in others.[126]

The OCA continues to support resetting the CHEF threshold to $19,000 per eligible case. CHEF has had sufficient appropriations in recent years to cover all eligible cases, and the lower threshold will assist smaller PRC programs that lack the resources to forward-fund catastrophic cases.

The OCA also supports the current PRC formula, which prioritizes new PRC appropriations towards inflation and population growth, mitigating the erosion of purchasing power per patient. Although the PRC formula contributes to this effort, OCA continues to experience a steady reduction in PRC funding per patient each fiscal year due to insufficient appropriations. New PRC appropriations must continue to be prioritized to maintain the current level of services with the formula, before addressing other needs.

Urban Facilities

Although 78% of AI/ANs reside in urban areas, the IHS funding allocation for urban Indian health only reflects close to 1% of the total annual IHS budget. The Urban Indian Health budget request is at $970 million for FY2024 for essential funding to support and sustain the capacity demand on programs, to support ongoing chronic effects of the COVID-19 pandemic, and to address the systemic gap in social determinants of health.

In addition, Urban Indian Organizations (UIOs) do not receive funding from other line items which

126 Department of Health and Human Services, Indian Health Service. (2019) Indian Health Service Strategic Plan. Retrieved from https://www.ihs.gov/sites/strategicplan/themes/responsive2017/display_objects/documents/IHS_Strategic_Plan_FY%202019-2023.pdf

the other facets of the IHS system receive, such as the facilities line-item budget. While billions in facilities funding has been allocated to IHS, UIOs are not eligible for the IHS Facilities or Sanitation line items and zero of the 41 UIOs are on the IHS Facilities Priority List or are eligible to be on the list. It is critical that all three parts of the I/T/U (IHS, Tribal Health Program, UIO) system receive adequate facility funding to better serve the AI/AN population.

UIOs are also ineligible for other payment options that reduce costs for the other facets of the IHS system – including 100% Federal Medical Assistance Percentage (FMAP). Historically, in the I/T/U system, only UIOs have been excluded from the 100% FMAP rate. Because services provided at UIOs have not been reimbursed by the federal government at 100%, UIOs receive less third-party funds, limiting their ability to collect additional reimbursement dollars that can be used to provide additional services or serve additional patients. The American Rescue Plan Act temporarily authorized 100% FMAP for services at UIOs for two years, however, permanently authorizing this rate is crucial for UIOs to better provide services to Urban Indians.

There is a total of 41 UIOs spanning across 22 states, including five UIOs in the Oklahoma City Area: Hunter Health in Wichita, KS; Kansas City Indian Center in Kansas City, MO; Urban Inter-Tribal Center of Texas in Dallas, TX; Indian Health Care Resource Center in Tulsa, OK; and Oklahoma City Indian Clinic in Oklahoma City, OK. These UIOs are operating pursuant to a grant or contract under Title V of the Indian Health Care Improvement Act and embody the third prong of the Indian health care delivery – I/T/U system.

Because UIOs receive substantially less funding from the IHS budget, they are often faced with the harsh reality of obtaining supplemental sources of funding to provide more services to more AI/ANs living in urban areas. It is recommended we prioritize urban Indian health funding as a part of our Tribal health priorities to advocate that Congress increase the budget to appropriate funding levels for all American Indians and Alaska Natives.

Hot Issues

Mandatory Funding & Advanced Appropriations

ISSUE

To fulfill the federal government's trust responsibility to provide health care to its First Americans, the funding for IHS must be designated as Mandatory Funding.

BACKGROUND

The President's FY2023 and FY2024 budget request for mandatory funding was truly historic and we appreciate the budget requests. We also understand that these budget requests were an initial step in the process to convert to a mandatory appropriation and hope the administration will continue to work with Tribes to refine the proposal.

This initial step led to a historic accomplishment of Advance Appropriations for the Indian Health Service. For that we are very grateful. We urge the administration to continue advocating for Advance Appropriations each year and include all IHS line items in the authority.

However, we also believe Advance Appropriations is an interim measure until mandatory funding for IHS and other Tribal Health provisions can be achieved. While the use of the term entitlement is not respected as it should be, like social security, Tribal Health was prepaid in full based on over ½ billion acres of Indian lands ceded in exchange for the "Health" provisions in treaties.

There are several activities being worked out between IHS and the Tribes to ensure any mandatory proposal is endorsed by both the administration and Tribes. The IHS Mandatory Funding sub-workgroup has met three times this past year and will continue to meet in the new year. The sub-workgroup and IHS is also meeting with the National Indian Health Board who is leading the effort to create an estimate for full funding for Indian Health Service by January 31, 2025.

RECOMMENDATION

The OCA recommends that IHS, HHS, OMB, and the administration commit to continue engaging with the IHS Mandatory Funding sub-workgroup to develop the mandatory funding proposal and the National Indian Health Board in creating an estimate for full funding for Indian Health Service by January 31, 2025. The estimate should also include a full funding distribution using only a fair and equitable

methodology. The OCA also recommends that mandatory funds should be distributed according to the current Indian Health Care Improvement Fund methodology until full need is met for all Tribes at which point the IHCIF would no longer be needed for future increases. Once all sites are fully funded, all annual increases in a mandatory funding environment should be based on population considering annual population growth and medical inflation rates.

Indian Health Care Improvement Fund Move to Hospitals & Health Clinics

ISSUE

The Indian Health Care Improvement Act (IHCIA) established the Indian Health Care Improvement Fund (IHCIF) to eliminate the deficiencies and inequities in health status and health resources in Indian Country. The IHCIA Section 1621(g) requires the IHCIF to be included in the IHS base budget for the purpose of determining appropriations. The IHCIF was traditionally managed under the Hospital & Health Clinics (H&HC) base budget line item; however, Congress moved the IHCIF appropriation to a separate line item in 2018. This move was detrimental for the OCA Tribes who rely heavily on the IHCIF allocation. For example, in the last five years, Congress applied base budget recurring inflationary increases only one time to the IHCIF- in FY2022. Furthermore, the final FY2023 appropriations authorizing FY2024 Advance Appropriations (AA) for the IHS left the IHCIF out of the appropriation, even though all other base budget line items were funded through AA.

BACKGROUND

The Indian health system faces significant funding disparities when compared to other Federal health care programs and remains chronically underfunded at around $4,000 per user. In addition, historic allocations of resources appropriated to the IHS have created significant inconsistencies throughout the system. Over the years, allocation methodologies have created a disparity of available resources by line items when reflected in a per capita amount. Because of this, the Oklahoma City Area (OCA) has been severely under resourced with an ever increasing population. Of all IHS Areas, the OCA has historically had the lowest funding per capita amongst the twelve IHS Areas and is currently funded at only $2,318 per user. The IHCIF exists to address such inequity.[127] The current IHCIF distribution methodology targets funding to the neediest of Tribes to bring funding and health status equity to more sites across the IHS. For this reason, OCA Tribes rely heavily on the IHCIF allocation, and it is consistently the top budget priority for the severely underfunded OCA.

RECOMMENDATION

The OCA strongly recommends that the Indian Health Care Improvement Fund budget line should be moved back to the Hospitals & Health Clinics line item where it can be treated as base funding for future Advance Appropriations and inflationary increases.

Necessity for a Youth Regional Treatment Center

ISSUE

Indian youth in the Oklahoma City Area (OCA) face a myriad of risk factors including fragmented families with little structure/stable living conditions or income, history of substance abuse and mental health issues among family members, incarceration of family members, physical, psychological, and sexual trauma, peer pressure, bullying, substance abuse, neglect, abuse, emotional difficulties/ depression, and suicide. An environment in which a high prevalence of mental health and substance abuse disorders is the result. A Youth Regional Treatment Center in the OCA comprehensively dedicated to mental health and substance abuse disorders will help young people move forward into adulthood with the better outcomes available to them than without the center.

BACKGROUND

The 2019/2020 Oklahoma Prevention Needs Assessment Survey cited the following issues among American Indian/Alaska Native children and youth compared to non-Indians in their grade level:

- 65.9% of Indian children in grade 12 drank in their lifetime compared to 63.4% of non-Indians
- 48.1% of Indian children in grade 12 used marijuana in their lifetime compared to 44.2% of non-Indians
- 13.5% of Indian children in grade 12 used prescription pain relievers in their lifetime compared to 8.5% of non-Indians
- 3.8% of Indian children in grade 6 had been drunk or high at school during the past year and this further increased to 20.8% of Indian children in grade 12
- 10.4% of Indian children in grade 12 had attacked someone during the past year with the idea of seriously hurting them compared to 4.3% of non-Indians

127 https://www.govinfo.gov/content/pkg/USCODE-2011-title25/pdf/USCODE-2011-title25-chap18-subchapII-sec1621.pdf

- 14.5% of Indian children in grade 12 compared to 11.6% of non-Indian youth needed either drug or alcohol treatment during the past year
- 9.6% of Indian children in grade 12 attempted suicide compared to 7.2% of non-Indian youth

Anadarko, Oklahoma, a town in southwest Oklahoma home to several Tribal Nations, was the site of a suicide cluster involving four youth, three of whom were American Indian and there have been several other suicides in the area since then. At the Riverside Indian School (RIS) in Anadarko, during 2016, 18 hospitalizations were required for suicidal ideation and less than one-half way through the 2017-2018 academic year, 11 admissions to treatment had been required.

A survey within the last few years of students at the Riverside Indian School (RIS) in Anadarko showed that during the past three years, 476 students were in need of a mental health/substance abuse referral. Of students surveyed over the course of three years, 9.5% had a history of substance abuse in their family (13-14=13.8%, 14-15=5.3%, 15-16=9.7 %). Further, 30% of students had used some drug during their lifetime, 13% had used cannabis in the past 30 days, 6.5% had used alcohol in the past 30 days, and 0.8% had used any other drug including inhalants in the past 30 days. Further, 3.7% of the students had been in mental health or substance abuse treatment/ recovery and 0.8% desired treatment. Thus, there is a significant need for regional residential (inpatient) treatment for substance abuse/dual diagnosis youth at the Riverside Indian School.

The OCA, including RIS, has few mental health and substance abuse resources for young people, particularly those experiencing a high prevalence of risk factors and barriers to care. Present outpatient services are insufficient to deal with the serious problems of alcohol and substance abuse and accompanying co-morbidities. Native youth in need of professional and culturally appropriate mental health or alcohol or drug treatment must travel a great distance at significant expense.

The only AI/AN youth treatment facility for the OCA is in Tahlequah, Oklahoma, which is in the extreme northeastern portion of the state. Many families lack dependable transportation or funds to utilize such a distant facility. Indian youth in Oklahoma experience serious barriers to treatment because family therapeutic intervention, which is paramount, would be exceedingly difficult as well. Most addictions take more than one course of treatment over time, therefore having a more regional treatment center would improve the overall outlook for youth who need said treatment.

RECOMMENDATION

A Youth Regional Residential Treatment Center (YRTC) is necessary to serve several complex behavioral health functions, including a scaled down treatment option before students are returned to the boarding school or to their home communities; an interim placement alternative for youth who need more structure and a higher level of behavioral health services than that provided by a school; and/ or early screening and problem identification for all Native children is imperative to address more severe cases of emotional and behavioral problems before they reach crisis proportions.

Supporting Electronic Health Records Modernization Efforts

ISSUE

The Secretary should request the full amount necessary to acquire and implement an enterprise-wide Electronic Health Record (EHR) system.

BACKGROUND

In Fiscal Year 2019, the Department of Health and Human Services (HHS) and Indian Health Service (IHS) evaluated the current electronic health record system, the Resource and Patient Management System (RPMS) and, based on the evaluation, developed the Roadmap Report. The Roadmap Report identifies required actions to address the long-awaited requirement to modernize IHS systems, including establishment of a Project Management Office and governance structure, acquisition planning, Health Information Technology (HIT) selection and procurement, implementation planning, and testing. IHS continues to make progress on the plan, including the selection of General Dynamics Information Technology, Inc. to build, configure, and maintain a new IHS enterprise EHR system that utilizes Oracle Health's Cerner technology. Most recently, the Office of Information Technology has identified that the total costs for implementation over the next ten years will be $4.5 to $6.2 billion. Timely appropriations to support development and implementation of the EHR are critical to the project's success and the expected benefit.

Congress has made incremental investments in modernization efforts. However, to achieve the results that support stakeholder needs, HHS must request and receive dedicated and recurring

appropriations to stabilize RPMS functionality and to implement and maintain the future EHR system.

RECOMMENDATION

OCA supports continuation of the congressionally appropriated funding for IHS HIT modernization projects. Therefore, OCA recommends that IHS and HHS commit to requesting the funding necessary annually until the modernization planning, transition, and implementation is completed. Further, OCA recommends that this funding remain a separate line item within the IHS or HHS budget to create transparency and to ensure appropriate progress on the project. Finally, OCA requests that the Secretary initiate Tribal consultation to develop an equitable Tribal shares distribution methodology that ensures Tribes receive a proportionate share based on their specific requirements, user population size, and existing health care infrastructure including support for EHR systems that are currently funded and operated by Tribal health systems.

OCA recommends IHS continue to seek substantial Tribal input and provide transparent and regular updates about the process to Tribal leadership and technical stakeholders. Furthermore, OCA recommends Tribal representation to be on the multi-member governing body in order to achieve an effective and representative governance structure.

Special Diabetes Program for Indians

ISSUE

The Special Diabetes Program for Indians has gone through several rounds of temporary reauthorizations over the years and no increases to the mandatory funding in its 26-year history. The continued uncertainty of reauthorization leaves Tribes unable to adequately plan and implement a quality program. Tribes demand the SDPI to be a sustained, high-quality treatment and intervention program.

BACKGROUND

The SDPI program has made an impact within Tribal communities. Between 2013 and 2017, type II diabetes in Native adults has decreased from 15.4% to 14.6%. The program is also credited with decreasing End Stage Renal Disease by 54% and decreasing diabetic eye disease by 50%. However, over the past 26 years, the SDPI program has endured several funding extensions due to lack of timely congressional action; these extensions ranged from several weeks to several months!

SDPI has become a crucial preventative and clinical program for Tribal health care to prevent long-term illness. In fact, many Tribes have integrated SDPI fully into their clinical day-to-day responsibilities. The short studies referenced above are good indicators of a successful program, however a stably funded program would allow for the Tribes to evaluate the effects of program objectives and goals long-term.

RECOMMENDATION

First and foremost, permanent reauthorization of SDPI would decrease burdensome administrative constraints grantees currently experience, such as the ability to recruit highly qualified staff on a permanent basis; ability to extend diabetes prevention initiatives and practices beyond a grant cycle period; and lessen the burden of uncertainty for SDPI to be reauthorized. Tribal awardees have demonstrated the ability to create outstanding prevention programs with SPDI funds since the grant's inception.

An increase in funding to at least $250 million would provide a substantial increase to not only maintain current programs, but it would also allow for a continued opportunity to bring on new Tribal health programs who have not been able to apply for the SDPI previously without affecting the programs already in place. An increase would also allow Tribal programs to include new and innovative medicine to be used in prevention and treatment programs.

Another recommendation is to treat SDPI program funds in the same manner as other program compacted/contracted funds eligible for inclusion in Indian Self-Determination and Education Assistance Act agreements. By compacting or contracting this piece, the administrative burden would be lessened on or altogether eliminated for grantees. Tribes are also advocating for SDPI to be eligible to receive Contract Support Costs from the annual CSC appropriation line item. Such inclusion would allow for more SDPI funds to be obligated for treatment and intervention rather than administrative costs. Other burdens improved would be the application process, programmatic reporting, and financial accounting streamlined into Annual Funding Agreements and Title I/Title V negotiation processes.

Joint Venture Construction Program (JVCP)

ISSUE

The JVCP is one of the most successful, expedient and cost-effective means of providing new and replacement facilities in the Indian health system. It is a successful partnership with Tribes providing funding for the construction, and often the equipment, and the IHS committing to request Congressional appropriations for the operations. This leverages scarce Federal appropriations with Tribal resources, while also providing sustainable operating funds that allow the ability for health services to grow over time, unlike grant programs.

BACKGROUND

The IHS replicated the weaknesses of the Health Facilities Construction Priority System (HFCPS) by using the 2014 JVCP competition to create another prolonged waiting list, which delayed a new competition until late 2019. There are no facilities located in OCA on the HFCPS list (IHS or Tribal), and the last OCA facility was completed over sixteen (16) years ago. IHS would need HCFC appropriations of $750 million/annually to match the U.S. expenditures in health care facility construction, making the HCFC wholly unresponsive to needs in OCA, the largest IHS Area. The JVCP is simply the only viable option for timely addressing health facility needs in the OCA and across the nation. Despite the large relative number of JVCP facilities completed in OCA, the Area continues to lag 10% behind the national IHS average of level of need funded, at 38% LNF. Congress has historically strongly supported the JVCP, and IHS requests for funding are included in binding commitments that are separate from other budget priorities.

RECOMMENDATION

The IHS should increase its participation in JVCP, including the number of projects being undertaken or in process each year. There should be a larger number of projects ongoing in each fiscal year, given that this option saves scarce federal resources and is more responsive to dire facility needs in the IHS.

IHS should immediately adopt changes to the JVCP to incorporate all types of facilities to accommodate services authorized by the Indian Health Care Improvement Act, including but not limited to skilled nursing, behavioral health (inpatient and outpatient), and long-term care services and supports.

It is urgent and necessary that the JVCP be opened for competition on a regular cycle at least every two years, and select all projects that are eligible. At each competitive cycle, non-selected applications should be eligible to reapply during the next competitive cycle. Congress has supported in the Conference Language for the FY 2020 Interior Appropriations Bill. The JVCP is a cost-effective investment, and a true partnership; most importantly, it will increase access to care in the IHS, and specifically within the OCA.

Indian Health Grant Funding and Contract Support Costs

ISSUE

Addressing chronic Indian health conditions through disease-specific grant programs is not reasonable. Grants should never be used to fund ongoing critical health needs. Grants are mostly competitive, non-recurring and burdensome to manage due to varied application processes and reporting requirements. Simply put, grant funding does not uphold the trust and treaty obligations of the United States. The entire grant-making process often burdens the neediest Tribal communities who lack the capacity to secure or administer such programs. Ironically, additional administrative pre- and post-award mandates are placed on grantees, yet Contract Support Costs (CSC), the administrative funds obligated in addition to direct base funding, are not provided to manage grant awards. Instead, only indirect costs can be subtracted from the total grant award, resulting in far less funding for the provision of health services. Tribal communities are committed to long-term positive health outcomes and should not be held hostage to cumbersome and time-consuming grant processes that divert health resources away from patient care.

BACKGROUND

The OCA is concerned about current grant programs and funding increases for critical Indian Health programs that are redirected to special grant initiatives where not all I/T/Us receive grant awards. This continues to happen despite explicit feedback through Tribal consultation and National Tribal Advisory Committee on Behavioral Health recommendations to the contrary. One example is the reissuance of the IHS Behavioral Health[128] and Domestic Violence Prevention[129]programs (formerly Methamphetamine and Suicide Prevention Initiative (MSPI) and Domestic Violence Prevention Initiative (DVPI)). The decision to distribute this

128 https://sam.gov/fal/a86728e2c04743d3a37e7596203f3423/view.
129 https://sam.gov/fal/6364427463494ae4be72e8571d9459d2/view.

program funding through a granting mechanism is despite Tribal consultation feedback where the grant-making process was strongly opposed. The IHS issued 6 grant announcements, some of which created new programs. Tribes competed for each of these separate grants even though all experience critical behavioral health and alcohol and substance abuse crises. Although IHS proposes that competitive grants reach the neediest communities, this is not true. Instead, many of the neediest Tribes have no capacity to apply for, much less administer, such programs. Each of these grants require semi-annual progress and quarterly financial reporting and compliance with the standard and burdensome HHS grants management policies and procedures. However, additional CSC funding is not provided for grant administration, even though 1) statutes do not exempt special projects or grant funding from the mandate to pay CSC in full and 2) Congress appropriates CSC based on estimated need under an indefinite appropriation to prevent a CSC "shortfall" funding environment. Instead, grantees must subtract their administrative (indirect) costs from the total grant award, which results in less direct service provision funding.

RECOMMENDATION

OCA recommends that the IHS implement the President's Executive Order on Reforming Federal Funding and Support for Tribal Nations to Better Embrace Our Trust Responsibilities and Promote the Next Era of Tribal Self-Determination[130] by eliminating the practice of grant making. Instead, a permanent recurring base should be developed for Tribally determined programs and services. Tribes agree that directly providing services has greater impact and is a higher priority than competing for grant applications or managing burdensome grant processes. OCA continues to support the Congressional directive to transfer behavioral health initiative funding through direct funding mechanisms such as compacts and contracts as formula funds versus competitive grants, and to ensure that CSC are authorized and payable. The OCA strongly discourages funding new "set-aside" grant programs, which should always be gauged against ongoing critical funding shortages afflicting Tribal communities.

Sanitation Deficiency System Guidance and Implementation

ISSUE

IHS issued the final updated SDS guidance in September 2019 for implementation in FY 2020. One-third of the Tribal comments/ recommendations made in response to a published draft were determined to "conflict with the SFC Program's statutory requirements and/ or fundamental policy decisions" as outlined in the Summary of Tribal Consultation Comments and Recommendations and were not considered further. Several of the comments disagreed with the deficiency levels classifications of SFC projects. Other recommendations suggested that SFC funding allocation methodology be re-evaluated. This Tribal feedback remains unresolved today; the OCA has been alarmed that these recommendations were ignored because they are having a significant and detrimental effect on the funding of critical sanitation deficiencies in the OCA. During FY 2021, the IHS was awarded one-time SFC funds in the amount of $3.5 Billion under the Investment in Infrastructure and Jobs Act (IIJA) IHS used a static 2021 project list to "fully fund" the full SFC need. The OCA maintains that the project priority list is unfair and that the final allocation decisions detrimentally affect the OCA's Tribal communities. Finally, the IIJA provided up to 3 percent of the funds ($21 million) for "salaries, expenses, and administration" each fiscal year, yet these funds were only available to support federal costs.

BACKGROUND

The SFC-SDS Guidance, last updated in 2003, was revised and released for Tribal consultation in 2018 and finalized for implementation in FY2020. Critically essential elements of SDS that effect project funding, such as the classification of the deficiency levels, were not subject to consultation. The lower the deficiency level, the fewer points assigned to the SDS project; low-scoring SDS projects are usually not funded due to limited SFC funds. The funding allocation as outlined in the Criteria document[131] for Regular and Housing Support projects places a lower priority on Housing Support (New and Like-New) Projects. Regular funds make up a greater proportion of the total SFC funding allocation. Funds from the Regular category cannot be spent on projects supporting new and like-new construction, which is the largest part of the Housing Support category. This unfairly

130 https://www.whitehouse.gov/briefing-room/presidential-actions/2023/12/06/executive-order-on-reforming-federal-funding-and-support-for-Tribal-nations-to-better-embrace-our-trust-responsibilities-and-promote-the-next-era-of-Tribal-self-determination/.

131 https://www.ihs.gov/sites/dsfc/themes/responsive2017/display_objects/documents/Criteria_March_2003.pdf.

underfunds the OCA, which has a higher share of projects in the Housing Support category. The allocation of funds between Regular and Housing Support is made solely at the discretion of IHS Headquarters OEHE, without Tribal Consultation.

The Project-based funding allocation methodology is flawed and was never more apparent during the unprecedented amount of SFC funding received through the IIJA. $3.5 Billion was set aside to address the full SFC need based on a static project list. In addition, Congress directed IHS to use a potentially sizable portion, up to $2.2 Billion, to fund "economically infeasible projects". Economic infeasibility could mean that the costs far exceed the benefit in an unreasonable way; for example, the construction of a water line hundreds of miles away to serve only one or two homes comes at an astronomically cost – a cost that could otherwise impact many homes or a community. Without reasonable criteria and guardrails, economically infeasible projects could consume most of the funds, leaving many economical, feasible, water and sanitation needs still unfunded. Finally, Congress required up to 3 percent of the funds ($21 million) be used for "salaries, expenses, and administration" each fiscal year, yet these funds were only specified for federal versus Tribal administrative costs.

RECOMMENDATION

IHS must reengage in meaningful discussion with Tribes regarding the outstanding/unresolved Tribal comments received during the consultation period; in addition, the Guidance document incorporates the outdated Criteria document, which should be submitted for meaningful Tribal consultation as soon as possible. Furthermore, if IHS continues to use its static project list to fund large economically infeasible projects then much of the unprecedented funding available for SFC under IIJA could consume most of the funds, leaving many economical, feasible, water and sanitation needs still unfunded.

OCA recommends that the IHS implement the President's Executive Order on Reforming Federal Funding and Support for Tribal Nations to Better Embrace Our Trust Responsibilities and Promote the Next Era of Tribal Self-Determination to work with Tribes to develop a formula that considers population and other existing factors, rather than project-based methodology to fund SFC-SDS. Though Chapter Four of the Criteria document validates funding allocation through the Project-Based Funding Principle, the use of this allocation methodology is flawed. SFC-SDS is an ongoing program in which projects should be prioritized as a plan approved by health boards, much like Tribal housing or transportation improvement plans. Lastly, IHS should propose and support an annual Tribal administrative cost set-aside at least equal to the statutorily mandated IIJA federal set-aside.

Workforce Development

ISSUE

OCA health programs and facilities face longstanding challenges in recruiting and retaining essential staff, ensuring access to needed care and training resources, and maintaining clinical proficiency of professional staff. Recruitment and retention challenges are attributable to a variety of factors that include, but are not limited to, the remoteness of some IHS facilities, rural communities, aging IHS facilities and medical equipment, housing shortages and limited affordable housing options, limited access to schools, child care, and basic amenities, limited spousal employment opportunities, and competition with higher paying public and private health care systems. Although IHS and Tribal facilities in OCA do a very admirable job in keeping vacancy rates low using existing resources, much more needs to be done to enhance the ability of IHS and Tribes to keep a consistent supply of qualified personnel and be competitive in the employer market.

BACKGROUND

A sufficient and qualified workforce improves access to care by having vacancies filled and services operational and available. It improves quality of care by having personnel with the expertise and qualifications for high performance and improvement of health outcomes, as well as maintaining accreditation. Finally, it improves performance of both IHS and Tribal facilities by providing teaching/learning environments and raising the performance of all personnel to an exceptional level, which in turn becomes a tool for recruiting top talent. This directly addresses all three goals in the IHS Strategic Plan, Access to Care, Quality of Care and Performance Improvement.

RECOMMENDATION

- Fully fund Health Professions Scholarship Program
- Fully fund and increase award levels for the Loan Repayment Program (LRP) to levels commensurate with other federal loan repayment programs (e.g. Navy/VA, HRSA).

- Increase funding for native medical school programs such as INMED.
- Provide recurring direct funding and support for IHS and Tribal graduate medical education (GME) programs.
- Provide accelerated loan repayment for service in extremely underserved areas.
- Provide accelerated loan or scholarship repayment for those recipients who return to their home Tribal communities to serve.
- National Health Service Corps (NHSC) waived the scores for their loan repayment and made Tribes automatically eligible. The IHS should do the same as NHSC and waive the scores for their loan repayment and make Tribes automatically eligible.
- Develop regional combined STEM/clinical programs to stimulate those students at a young age to develop the motivation to enter professional school.
- Decentralize funding previously diverted to universities back to Native entities that have proven records in developing and implementing programming for Native students into the health professions.
- Ensure Federal Income Tax laws and policies do not negatively impact students receiving Scholarship or LRP funding. Presently the IHS Scholarship and LRP are subject to Federal Income Tax Withholding, while other federal program receipts are exempt (e.g. National Service Corp Program, VA or Military, and HRSA).
- Acquire recurring resources for provider housing development, maintenance and improvement for both IHS and Tribal sites, for all provider types and interns/residents.

HHS (non-IHS) Self-Governance Expansion and Other Program/Operation Flexibility

ISSUE

Tribal governments are not grantees; they are sovereign nations that expect the highest level of respect from the federal government. Yet, within the Department of Health and Human Services (HHS), Tribal health and social services are only funded through a patchwork of discretionary grants. This system is over-regulated and somewhat duplicative. Some grants are directly to states bypassing Tribes altogether. This does not fulfill the Federal trust responsibility to Tribal Nations. A 2003 HHS-led study determined that Self-Governance expansion was feasible, but legislation authorizing a demonstration project has yet to be enacted. While Tribes move this priority legislation forward, existing program and operation flexibility within HHS should be considered.

BACKGROUND

All but one HHS agency interact with Tribes through grant agreements, which are discretionary and do not uphold the trust responsibilities and treaty obligations of the United States. Grants do not provide Tribal governments the opportunity to redesign programs, effectively leverage resources, or enjoy the other benefits of Self-Governance. Additionally, smaller Tribes may not have the infrastructure to apply for, manage, and report on grants, leaving those Tribes unable to participate despite demonstrated need.

Since the HHS-led study in 2003, which determined Self-Governance expansion was feasible across HHS, Tribes continue to advance legislation to enact a Self-Governance demonstration project. Meanwhile, Tribes have been managing non-IHS health and human services programs through a cumbersome discretionary grant process across HHS agencies like Administration for Children and Families, Centers for Disease Control, Health Resources and Services Administration, and Substance Abuse and Mental Health Services Administration. Agency programs may be similar but do not always compliment or work with one another. None allow consolidation. Each requires separate annual applications and tedious reporting. None of this fulfills the Federal trust responsibility.

RECOMMENDATION

While Tribes advance legislation to prove that Self-Governance expansion across HHS will be successful, IHS could work with other HHS agencies under existing authorities to transfer programs to the IHS through various funding mechanisms in accordance with the President's Executive Order on Reforming Federal Funding and Support for Tribal Nations to Better Embrace Our Trust Responsibilities and Promote the Next Era of Tribal Self-Determination.[132] For example, IHS could enter into Memorandums of Agreements with sister agencies to transfer existing programs and funds while maximizing program flexibility wherever possible. An example of this occurred during the coronavirus pandemic when the Centers for Disease Control transferred funds to IHS to support pandemic relief efforts.

132 https://www.whitehouse.gov/briefing-room/presidential-actions/2023/12/06/executive-order-on-reforming-federal-funding-and-support-for-Tribal-nations-to-better-embrace-our-trust-responsibilities-and-promote-the-next-era-of-Tribal-self-determination/.

Community Health Aide Program

ISSUE

The Community Health Aide Program (CHAP) in the lower 48 states is an initiative aimed at addressing health care needs in underserved and rural communities. Developed to enhance access to health care services, CHAP trains community members to serve as frontline health care providers. These community health aides receive comprehensive training in basic medical care, health education, and emergency response. They play a crucial role in bridging the gap between formal health care institutions and isolated communities with limited access to health care. CHAP aims to improve preventive care, manage common health issues, and provide timely emergency assistance. The CHAP model reflects a community-based approach that not only addresses health care disparities, but also empowers Tribal citizens to actively participate in promoting culturally appropriate health care and the well-being of their communities.

BACKGROUND

CHAP was initially developed in Alaska in the 1960s as a response to the shortage of health care professionals and issues with accessing health care by American Indians and Alaska Natives (AI/AN) in remote and rural areas. The success of the program paved the way for its expansion to the lower 48 states. In 2016, the Indian Health Service (IHS) consulted with Tribes and established the CHAP Tribal Advisory Group (TAG) in 2018. Since this time, the CHAP TAG and been working to adapt the program to meet the unique needs and diversity of Tribes across the nation. IHS has provided funding opportunities through grants for Tribes to plan, assess, and implement CHAP in their health programs. However, official CHAP activities remain unfunded. Despite the efforts of the CHAP TAG and Tribes, there has been limited support from IHS to progress CHAP development and expansion.

RECOMMENDATION

OCA recommends that grant distribution should continue to aid Tribes exploring the development of CHAP in the lower 48 states and grant funding should be increased commensurate to needs. At the same time, IHS should request from Congress a permanent recurring annual base for the CHAP program. These reoccurring funds should be distributed throughout IHS Areas so the appropriate infrastructure can be established at a National and Area level. Areas will be able to utilize this funding to create Area Certification Boards customized to the unique needs of respective areas.

Unfunded Programs and Mandates

ISSUE

A longstanding concern within the Oklahoma City Area Office (OCA) is that existing program authorities as authorized under the Indian Health Care Improvement Act (IHCIA) remain unfunded. Such program authority includes long term care, behavioral and public health initiatives. Furthermore, the IHS is often required to carry out new requirements enacted by Congress without additional funding. One recent example of this can be found within the most recent Indian Child Protection and Family Violence Prevention Act (P. L. No. 101-630) reauthorization, which requires Tribes and Tribal organizations to conduct background checks, including Federal Bureau of Investigation (FBI) fingerprinting, for employees whose job duties involve contact with children. These required background checks are costly and most times are difficult to conduct, especially in rural areas which is where a large majority of Tribes reside. Though OCA understands the importance of the mandatory background investigations, the Tribes bear the burden of the cost of the background checks with no additional funding to address these needs.

BACKGROUND

The permanent reauthorization of the IHCIA under the Affordable Care Act was a victory for Indian health, yet today, several important provisions to expand critical health care remain unfunded. For example, it provides authorization for a spectrum of behavioral health programs, which include prevention and out- and in-patient treatment. The IHCIA also authorizes hospice care, assisted living, long-term care, and home- and community-based services. This program authority addresses critical health needs for our most vulnerable populations,

The IHS is required to carry out many program activities, some of which are unfunded., For example, he Indian Child Protection and Family Violence Prevention Act requires Tribes who receive funds under the Indian Self-Determination and Education Assistance Act to conduct extensive background checks, including Federal Bureau of Investigation fingerprinting, for employees who come into contact with Indian children. Indian Health Service has set forth minimum standards of

conduct which Tribes must utilize. The Act clearly defines the minimum standards of character and they shall be met after the background investigations review of:

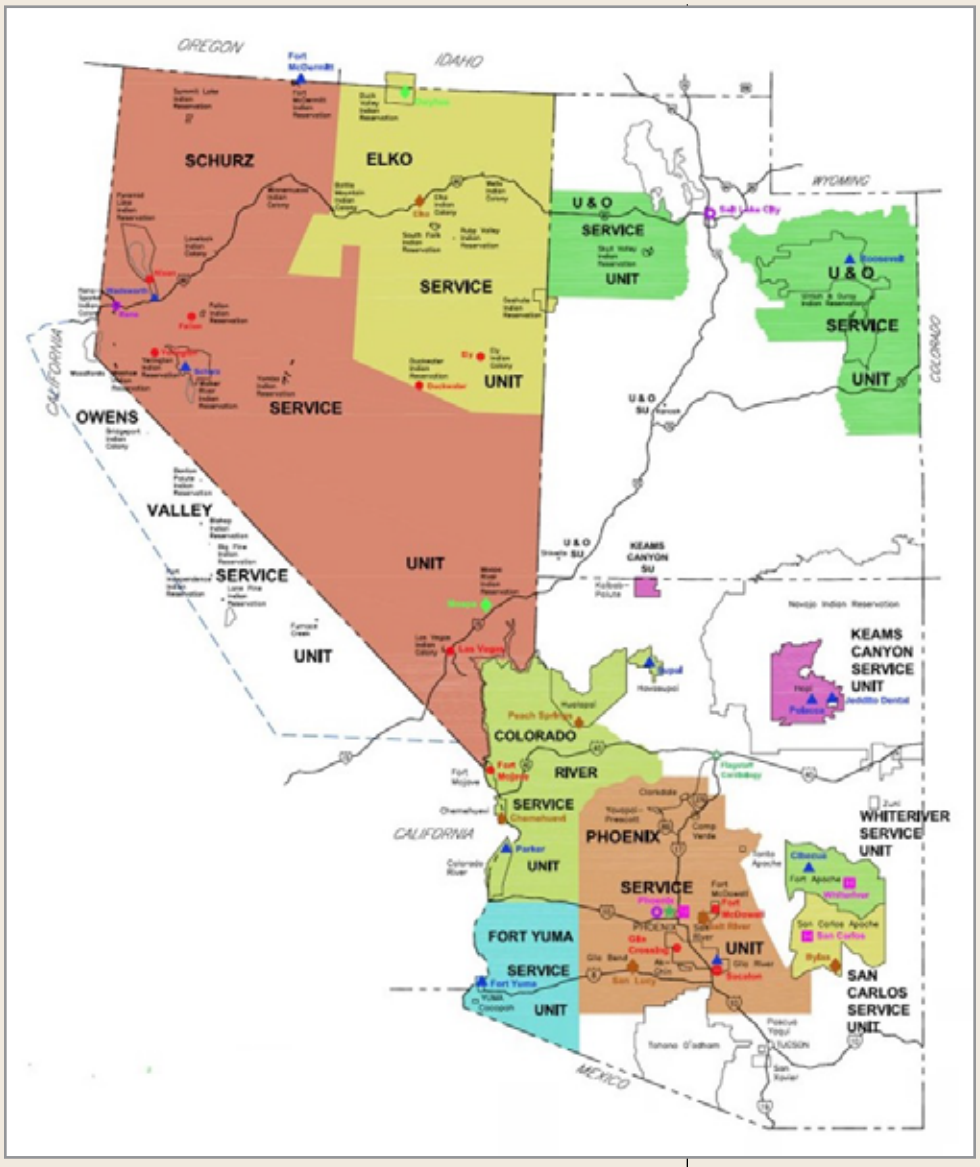
1. The individual's trustworthiness, through inquiries with the individual's references and places of employment and education;
2. A criminal history background check, which includes a fingerprint check through the Criminal Justice Information Services Division of the Federal Bureau of Investigation), under procedures approved by the FBI, and inquiries to State and Tribal law enforcement agencies for the previous five years of residence listed on the individual's application; and
3. A determination as to whether the individual has been found guilty of or entered a plea of nolo contendere or guilty to any felonious offense or any of two or more misdemeanor offenses under Federal, State, or Tribal law involving crimes of violence; sexual assault, molestation, exploitation, contact, or prostitution; crimes against persons; or offenses committed against children.

In short, Tribal communities suffer today because critical health provisions of the IHCIA and new requirements for managing health care programs remain unfunded.

RECOMMENDATION

OCA recommends fully funding the authorized but unimplemented IHCIA provisions, such as long-term care, behavioral and public health initiatives in addition to any existing or new unfunded mandates such as FBI background investigations. Collaboration and negotiation with Tribes is necessary to understand the extent of the cost and need and should be considered as party of the mandatory full funding need for the Indian Health Service. These reoccurring funds should be distributed equitably throughout all Areas and made available through self-determination and self-governance contracts and compacts.

Phoenix Area



In FY 2023, the Phoenix Area had a total user population of 178,750. That equates to 1,191 less active users than in 2019. The Phoenix Area is the third largest Area in the IHS.

- Active User Population 178,750 (FY 2023).
  - NV: 11,291
  - UT: 5,302
  - AZ: 162,157
- Phoenix Area is the third largest Area, in terms of population. It covers the states of UT, NV, AZ and 3 federally-operated health care clinic locations in CA.
- 45 Tribes and Bands in UT, NV, AZ & 7 Tribes in the Owens Valley Service Unit & in CA.
- 1 Adolescent Treatment Center (AZ) & 1 Satellite (NV).
- 4 Urban Indian Organizations – Salt Lake City, UT, Carson City, NV, and Phoenix, AZ (2).

The Annual Phoenix Area Indian Health Service (PAIHS) Budget Formulation process was conducted in a hybrid setting (in-person and virtually). The outcome of the session included agreeing on a full funding recommendation for the FY 2027 Indian Health Service (IHS) budget at $73 billion per the

instructions of the IHS National Tribal Budget Formulation Workgroup.

At this meeting Dr. Charles Reidhead, Director of the PAIHS, welcomed the Tribal Leaders, Tribal Health Directors and Urban Indian Organization (UIO) officials, provided an Area update and Mr. David Reede gave the opening prayer. Ms. Carol Lincoln, Executive Officer, facilitated the meeting. Dena Wilson, M.D., Chief Medical Officer, PAIHS, gave a presentation on the Phoenix Area Health Status. It included detail on demographics, leading causes of American Indian/Alaska Native (AI/AN) mortality in the Phoenix Area and by state, medical service trends and Government Performance Results Act (GPRA) results.

A principle focus of the morning session was to provide the FY26 timeline, instructions and required deliverables. Ms. Arikah Kiyaani-McClary, Phoenix Area Budget Officer, provided information on the current IHS budget and the status of the FY 2024 and FY 2025 Budget Requests. Updates were provided on activities under the PAIHS Office of Health Programs, Public Health Nursing and Community Health Representatives programs, the Office of Environmental Health and Engineering, Phoenix Indian Medical Center, Phoenix Area Dept. of Information Technology, and Desert Vision/ Nevada Skies. PAIHS Finance staff reviewed the FY 2026 spreadsheet and informed the participants that the formulation process will involve building on the FY 2027 Phoenix Area budget at the $73 billion level. This reflects the FY 2023 Enacted Budget as the base, which was a request received from the Workgroup during the Planning and Evaluation meeting and last year's National Work Session. By using this base funding level, the FY 2027 National Budget Worksheet includes $55,922,940 to spread.

Ms. Carol Lincoln led the discussion on Hot Topics and Budget Priorities that stemmed from discussion by the Tribes/UIOs listing their respective issues. The bulk of the meeting was to discuss 1) Overview of Budget Worksheet and 2) Hot Topics. The Tribes were able to begin to identify priority line Items and recommendations for FY 2026.

The afternoon session continued on with the budget worksheet and budget justification narrative. The Tribes would later decide on implementing a 12% increase to all budget line items submitted for FY 2025. Additionally, a request was made to remove amounts submitted for the Contract Support Cost and the 105(l) Lease line items.

Budget Recommendations

Recommendation I

Tribes and UIOs in the PAIHS FY 2026 Budget formulation process concur with and recommend a total budget of $54.8 billion. This includes a 12% increase made to all program increases submitted for the Phoenix Area's FY 2025 Tribal budget recommendation. A request was made to remove amounts submitted for the Contract Support Cost and the 105(l) Lease line items. Those amounts were redistributed to the Hospital & Clinics and Electronic Health Record System (EHR) line items expanding the increase by 145% and 100% since there were no amounts submitted for EHR in the FY 2025 budget:

CLINICAL SERVICES: +$2.4 billion
- Hospitals & Clinics: +$1.38 billion
- Electronic Health Records System: +$1 billion
- Dental Health: +$12 million
- Mental Health: +$141 thousand
- Alcohol & Substance Abuse: +$208 thousand
- Purchase Referred Care: +$1.2 million

PREVENTATIVE HEALTH: +$28.3 million
- Public Health Nursing: +$273 thousand
- Health Education: +$48 thousand
- Community Health Representatives +$27.9 million

OTHER SERVICES: +$32.7 million
- Urban Health: +$11.1 million
- Indian Health Professions: +$2.4 million
- Direct Operations: +$18.9 million
- Self-Governance: +$378 thousand

FACILITIES: +$9.8 million
- Maintenance & Improvement – +$2,000
- Health Care Facilities Construction: +$9.8 million
- Equipment: +$1 thousand

Recommendation II

Priority funding was determined based on the highest program increase amount submitted for FY 2026 that Tribes/UIOs noted have become especially critical when addressing the Covid-19 pandemic across all levels of the Indian health care system. Further these services and infrastructure needs connect to provisions of the Indian Health Care Improvement Act (IHCIA) (25 U.S.C. Chapter 18) passed into law in 1976 and permanently reauthorized in 2010. It contains a declaration of national Indian health policy that states it is the policy of the nation in fulfillment of its special trust responsibilities and legal obligations to Indians

— (1) to ensure the highest possible health status for Indians and Urban Indians and to provide all resources necessary to effect that policy. It was a notable achievement that cannot be ignored as the law guides the delivery of health care services by the Indian Health Service, Tribes and Urban Indian Organizations:

Hospitals & Clinics +$2.35 billion

The major increase includes several Phoenix Area priorities noted in last year's FY25 recommendation that we seek to advance in FY26 under H&C.

- Health Information Technology Modernization / Telehealth
- Recruitment and Retention
- Implementation of certain unfunded provisions of the IHCIA
- Extra Support for Small Tribes
- Long Term COVID-19 Repercussions

Electronic Health Record Systems +$1 billion

The major increase includes several Phoenix Area priorities that were not included in the FY2025 funding; a) telehealth and b) telephonic methods to re-engage with patients as a result of face-to-face restrictions during the Public Health Emergency.

Community Health Representatives +$260.9 million

The program increase of $260.9 million addresses long term static funding in Tribal/Urban CHR services, including salary enhancement and CHAP Community Health Aide program implementation in the lower 48 states.

The IHCIA provisions aligned with this priority are included in the following statutes.

- § 1616. Community Health Representative Program
- § 1616 (d). Nationalization of the Community Health Aide Program
- § 1621 (q). Prevention, control, and elimination of communicable and infectious diseases
- § 1660(f). Title 1 – Subtitle E. Health Services for Urban Indians – CHR

Direct Operations +$176.3 million

The program increase of $176.3 million addresses the need for administrative and support services infrastructure to meet the need for provision of health care services funded through other recurring line items.

The IHCIA provisions aligned with this priority are included in the following statutes.

- § 1621 (c). Diabetes prevention, treatment, and control
- § 1621 (b). Health Promotion and disease prevention services
- § 1621 (q). Prevention, control, and elimination of communicable and infectious diseases

Dental Health +$112 million

The program increase of $112 million was identified for Dental Therapy where oral health care remains a top concern. These are essential health care services that impact the whole health of our population.

The IHCIA provisions aligned with this priority are included in the following statutes.

- § 1616 (l). Community health aide program
- § 1621. Indian Health Care Improvement Fund (§ 1621 et al)

Urban Health +$103.7 million

The program increase of $103.7 million identified in FY24 and FY5 remains a top concern in FY26. This line item has remained static for too long. Services must be aligned and enhanced across the Indian health care system.

The IHCIA provisions aligned with this priority are included in the following statutes.

- SUBCHAPTER IV—HEALTH SERVICES FOR URBAN INDIANS §1651. et al

Health Care Facilities Construction +$91.7 million

The program increase identified in FY24 and FY25 remains a top concern in FY26. $91.7 million would fund the following:

- Maintenance & Improvement: +$22,000
- Health Care Facilities Construction: +$91.6 million
- Equipment: +$8,000

The IHCIA provisions aligned with this priority are included in the following statutes.

- SUBCHAPTER III—HEALTH FACILITIES (§1631 et al)

Indian Health Professions +$22.4 million

The program increase identified in FY24 and FY25 remains a top concern in FY26. $22.4 million will provide funding for needed recruitment and professional development opportunities in order to fill critical vacancies.

The IHCIA provisions aligned with this priority are included in the following statutes.

- § 1612. Health professions recruitment program for Indians
- § 1613. Health professions preparatory program for Indians
- § 1616 (b). Recruitment activities
- § 1616 (d). Advanced training and research

Purchased/Referred Care (PRC) +$11.2 million

The program increase of $11.2 million addresses the need to ensure referral care and specialty services and to implement the PRC Delivery Area Expansion in the State of Arizona.

The IHCIA provisions aligned with this priority are included in the following statutes.

- § 1646. Authorization for emergency contract health
- § 1621 (r). Contract health services payment study
- § 1621 (y). Contract health service administration and disbursement formula

Self-Governance +$3.5 million

The program increase of $3.5 million addresses the need for additional funding for Self-Governance Planning and Negotiation Cooperative Agreements.

The IHCIA provisions aligned with this priority are included in the following statutes.

- § 1680 (h). Demonstration projects for Tribal management of health care services
- § 1680 (r). Tribal health program option for cost-sharing

Public Health Nursing +$2.5 million

The program increase of $2.5 million addresses the continued demand for recruitment and services provided by the Public Health Nurses.

The IHCIA provisions aligned with this priority are included in the following statutes.

- § 1621 (b). Health promotion and disease promotion
- § 1621 (n). Comprehensive school health education programs
- § 1621 (q). Prevention, control, and elimination of communicable and infectious diseases

Alcohol/Substance Abuse +$1.9 million

The program increase of $1.9 million identified in FY24 and FY25 remains a top concern in FY26. The increase is needed to implement the Comprehensive Behavioral Health Prevention and Treatment Program authorized by the Indian Health Care Improvement Act (25 U.S.C. §1665c) in 2010.

The IHCIA provisions aligned with this priority are included in the following statutes.

- § 1665 (c). Comprehensive behavioral health prevention and treatment program
- § 1665 (f). Indian women treatment programs
- § 1665 (g). Indian youth program

Mental Health +$1.3 million

The program increase of $1.3 million addresses the need for recruitment and retention for behavioral health professionals and mid-level providers.

The IHCIA provisions aligned with this priority are included in the following statutes.

- § 1665 (c). Comprehensive behavioral health prevention and treatment program
- § 1665 (f). Indian women treatment programs
- § 1665 (g). Indian youth program

Health Education +$446,000

The program increase of $446,000 addresses the continued need for health education in Indian health care facilities and Tribal communities.

The IHCIA provisions aligned with this priority are included in the following statutes.

- § 1665 (c). Comprehensive behavioral health prevention and treatment program
- § 1665 (f). Indian women treatment programs
- § 1665 (g). Indian youth program

Maintenance & Improvement +$22,000

The program increase of addresses Maintenance and Improvement needs across the Indian Health Service.

The IHCIA provisions aligned with this priority are included in the following statutes.

- § 1634. Expenditure of non-service funds and renovations
- § 1638 (a). Tribal management of federally owned quarters
- § 1638 (e). Other funding, equipment, and supplies for facilities

Equipment +$8,000

The program increase of $8,000 will help to address critical equipment replacements across the Indian Health Service.

The IHCIA provisions aligned with this priority are included in the following statutes.

- § 1634. Expenditure of non-service funds and renovations
- § 1638 (a). Tribal management of federally owned quarters
- § 1638 (e). Other funding, equipment, and supplies for facilities

Hot Issues

The Tribes and Urban Indian Organizations in the Phoenix Area recommend a total IHS budget of $54.8 billion in Fiscal Year 2026, to provide full funding for the Indian health care system. The Phoenix Area IHS held the Phoenix Area Tribal Budget Formulation Meeting on December 5, 2023 with subsequent follow up with Tribes and Urban Indian Organizations. Increases are spread across all line items of the IHS budget to address health care needs in addition to the following "hot issues" which address prevailing health concerns and policy considerations in the Phoenix Area.

Full Funding for the Indian Health Service

ISSUE

Tribal Leaders in the Phoenix Area support a concrete commitment by the administration to secure full funding for the Indian Health Service at $54.8 billion. Tribes understand it would require a significant multi-year investment and suggest that that these resources be phased-in over 12 fiscal years. The total is based on analysis of the cumulative amounts required for community based medical, behavioral, dental, and public health services for the estimated 2.9 million American Indian and Alaska Natives (AI/ANs) of 574 federally recognized Tribes eligible to be served by IHS, Tribal and Urban Indian Organizations.

BACKGROUND

The funds necessary to eliminate the health disparities of American Indian and Alaska Native people have never been adequately appropriated. IHS, Tribes and Urban Indian Organizations endeavor to provide quality health care, but with inadequate funding levels. Full funding would bring health resources in line with the rest of the nation. While the IHS received marginal increases that are appreciated, it's not enough to effectively address underfunded health measures.

RECOMMENDATION

The actions requested by Tribal Leaders in the Phoenix Area include:

- Continue to engage Tribal leaders in a process to enact mandatory appropriations for the IHS and other Indian programs.
- Implement the Purchased Referred Care (PRC) statute (25 U.S.C. §1678, §1678(a) that provides permanent designation of Arizona, North Dakota and South Dakota as statewide PRC delivery areas. Within the PRC recommendation of $11.2 million, a designated portion is sought for planning and implementation.
- IHS is impacted by the VA's decision of June 5, 2017, to end the use of the Veterans Health Information Systems and Technology Architecture (VistA). The IHS Resource Patient Management System (RPMS) is based on VistA. In order to advance the IHS Information Technology Modernization Project and transition to a new Electronic Health Record system, funding in the amount of $1 billion has been requested to address this need and several other technological initiatives.
- Tribes seek the permanent reauthorization of the Special Diabetes Program for Indians (SDPI). The program was nearly phased out, but was extended at existing 2004 funding levels until the end of FY 2023, as a part of the Omnibus Coronavirus Relief bill of 2020. AI/ANs across the nation greatly benefit from this model program, but are impacted by the nonstop uncertainty surrounding the continuation of this program. Tribal leaders affirm the best option would be to make available SDPI funding thru compacts and contracts.

Provide Full and Mandatory Funding for all provisions of the Indian Health Care Improvement Act

ISSUE

On March 23, 2010, the Patient Protection and Affordable Care Act (PPACA) (P.L. 111-148) permanently reauthorized the Indian Health Care Improvement Act (IHCIA). As a part of the IHCIA reauthorization, there were provisions which authorized various IHS service expansions, but have yet to receive adequate funding for implementation. These services include, but are not limited to, the following.

- Long Term Care Services, including assisted living services, home and community based services, hospice care and convenient care services.
- Comprehensive Behavioral Health Treatment and Prevention services, including community-based care, detoxification, hospitalization, intensive outpatient treatment, residential treatment, transitional living, emergency shelter, case

management, and diagnostic services. The IHS is also authorized to establish not less than one inpatient mental health care facility or equivalent in each IHS Area.
- Traditional Healing
- Community Health Aide Program
- Statewide PRCDA Expansion

BACKGROUND

The efforts by Tribes that led to the adoption of these IHCIA provisions were driven by the concern that American Indians and Alaska Natives (AI/AN) are especially impacted by disparities in health and health care access. Historically, one outcome of treaties between Tribes and the federal government is that all federally recognized Tribes have a right to health care services. The IHS was created in 1955 to meet this federal commitment. Certain Elder Care, Behavioral Health, Traditional Healing, Community Health Aide Program, and other services and programs were not authorized until 2010 and have since not been fully funded. The leading causes of mortality in all age groups of AI/AN in Arizona, Nevada, and Utah from 2016 through 2020 are ranked from highest to lowest below.

1. Unintentional Injury
2. Heart Disease
3. Malignant Neoplasms
4. COVID-19
5. Liver Disease
6. Diabetes Mellitus
7. Suicide
8. Cerebrovascular
9. Influenza and Pneumonia
10. Homicide

RECOMMENDATION

The Tribes in the Phoenix Area recommend full funding and mandatory funding of the Indian Health Care Improvement Act provisions.

Purchased/Referred Care

ISSUE

Tribal Leaders in the Phoenix Area support Purchased Referred Care Delivery Area (PRCDA) Statewide Expansion efforts with an increase of $11.2 million in funding.

BACKGROUND

The Purchased Referred Care (PRC) Program is a benefit specific to the Indian Health Service beneficiaries to provide specialty services that are not available as a direct care service. American Indian and Alaska Native (AI/AN) patients that have chosen to move to urban areas and no longer qualify for PRC funding due to limitations regarding PRC eligibility, which is based on place of residence.

Expanding the PRCDA to the entire State of Arizona would increase eligibility and provide increased access to care. Based on available data; if the statewide expansion were to be implemented, the greatest impact would be in Maricopa County, and possibly adjacent Pinal County. However, given the current IHS operational issues, adding additional patients to an already overburdened PRC system, will require more funding for the purchase of services and funding for staffing, space and equipment. The funds necessary to eliminate the health disparities of AI/AN people have never been adequately appropriated. The IHS, Tribes and Urban Indian Organizations endeavor to provide quality health care, but with inadequate funding levels.

RECOMMENDATION

Phoenix Area Tribes recommend an additional $11.2 million in funding to allow for the PRCDA Statewide expansion in Arizona.

Funding to Increase Recruitment and Retention

ISSUE

Tribal Leaders in the Phoenix Area request additional funding to increase Recruitment and Retention activities for Indian Health Professions and "growing our own." The latter concept includes activities to provide education, training, and professional development opportunities for American Indian and Alaska Native youth interested in careers in the health care field and, specifically, the Indian health system.

BACKGROUND

There are significant ongoing Recruitment and Retention challenges for the Indian health system. Some of the most significant challenges include the following.

- Location – Due to the rural and remote locations of many Indian health care facilities, it is difficult to recruit qualified health care professionals.
- Housing – Due to the rural and remote locations of many Indian health care facilities, it is difficult for prospective employees to find suitable housing.
- Competitive Salaries – Health care professionals often have to be paid additional incentives for recruitment and retention to compete with other governmental agencies and the private sector.
- Professional Service Contractors – Professional service contractors often provide even more

competitive salaries to providers seeking higher pay. This limits the availability of qualified providers from which to recruit and, subsequently, leads to reliance on professional service contracts which can be costly. This impacts not only administrative burden on the Indian health care system, but may significantly impact continuity of quality health care when various providers are cycled through to meet the needs of the facilities.

- Limited Availability of Qualified Providers – Aside from professional service contractors providing enticing salaries to the existing pool of qualified providers; there are fewer providers in certain disciplines.
- Provider Burnout – Due to the increased administrative burden of the COVID-19 pandemic and continued vacancies in health care professional positions; existing employed health care professionals are in need of relief, rest/self-care, and work-life balance.

RECOMMENDATION

The Tribes in the Phoenix Area recommend additional funding to increase efforts to recruit and retain talented health care professionals and alleviate burden and strain on the Indian health care system. As a part of this recommendation, Tribes recommend authority and funding to allow Tribal and urban Indian communities to grow their own – focusing on early education and professional development opportunities for American Indians and Alaska Natives at a young age. The total recommended funding for FY 2027 for Indian Health Professions is $193.95 million.

Telehealth and Information Technology Modernization

ISSUE

Phoenix Area IHS Federal and Tribal Hospitals and Clinics have employed the use of telehealth to deliver care, which has increased substantially since the start of the COVID-19 pandemic. Telehealth allows patients to receive care in an alternate setting, such as their home, which has been very effective in serving our remote areas. Telehealth has further allowed patients to receive care from various specialty providers, which have traditionally been very difficult to obtain. Key to the successful provision of telehealth services is ensuring our facilities and communities have adequate bandwidth and equipment for the originating and receiving locations. While many improvements have been made in the past few years to IHS/638 clinical facilities, challenges still remain in obtaining adequate bandwidth and equipment for our remote communities. Specifically, our beneficiaries need access to video technology so they can engage with IHS service providers.

BACKGROUND

Indian health care providers have expanded the use of telehealth and telephonic methods to re-engage with patients as a result of face-to-face restrictions during the Public Health Emergency. Upon the Executive Order establishing the COVID-19 Public Health Emergency on March 6, 2020, the Centers for Medicare and Medicaid Services (CMS) was able to initiate emergency telehealth flexibilities that are normally not allowed under Medicare without statutory authority. CMS also issued guidance to all state-operated Medicaid systems whose telehealth policies and payment levels vary by state. The IHS and Tribes have had to ramp up the provision of these services under these challenging circumstances, but patients have benefitted.

Flexibility in Medicare Telemedicine Services

As of March 6, 2020 and for the duration of the COVID-19 Public Health Emergency, Medicare is making payments for professional services furnished to beneficiaries in all areas of the country in all settings. Medicare telehealth services are services ordinarily furnished in person and are subject to geographic, site of service, practitioner, and technological restrictions. CMS was able to waive a number of these restrictions as well as adopt regulatory changes to expand access to Medicare telehealth broadly. Under the PHE, the patient's home is now considered a site of service, which has aided the delivery of provider services through telehealth and telephonic means.

States Increase Medicaid Telehealth Flexibilities

States have broad authority to authorize reimbursement for telehealth services and many States authorize reimbursement for telehealth services at the same rates they reimburse in-person services. This is what has occurred in Arizona and the outpatient OMB all-inclusive rates apply to Indian Health Care Providers, including services under the auspices of free-standing clinics. All forms of covered telehealth services are covered which include asynchronous (store and forward), remote patient monitoring, tele-dentistry, and telemedicine (interactive audio and video).

RECOMMENDATION

Tribes and UIOs in the Phoenix Area seek continued funding for telehealth. Indian health care providers

have demonstrated they can increase access to needed primary, specialty and behavioral health services particularly in rural areas through telehealth modalities. Accessing resources to enhance bandwidth and expand the use of video technology could potentially be achieved through grants from other federal agencies as well as direct appropriations made available to IHS.

In addition to the IHS' efforts to modernize its IT Systems, the agency has recently introduced RingMD to administer telehealth in the agency and has awarded a contract to Cisco to use their WebEx platform. Additional bandwidth and upgrades to hardware are needed through to fully utilize these platforms. Bandwidth upgrades via infrastructure improvement projects should be instituted to Tribal communities and hardware, such as tablets, should to be given to federal providers to facilitate video communication with patients.

States are now encouraged to facilitate clinically appropriate care within the Medicaid Program using telehealth technology to deliver services. While States have a great deal of flexibility with respect to covering Medicaid services provided via telehealth, these were expanded under the PHE. Most of these should continue, in particular reimbursement for telehealth services at the same rates they reimburse in-person services.

Extra Support for Small Tribes

ISSUE

Tribes in the Phoenix Area have concerns that about 200 Small Tribes nationwide, with populations of approximately 1,700 or less, have challenges that are unique to operating Tribal health programs. Their challenges are of equal importance to larger Tribes in recognition of historical factors, remote geographic locations and apportionment of funds that may have been based on population figures resulting in neglecting the health issues and limited access to health care faced by their Tribal members.

BACKGROUND

There are approximately 20 Tribes in the Phoenix Area that their identified 2019 active users meet the population criteria for a small Tribe. They are located in all three states (Arizona, Nevada and Utah). Therefore, this a regional concern shared by Tribal Leaders. The IHS currently operates the Small Ambulatory Program (SAP) that addresses needed renovations, modernization, and the construction of small health care facilities. The SAP funding is administered through a competitive grant process which small Tribes have begun to voice concerns about due to difficulties these Tribes experience when seeking to write proposals due to insufficient staff. The SAP funding levels have become consistent in the past 5 years, increasing from $5 million annually in FY2016 to $25 million in FY2022 and FY2023. SAP applications for FY2022 and FY2023 were solicited during the winter of 2023.

RECOMMENDATION

The Tribes in Arizona recommend additional funding to support Small Tribes, especially in the funding line items of Hospital and Health Clinics (H&C), Maintenance and Improvement (M&I), and Equipment.

Increases for Community Health Representatives, Health Education, and National Community Health Aide Program (CHAP) Expansion

ISSUE

Community Health Representatives (CHRs) and Health Educators are currently the principle paraprofessionals in Tribal communities conducting health promotion and disease prevention activities in the lower 48 states. Tribal leaders value their roles and are concerned that these two line items are long overdue for program increases. The Community Health Aide Program (CHAP) operating in Alaska serves as a model for the inclusion of CHAP mid-level providers in other regions of the country. These mid-level providers will be trained to provide basic medical attention and connect patients to clinical care, thereby enhancing the Indian health care system.

BACKGROUND

In 2018, the IHS National CHAP Tribal Advisory Group (CHAP TAG) was formed and the formal CHAP policy and implementation plan was worked on. In 2019, Tribal Consultation was initiated and in 2020, a study was initiated to examine the factors that promote or restrict the implementation of the program. In 2021, two new grant programs were announced to assess, plan and initiate CHAP outside of Alaska. CHAP affords Tribes wide ranging opportunities, including career opportunities and advancement considerations for other mid-level providers such as CHR's, Health Educators, Behavioral Health Technicians, Hygienists, Dental Assistants and others.

Some states, including Arizona, have adopted legislation to establish a voluntary certification process. CHR Directors have stayed apprised of

these efforts and provide input on how this process would involve Tribes as they employ the largest CHW workforce in the state. Another effort at the request of Tribes in Arizona, is engaging with the Arizona Health Care Cost Containment System (AHCCCS) to examine Medicaid reimbursement. This could lead to sustainable resources in light of any potential elimination or cuts to CHR program funding in the future, which had been sought in FY 2019 and FY 2020 IHS Budget Requests, although not agreed to by the appropriations committees.

RECOMMENDATION

The Tribes in Arizona recommend that the FY2026 budget include the necessary resources to provide increases of $261 million for CHRs and $446,000 for Health Education. Additional funding affords the opportunity to provide salary enhancements and continue CHAP expansion in the lower 48 states. Of note, Tribes in Arizona also recommend a program increase to $823.22 million to support Public Health Nursing in FY 2026.

Urban Indian Health Programs

ISSUE

Indian Health Service (IHS) and Tribal providers, as well as other comparable federal health care centers, are covered by the Federal Tort Claims Act (FTCA). Urban Indian Organizations (UIOs), however, have been denied this coverage and must purchase their own expensive insurance on the open market. The UIOs lack access to facilities funding under the general IHS budget, meaning there is no specifically allocated funding for UIO facilities, maintenance, sanitation, or medical equipment, among other imperative facility needs.

BACKGROUND

Federal Tort Claims Act Coverage

FTCA provides coverage for certain tortious acts or omissions, subject to exceptions as set forth in 28 U.S.C. § 2680, committed by a covered employee or individual that occurred within the employee's scope of official duties (i.e., employment or contract). Tortious acts or omissions that occur after hours or offsite are usually not covered by the FTCA unless part of one's official duties. The FTCA does not provide coverage for intentional or deliberate torts, such as battery or fraud. This Act covers medical, dental, pharmaceutical, and behavioral health counseling related health care services including ancillary services provided to eligible Urban Indians pursuant to grants and contracts awarded by the Indian Health Service (IHS), under 25 U.S.C. Subchapter IV – Health Services for Urban Indians, of the IHCIA. The FTCA provides medical malpractice coverage for certain covered individuals (i.e., governing board members, officers, employees, and certain individual contractors) working for FTCA-covered entities. The few Urban Indian Organizations that serve non-Indians are already classified as Community Health Centers, receive Section 330 funds through the Health Resources & Services Administration and have FTCA coverage. The vast majority of Urban Indian Organizations limit their services to AI/AN, are not Section 330 Community Health Centers and, therefore, do not have FTCA coverage. The Health Center FTCA Medical Malpractice Program is intended to increase the funds available to health centers by reducing or eliminating health centers' malpractice insurance premiums, which frees up these resources and instead allows them to go towards furnishing additional services. For example, some UIOs pay $250,000 per year for malpractice insurance. If UIOs are provided FTCA coverage, those insurance costs would instead be available for the provision of additional services. This change would maximize the value of IHS appropriations.

Facilities Funding

Section 509 of the Indian Health Care Improvement Act (IHCIA) currently authorizes the IHS to provide UIOs with funding for minor renovations by mandating that funding only be provided to UIOs that meet or maintain compliance with the accreditation standards set forth by The Joint Commission (TJC). These restrictions on facilities funding have ultimately prevented UIO facilities from obtaining the funds necessary to improve the safety and quality of care provided to American Indian/Alaska Native (AI/AN) persons in urban settings.

RECOMMENDATION

FTCA coverage has been provided to Tribes and Tribal Organizations that have contracts with the IHS. Tribes recommend that IHS officially support the permanent inclusion of UIO services in the coverage of the FTCA and take any potential steps to effect that change. Tribes in Arizona recommend funding Section § 1659 of the IHCIA for minor renovations to Urban Indian Organization facilities, as well as potential construction or expansion of these facilities, including leased facilities and funding increases to support UIO facilities, maintenance, sanitation, or medical equipment, among other facility needs. The recommended increase for Urban Indian Health is $874.24 million for FY 2027.

Self-Governance

ISSUE

Additional funding is required to carry out functions supported by the Indian Health Service (IHS) under Self-Governance Funding Opportunities.

BACKGROUND

Title V of the ISDEAA provides the IHS with the statutory authority to offer Planning and Negotiation Cooperative Agreements to assist Tribes in planning and negotiations activities associated with the IHS Tribal Self-Governance Program.

Planning Cooperative Agreements provide resources to Tribes interested in entering the TSGP and to existing Self-Governance Tribes interested in assuming new or expanded PSFAs. Title V of the ISDEAA requires a Tribe or Tribal organization to complete a planning phase to the satisfaction of the Tribe. The planning phase must include legal and budgetary research and internal Tribal government planning and organization preparation relating to the administration of health care programs. See 25 U.S.C. 458aaa-2(d). The planning phase helps Tribes to make informed decisions about which PSFAs to assume and what organizational changes or modifications are necessary to successfully support those PSFAs. Five awards are available for $120,000 each.

Negotiation Cooperative Agreements provide resources to Tribes to help defray the costs related to preparing for and conducting TSGP negotiations. The design of the negotiation process:

1. Enables a Tribe to set its own priorities when assuming responsibility for IHS PSFAs;
2. Observes the government-to-government relationship between the United States and each Tribe; and,
3. Involves the active participation of both Tribal and IHS representatives, including the IHS Office of Tribal Self-Governance. Negotiations provide an opportunity for the Tribal and Federal negotiation teams to work together in good faith to enhance each Self-Governance agreement. Five awards are available for $48,000 each.

RECOMMENDATION

Phoenix Area Tribes recommend additional funding be available for both the Planning and Negotiation Cooperative Agreements. This will enable more Tribes to participate and/or Tribes that enter into a Cooperative Agreement to have the financial resources necessary for planning and/or negotiation.

The total recommended funding in FY 2027 for Self-Governance funding is $20.07 million.

Enhance Dental and Emergency Services Operated by Tribes

ISSUE

Due to chronic underfunding and high dental disease rates; dental programs face significant challenges to address the oral health needs of their communities. Emergency Medical Services (EMS) programs operated by Tribes are not reimbursed adequately by State Medicaid programs. Tribes who do not operate either of these programs often rely on the Purchased Referred Care (PRC) program to obtain necessary dental and emergency medical transportation services for eligible Tribal community members.

BACKGROUND

Dental Health Services

The following are some of the most critical challenges experienced by dental programs in the Indian health system.

1. Insufficient funding for specialty dental services including oral surgery, pediatric dental care, endodontic and periodontic care. Specialty referral care at PIMC – the regional referral medical center in the Phoenix Area – is limited due to the number of staff, and availability of Operating Room time for oral surgeries. Purchased Referred Care (PRC) funding for dental specialty care is limited by PRC funding amounts and insufficient PRC and patient care coordination staff.
2. Lower salary rates compared with the private sector for auxiliary and ancillary dental personnel. Current salary rates are not competitive with private sector jobs for auxiliary and ancillary dental positions. Funding is needed to increase salaries to improve recruitment efforts and fill vacant positions. Additional staff including dental assistants, dental hygienists, PRC and patient care coordinators are needed in order to address the unmet needs in regular and referred specialty dental care.
3. Lack of funded advanced training opportunities for auxiliary and midlevel dental staff. Funds are required to support advanced training for auxiliary and mid-level dental staff. These career and advanced skills development opportunities can increase recruitment and retention, to expand the workforce to incorporate Dental Health Aide Therapists.

Emergency Medical Services
Emergency Medical Services (EMS) provided by Tribes through P.L. 93-638 contracts with the Indian Health Service are crucial in providing necessary emergency transportation. However, EMS programs are costly to operate and maintain licensure/certification. Medicare and Medicaid reimbursement rates for Tribal EMS programs needs to be reviewed. Tribes that do not operate EMS programs often rely on the PRC program to ensure that reimbursement is provided to privately-operated EMS programs in cases of emergency for PRC-eligible Tribal community members.

RECOMMENDATION

Tribes in the Phoenix Area recommend $112 million in funding to increase recruitment and retention of qualified dental health care professionals and mid-level providers and to increase access to necessary dental care.

Tribes in the Phoenix Area recommend a program increase to support the EMS program operated by Tribes as well as funding to support these services when approved through the PRC program. This will help the Indian health system lessen administrative burden, maintain certified/licensed staff, and improve health care outcomes for American Indians and Alaska Natives.

No Competitive Grants and No Matching Requirements for Tribes

ISSUE

Competitive grants for funding provided through the Indian Health Service, agencies under the Department of Health and Human Services (including the Substance Abuse and Mental Health Services Administration), other federal agencies, and states and associated match requirements pose a significant challenge to Tribes in Arizona.

BACKGROUND

Competitive grants that are available to non-Tribal governments pose a significant challenge for Tribes as they have to compete with a larger number of other grant proposals. Competitive grants provided through the IHS and other federal agencies that are only available to Tribal governments are beneficial; however, the competitive grants which relay on discretionary funds create uncertainty for continuity of these Tribal programs.

RECOMMENDATION

Tribes in the Phoenix Area recommend recurring funding in place of competitive grants. In cases where there is no budget authority to achieve this; the Tribes recommend non-competitive grants specifically for Tribal governments and recommend that there be no Tribal match requirements in cases where Tribal governments are recipients of grant funding.

Additional funding for Long-Term COIVD Repercussions

ISSUE

The COVID -19 National Public Health Emergency (PHE) was a topic re-addressed by the attendees during the FY2026 PAIHS Tribal Budget Consultation Meeting. They shared some of the impacts on their communities, challenges with regard to patient care, long term effects on patient's health and the broader societal issues within Tribes and the AI/AN population. The concern was that COVID-19 funding may diminish over time. Therefore, IHS/Tribes/Urban Indian Organizations (UIOs) should be strategically prepared to shore up mitigation efforts through IHS appropriations or other federal or state resources in order to:

1. Respond to COVID-19 variants to mitigate the spread of the disease to protect Tribal populations, including different age groups and individuals with co-morbidities;
2. Stand up appropriate public health prevention and preparedness measures if new variants emerge; and ,
3. Ensure the Indian health care system has the necessary inpatient and outpatient clinical care, including long COVID (also known as post-COVID conditions or PCC) treatment, ongoing testing, vaccination, boosters and public health measures to sustain or implement if outbreaks occur.

BACKGROUND

On January 31, 2020, U.S. Secretary of Health and Human Services, Alex Azar, declared the SARS-CoV-2 virus a public health emergency that has been continuously renewed to its current 90 day term through January 13, 2023. On March 13, 2020, the President Donald Trump declared a nationwide emergency and the nation began to shut down. On March 27, 2020, the U.S. Congress passed the Coronavirus Aid, Relief and Economic Security Act (CARES Act) (P.L. 116-136) and IHS began to consult with Tribal Leaders on it as well as supplemental appropriations gained in 2020 under P.L. 116-123 and P.L. 116-127. Consultation continued under the Biden-Harris Administration. This was heightened once the American Rescue Plan Act (P.L. 117-2) was signed into law on March 3, 2021.

The IHS has reported, "the COVID-19 pandemic has disproportionately affected American Indian and Alaska Native (AI/AN) populations across the country. AI/ANs have infection rates over 3.5 times higher than non-Hispanic whites, are over four times more likely to be hospitalized as a result of COVID-19, and have higher rates of mortality at younger ages than non-Hispanic whites." In 2021, the White House and federal agencies, such HHS, IHS, CDC and CMS intensified their efforts on consultation and allocating appropriated funds to IHS facilities, Tribes and Urban Indian Organizations. These sessions were open to non-elected Tribal health officials to stay abreast of the situation as COVID -19 continues to impact Tribal communities.

The response by Tribal Nations has involved the establishment of incident command teams and significant local policy adjustments to address the rise in COVID-19 cases. This resulted in some reconfiguration of health care service delivery that shifted to urgent or emergent health services for a time, telehealth or telephonic care, isolation and quarantine measures, enhancing or referrals for inpatient treatment, masking advisement and setting up testing and vaccination sites. Other measures addressed the severe economic downturn that reservation communities began to experience and the shifts to virtual education in local schools. The Tribes instituted emergency lockdowns, curfews, stringent public gathering quotas and staff travel was curtailed. These measures were instituted to curb the growing number of positive cases (symptomatic or asymptomatic).

Federal agencies and organizations stepped up to provide information on the disease. These include the following:
https://www.ihs.gov/coronavirus/view
https://www.cdc.gov/coronavirus/2019-ncov/covid-data/covidview/index.html
https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page
https://www.nihb.org/covid-19/
https://coronavirus.jhu.edu/data

COVID-19 vaccines have been available in the U.S. since December 2020 followed by multiple booster formulations available to age groups down to 6 months of age. The vaccine supply is abundant to Tribal communities and Tribes demonstrate some of the highest COVID-19 vaccination rates among an US population. This protective factor has greatly reduced severe health outcomes and alleviated the stress on the health care delivery system experienced pre-vaccine availability. As a result, ITU health care operations have resumed many normal operations albeit with continued emphasis on COVID response and prevention.

RECOMMENDATION

Tribes in Arizona recommend ongoing funding to address the long term effects of COVID-19 on community members and health care delivery through increased funding. Ongoing advisement to the Administration from Tribal Leaders and Tribal and Urban Indian Organization officials should continue to address needs, challenges and report successes. Tribes continue to actively engage in the operation of their own specific public health emergency plans which are vital. As the ITU health delivery network evolves in the post-pandemic era, it is important to learn from the lessons of the pandemic, and integrate and expand care strategies (e.g., telehealth, long COVID).

Behavioral Health (Alcohol & Substance Abuse, Mental Heath) Authorities

ISSUE

Tribal Leaders continue to advocate for resources to address alcohol, substance abuse and mental health issues. Tribal members and their families that experience these issues require professional behavioral assistance and psychological evaluation services for appropriate treatment they can access within Tribal communities or if required, at state facilities when services are not available locally. More recently grants have become available to Tribes and Urban Indian Organizations to address prescription drug and opioid addiction from states or federal agencies. With this issue now affecting our Tribal and urban communities, efforts to heal AI/AN people must be advanced in earnest.

A continued struggle for IHS, Tribal and UIO's Behavioral Health programs is recruitment and retention of qualified behavioral health professionals. In order to address alcohol, substance abuse and mental health issues in Tribal and urban Indian communities; there is a need for licensed Behavioral Health professionals. There is extremely limited psychiatric prescriber service availability across the Phoenix Area. Currently, this is supplemented with increased tele-psychiatry and medication delivery services. Staff shortages and turnover leads to increased costs for continued recruitment, training, orientation, and retention efforts.

BACKGROUND

While reported visits to Indian health treatment facilities remain high for alcohol, cannabis dependence and methamphetamine, prescription drug abuse, including addiction to opioid pain killers and heroin affects Tribes. According to a U.S. HIDTA report in 2007-2009, the AI/AN drug-related death rate was 1.8 times greater than the U.S. all races rate of 12.6 for 2008. In Arizona, for example, the 2014 Arizona Youth Survey included a question on past 30 day prescription drug misuse among 3,871 American Indian youth. The statewide average rate among 48,244 of 8th, 10th and 12th grade students was 6.3 percent, however among American Indian youth the average rate was about 7.9 percent.

Since 2016, IHS required that providers attend mandatory training and check State Prescription Drug Monitoring databases before prescribing opioids. In 2017, IHS established the IHS National Committee on Heroin, Opioid and Pain Efforts (HOPE). The IHS has conducted Naloxone training and instituted Medication Assisted Treatment (MAT) training through its Tele-Behavioral Health Center of Excellence (TBHCE). In the FY 2021 IHS Enacted Budget, opioid related funding continued at FY 2020 levels.

RECOMMENDATION

Tribes have advised that integrated medical and behavioral health treatment teams can work effectively to address substance abuse and mental health concerns. Consideration should be given to incorporate Traditional Healers as members of these teams. Funding increases will assist with the provision of competitive salaries for behavioral health care professionals and mid-level providers. The amounts requested in FY 2027, include a funding of $4.77 million for Mental Health and $3.97 million for the Alcohol and Substance Abuse program.

IHS, Tribes and UIOs must continue to ramp up and sustain efforts to address risks associated with opioid and prescription drug misuse. This includes maintaining clinical practices that address opioid high risk infant care. This also includes program efforts that focus on detoxification, treatment and utilizing MAT.

Unmet Construction Needs for All Areas and Urban Indian Health Programs

ISSUE

Major increases are needed to fund construction projects that are already identified by the Indian Health Service. The Health Care Facility Construction (HCFC) and Sanitation Facilities Construction backlogs are reported to the U.S. Congress which include the following projects and funding levels the Tribes continue to prioritize in FY23, FY24 and beyond:

- Health Care Facilities Construction:
  - Priority List +$3.18 billion (Includes Small Ambulatory Program +$25 million)
  - New IHCIA construction system/projects already identified by IHS Areas +$14.5 billion
- Sanitation Facilities Construction (unfunded need) +$4.4 billion ($166M Phoenix)
- Urban Indian Organization facility renovation +$2 billion (new)

As noted above, Tribes in the Phoenix Area seek the continuation of the Small Ambulatory Program. Also of importance is the need to fund Section § 1659 of the IHCIA for minor renovations to Urban Indian Organization facilities, as well as potential construction or expansion of these facilities, including leased facilities. Following passage of the Infrastructure Investment and Jobs Act (IIJA), approximately 4 times the funding is available for Phoenix Area sanitation facilities from FY22 – FY26. These increase resources also increase the staffing resource needs by nearly two fold. The IIJA allowed for 3% of funds be designated for project administration (including Sanitation Facilities Construction engineering and support staff); however 15% of construction cost is typically required for IHS engineering – thus leaving a gap in funds to staff these projects with the necessary engineers.

BACKGROUND

Phoenix Area Health Care Facilities Construction Activity

Reported below are four facility replacement projects in final planning stages or already under construction in the Phoenix Area.

- Phoenix Indian Medical Center (PIMC) is the IHS referral care facility for the Phoenix Area's AI/AN population of 178,854. The 50-year old facility has been on the IHS hospital replacement list since 1990. The facility requires ongoing investments in electrical, mechanical, and water & sewer improvements, with $35M in essential maintenance projects identified without current funding. This includes $15M for a multistory parking garage required for the approximately $1.2B PIMC replacement facility. The closure of the PIMC Obstetric/Labor & Delivery Department and a surgical operatory in 2020 due to

maintenance issues caused great concern among patients and resulted in a meeting between Tribal Leaders and PAIHS leadership.
- The Salt River People Health Center (SRPHC) was completed in January 2022 under a self-determination construction agreement with the Salt River Pima-Maricopa Indian Community.
- Replacement of the 45-year old, 2,200 sq. ft. Havasupai Clinic was expected to begin in January 2021 with the construction of a new $13M, 9,000 sq. ft. clinic with integrated staff quarters. Due to the COVID-19 pandemic the construction start was delayed to October 2021. The location of the clinic at the bottom of the Grand Canyon has created extensive logistical and cost factors unique to this project with estimated completion by late 2023.
- The 42-year old Whiteriver Indian Hospital has been identified for replacement with a new 400,000 sq. ft. facility and 250+ new staff quarters. The current estimated project cost is $726M. The planning documents were approved in April 2022 with an anticipated FY23 appropriation of $100M to enable initiation of A-E design services and utilities improvements. The A-E design solicitation closes in January 2023 with award anticipated for the spring of 2023.

Tribes in the Phoenix Area also commend the IHS policy that all new HCFC funded projects include an additional 4% of the necessary resources dedicated to the incorporation of sustainability features into the project. Tribal values align with promoting human health and energy efficiency which lessen any negative environmental impacts on Tribal lands in the construction process.

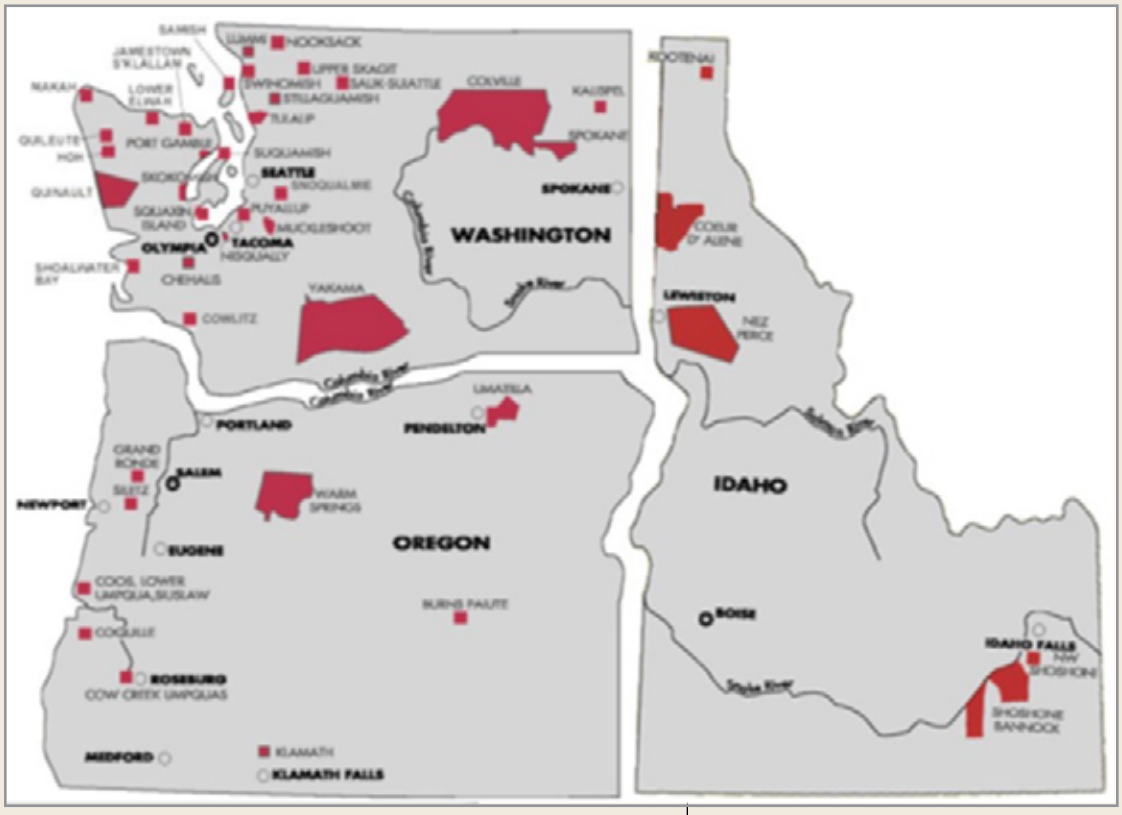
Phoenix Area Sanitation Facilities Construction (SFC) Activity

There are currently 205 active Phoenix Area funded SFC projects with $121M in undisbursed funds. There are 71 unfunded projects valued at $166M that are expected to be funded in the next 4 fiscal years with IIJA, SFC Regular and contributed funds with an estimated $47M in projects expected to be funded in FY23. Reported below are four active Phoenix Area SFC projects in final planning stages or already under construction.
- The San Carlos Regional Wastewater Treatment System is in need of replacement wastewater treatment facility (WWTF) due to being drastically undersized for the incoming wastewater load. In 2022, a preliminary engineering report was completed by SFC staff recommending a new $33M WWTF that is expected to be funded in FY23 for design and construction.
- The Colorado River Indian Tribes (CRIT) requires a new water treatment plant to ensure that safe drinking water is provided to the CRIT community now and in the future. This project is funded and is being designed with construction completion planned for 2025.
- The Hopi Tribe village of Old Oraibi has never had running water or sewer collection and disposal services. In 2021, the Tribe and Village agreed to receive these sanitation facilities and in FY22 a new sanitation facilities construction project was funded for $11.6M. New water and sewer service have been preliminarily designed and are planned for construction completion by the end of CY2025.
- The Fallon Paiute-Shoshone Tribe requires a WWTF expansion to meet the growing community's wastewater disposal needs. In FY20, a $1.9M project was funded to increase the capacity of the existing WWTF. This project is currently out for bid and construction is expected to be completed by the end of CY 2023.

RECOMMENDATION

The national facility and sanitation infrastructure needs and estimated funding were identified in the 2020 Facilities Appropriations Information Report completed by IHS. Tribes continue to advocate for the required funding to alleviate lack of space and old infrastructure which effects the quality of patient health care and delay the new construction priority system. This request is associated with numerous IHCIA provisions in SUBCHAPTER III—HEALTH FACILITIES (§1631 et. al.) that require committed funding. For these reasons, a total of $703.44 million has been identified as recommended increase for Facilities in FY 2027. Further, increases in funds are encouraged to assure the appropriate SFC engineering workforce to deliver funded projects and associated workload.

Portland Area



13 Title 1 Tribes
- 3 Title 1 Orgs & YRTC
- 5 Title 1 DST
- 25 Title V Tribes
- 3 Urban Indian Organizations
- User Pop –(Approx.)
  - 218,000 registrants
  - 114,600 active

Consultation

Portland Area IHS held a virtual consultative meeting on December 11, 2024, with the Northwest Portland Area Indian Health Board and the Area's 43 Tribes. Following a thorough discussion of the Area Tribal health care needs, the Portland Area IHS national FY 2027 budget recommendations were established, as highlighted below.

Summary of FY 2027 Budget Recommendations

The national budget mark for FY 2027 is a full funding request of $71.8 billion. With the exception of funding a Regional Specialty Referral Center, Portland Area Tribes do not support additional funding in Health Care Facilities Construction (HCFC) due to decades of non-funding for the 43 Tribes in Portland. Portland Area and lack of equity with the Health Care Facilities Construction Priority System as to new health care facility construction and staffing.

PRIORITY	RECOMMENDED PERCENTAGE INCREASE
Purchased/Referred Care	74%
Mental Health	8%
Alcohol & Substance Abuse	8%
Hospitals and Health Clinics	4%
Urban Health	2%
Dental Services	1%
Indian Health Professions	1%
Maintenance & Improvement	1%
Public Health Nursing	1%
Comm. Health Reps	1%

Current Services

FUND PAY COSTS, INFLATION AND POPULATION GROWTH

IHS funded programs have absorbed significant inflationary cost increases over the past twenty years. Federal and Tribal programs struggle to absorb resource losses associated with inadequate funding for inflation, Pay Act increases and population growth.

Binding Obligations

STAFFING FOR NEW FACILITIES, HEALTH CARE FACILITIES CONSTRUCTION & CONTRACT SUPPORT COSTS

The Health Care Facilities Construction Priority System resource allocation process does not equitably benefit areas nationally and adversely impacts funding for inflation, pay costs and population growth. Therefore, Portland Area does not support funding for Health care Facilities Construction and related staffing.

Portland Area supports the Contract Support Costs indefinite appropriation for this account to ensure full funding required to support contracted or compacted programs. However, this line item continues to take up a significant percentage of the IHS discretionary budget reducing funds for program increases, population growth, and medical inflation within the discretionary appropriations caps. To address this, Contract Support Costs must move to mandatory appropriations to ensure that other areas of the IHS budget are not reduced or impacted.

Budget Line Allocation Justification

PURCHASED/REFERRED CARE

Portland Area recommends allocating 74% of FY 27 increases to the Purchased/Referred Care (PRC) budget line item. Portland Area IHS does not have hospitals or specialty care centers yet. The Portland Area received funding for the first Regional Specialty Referral Center anticipated to be constructed by 2027. The Center will alleviate some of the PRC demands in the Seattle area until the two other Centers are funded and constructed.

As of FY 2024, thirty percent (30%) of the Portland Area budget is comprised of PRC. Tribes -must rely on the PRC program for tertiary and inpatient care. The increase would increase access to hospitals and specialty care for AI/ANs in the Northwest to address the following health disparities and unintentional injuries:

Cancer: In the Portland Area, cancer is the second leading cause of death for AI/AN people. [133]

In 2021-2023, the age-adjusted rate of cancer mortality was similar between AI/AN and NHW, at 144.7 deaths per 100,000 people and 150. 7 deaths per 100,000 people, respectively. However, disparities can be found when looking at site-specific cancer mortality. Colorectal cancer mortality was 20.8% higher for AI/AN than NHW. Liver cancer mortality was 73.4% higher for AI/AN than NHW.[134] In 2019-2021, the age-adjusted rate of cancer incidence was 15.7% higher for AI/AN than NHW.[135] One factor contributing to these disparities is limited access to cancer screening. In 2020, less than 30% of Portland Area IHS patients received age-appropriate breast, cervical and colorectal cancer screenings.

Cardiovascular, Heart Disease and Stroke: Cardiovascular disease is the leading cause of death for AI/AN people.[136] In 2021-2023, the age-adjusted cardiovascular mortality rate for AI/AN appeared to be 7% higher than that of NHW (225.0 deaths per 100,000 and 210.1 deaths per 100,000, respectively).[137] The age-adjusted stroke mortality rate was similar between AI/AN and NHW.The prevalence of risk factors for cardiovascular disease (CVD) among AI/AN people is significant, with 63.7% of AI/AN men and 61.4% of AI/AN women having one or more CVD risk factors. The sharp rise

133 Death certificates from the Washington Center for Health Statistics, Oregon Center for Health Statistics, and Idaho Bureau of Vital Records and Statistics that were corrected for AI/AN misclassification through linkage with the Northwest Tribal Registry by NPAIHB's Improving Data & Enhancing Access – Northwest (IDEA-NW) Project, 2017-2022.

134 Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Mortality 2018-2023 on CDC WONDER Online Database, released in 2025. Data are from the Multiple Cause of Death Files, 2018-2023, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/ucd-icd10-expanded.html on March 5, 2025.

135 United States Cancer Statistics - Incidence: 1999 - 2021, WONDER Online Database. United States Department of Health and Human Services, Centers for Disease Control and Prevention and National Cancer Institute; 2023 submission; 2024 release. Accessed at http://wonder.cdc.gov/cancer-v2021.html on Mar 5, 2025.

136 Death certificates from the Washington Center for Health Statistics, Oregon Center for Health Statistics, and Idaho Bureau of Vital Records and Statistics that were corrected for AI/AN misclassification through linkage with the Northwest Tribal Registry by NPAIHB's Improving Data & Enhancing Access – Northwest (IDEA-NW) Project, 2017-2022.

137 Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Mortality 2018-2023 on CDC WONDER Online Database, released in 2025. Data are from the Multiple Cause of Death Files, 2018-2023, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/ucd-icd10-expanded.html on March 5, 2025.

in diabetes prevalence unquestionably plays an important role in the increasing rates of heart and other cardiovascular diseases in Indian Country. Screening rates for key predictors of cardiovascular health has increased in Portland Area and the proportion of patients with these diseases are benefitting from treatment with greater percentages having blood pressure and cholesterol in the healthy range.

Liver Disease: Chronic liver disease is the 5th leading cause of death among AI/AN people in the Northwest, while being the 8th leading cause of death for NHW.[138] In 2021-2023, the age-adjusted rate of mortality due to chronic liver disease and cirrhosis for AI/AN was 3.6 times that of NHW (59.1 deaths per 100,000 and 16.3 deaths per 100,000, respectively).[139] A majority of deaths are attributed to cirrhosis of the liver due to Alcoholic Liver Disease (ALD) or infection of hepatitis C. 25 to 44 year old women are 15 times more likely to die of chronic liver disease than whites. In the Portland Area, AI/AN people died from hepatitis C at more than 4 times the rate of NHW.[140]

Diabetes: In the Portland Area, approximately 12.2% of AI/AN adults report having been diagnosed with diabetes in 2022.[141] AI/AN people have twice the rate of avoidable hospitalizations for diabetes compared to non-Hispanic whites. Diabetes mortality rates for AI/AN people are twice the rate of NHW people in the region (44.7 per 100,000 and 22.5 per 100,000, respectively). The consequences of uncontrolled diabetes can affect the functioning of many different organ systems, primarily through chronic damage to blood vessels resulting in heart attacks, strokes, kidney failure, blindness, and amputations. AI/AN people not only have an increased prevalence of diabetes, they also have high rates of complications and uncontrolled diabetes and a higher rate of mortality as a result of diabetes.

Long Covid: The long term impacts of Covid-19 are still unknown. AI/AN people in the Portland Area and nationwide have experienced disproportionate rates of Covid-19 infections, hospitalizations, and deaths. Covid-19 was the fourth leading cause of death for AI/AN people in the Northwest in 2020-2022, and was the primary cause for the sharp decrease in life expectancy experienced by AI/AN people in 2020.[142] While research on the burden and treatment of long Covid needs to be conducted, there is an urgent need for immediate funding to treat AI/AN people living with this often-debilitating condition.

Other Diseases: In 2016, 8.7% of AI/AN hospitalizations were due to infectious causes, compared to 6.4% for non-AI/AN people. In 2021-2023, AI/AN people were 2.1 times more likely to die from influenza and pneumonia compared to NHW people in the region.[143] While the prevalence of HIV for AI/AN people is relatively lower, Northwest AI/AN people are 2.8 times more likely to die from HIV and its complications compared to the general population. In 2021-2023, viral hepatitis mortality for AI/AN was 4.5 times higher than that of NHW.[144]

Unintentional Injuries: Unintentional injuries are the leading cause of death for AI/AN people from ages 5 to 54, and the third leading cause of death overall for AI/AN people in the Portland Area.[145] In 2021-2023, AI/AN people experienced over twice the

138 Death certificates from the Washington Center for Health Statistics, Oregon Center for Health Statistics, and Idaho Bureau of Vital Records and Statistics that were corrected for AI/AN misclassification through linkage with the Northwest Tribal Registry by NPAIHB's Improving Data & Enhancing Access – Northwest (IDEA-NW) Project, 2017-2022.

139 Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Mortality 2018-2023 on CDC WONDER Online Database, released in 2025. Data are from the Multiple Cause of Death Files, 2018-2023, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/ucd-icd10-expanded.html on March 5, 2025.

140 Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Mortality 2018-2023 on CDC WONDER Online Database, released in 2025. Data are from the Multiple Cause of Death Files, 2018-2023, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/ucd-icd10-expanded.html on March 5, 2025.

141 Fiscal year 2018- October 2022 data, Portland Area, National Data Warehouse, Indian Health Service. Accessed April 19, 2023.

142 Death certificates from the Washington Center for Health Statistics, Oregon Center for Health Statistics, and Idaho Bureau of Vital Records and Statistics that were corrected for AI/AN misclassification through linkage with the Northwest Tribal Registry by NPAIHB's Improving Data & Enhancing Access – Northwest (IDEA-NW) Project, 2017-2022.

143 Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Mortality 2018-2023 on CDC WONDER Online Database, released in 2024. Data are from the Multiple Cause of Death Files, 2018-2023, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/ucd-icd10-expanded.html on Feb 3, 2025.

144 Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Mortality 2018-2023 on CDC WONDER Online Database, released in 2024. Data are from the Multiple Cause of Death Files, 2018-2023, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/ucd-icd10-expanded.html on March 5, 2025.

145 Death certificates from the Washington Center for Health Statistics, Oregon Center for Health Statistics, and Idaho Bureau of Vital Records and Statistics that were corrected for AI/AN misclassification through linkage with the Northwest Tribal Registry by NPAIHB's Improving Data & Enhancing Access – Northwest (IDEA-NW) Project, 2017-2022.

mortality rate for unintentional injuries compared to NHW in the region (178 deaths per 100,000 and 69 deaths per 100,000, respectively).[146] Deaths from unintentional injuries among Northwest AI/AN people have increased sharply since 2019, driven by increases in overdoses, motor-vehicle accidents, falls, and homicide and suicide deaths involving firearms.[147]

Mental Health

Portland Area IHS recommends allocating 8% of FY 27 increases to the Mental Health budget line item. Increased funding is needed in Mental Health to increase services and/or providers. Funding to support youth inpatient and outpatient treatment services for both mental health and inpatient care.

In addition, IHCIA allows for expansions to behavioral health programs which have not received substantial funding since enacted. Funding increases would be used to implement IHCIA Section 702 to expand behavioral health care for prevention and treatment and Section 704 to provide more comprehensive care through detox, psychiatric hospitalization and community-based education and rehabilitation programs. The Area would also like IHCIA Section 705 funded to expand the use and dissemination of a Mental Health Technician Program to serve patients, as well as Section 715 to expand Behavioral Health research grants to allow Tribes to find more innovative and effective approaches to address issues like AI/AN youth suicide.

This request is supported by current mental health data:

Depression: AI/AN people in the Northwest are more likely to report depression or poor mental health than non-Hispanic whites.[148]Over 30% of adult AI/AN people in the Northwest have been told they have a depressive disorder, compared to 25.4% of NHW.[149] AI/AN people are less likely to report receiving mental health treatment, despite screening for depression in Portland Area clinics which meets or exceeds the IHS GPRA standard in most facilities.

Suicide: Suicide was the 8th leading cause of death among AI/AN people in the Portland Area in 2020-2022 and accounted for 2.5% of all deaths among AI/AN people.[150] Data from Oregon, Washington, and Idaho for the years 2018-2022 show that the age-adjusted suicide rate for Northwest AI/AN was 19.5 deaths per 100,000 (95% confidence interval: 17.0-22.0), which seemed to be 11% higher compared to the total Northwest population's suicide rate of 17.5 deaths per 100,000 (95% confidence interval: 17.2-17.8).[151] In 2020-2022, when looking at age groups, suicide was the second leading cause for AI/AN ages 5-29 and the third leading cause of death for AI/AN ages 30-44.[152]

Covid-19

The COVID-19 pandemic has exacerbated the burden of mental illnesses and suicide among Northwest AI/AN communities. Emergency department visits for suicide ideation and attempts increased between 2019 and 2020. The majority of suicide-related emergency department visits among AI/AN people occur among younger people ages 10-29. In 2021-2023, the age-adjusted COVID-19 mortality rate for AI/AN was twice that of NHW (74.9 deaths per 100,000 and 37.2 deaths per 100,000).[153]

146 Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Mortality 2018-2023 on CDC WONDER Online Database, released in 2025. Data are from the Multiple Cause of Death Files, 2018-2023, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/ucd-icd10-expanded.html on March 5, 2025.

147 Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Provisional Mortality on CDC WONDER Online Database. Data are from the final Multiple Cause of Death Files, 2018-2021, and from provisional data for years 2022 and later, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/mcd-icd10-provisional.html on Nov 20, 2023.

148 Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System (BRFSS), 2022. https://nccd.cdc.gov/weat/#/crossTabulation . Accessed: 05 Mar 2025.

149 Ibid.

150 Death certificates from the Washington Center for Health Statistics, Oregon Center for Health Statistics, and Idaho Bureau of Vital Records and Statistics that were corrected for AI/AN misclassification through linkage with the Northwest Tribal Registry by NPAIHB's Improving Data & Enhancing Access – Northwest (IDEA-NW) Project, 2017-2022.

151 Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Mortality 2018-2022 on CDC WONDER Online Database, released in 2024. Data are from the Multiple Cause of Death Files, 2018-2022, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/ucd-icd10-expanded.html on May 23, 2024.

152 Death certificates from the Washington Center for Health Statistics, Oregon Center for Health Statistics, and Idaho Bureau of Vital Records and Statistics that were corrected for AI/AN misclassification through linkage with the Northwest Tribal Registry by NPAIHB's Improving Data & Enhancing Access – Northwest (IDEA-NW) Project, 2017-2022.

153 Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Mortality 2018-2023 on CDC WONDER Online Database, released in 2025. Data are from the Multiple Cause of Death Files, 2018-2023, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/ucd-icd10-expanded.html on March 5, 2025.

Trauma: Up to 74% of AI/AN youth have experienced at least one traumatic event during childhood. AI/AN people are 2-3 times more likely to meet Post Traumatic Stress Disorder (PTSD) criteria compared to the US adult population. AI/AN people have 2.5 times greater risk than the national average of experiencing physical, emotional and/or sexual abuse. AI/AN communities experience a layering effect of these conditions along with historical trauma.

Intimate Partner Violence and Sexual Assault: According to the US Department of Justice, AI/AN women are 2.5 times more likely to be raped or sexually assaulted than women in the US in general. 34.1% of AI/AN women will be raped during their lifetime. In the Northwest, AI/AN people are 40-70% more likely than White people to seek care at an emergency room for sexual violence. It's widely accepted that these statistics do not accurately portray the extent of the sexual violence against AI/AN women

Alcohol and Substance Use

Portland Area IHS recommends allocating 8% of FY 27 increases to Alcohol and Substance Abuse budget line item. Increased funding is needed to expand alcohol and substance use services and providers.

In the Portland Area, NH-AI/AN people are more than 3.0 times more likely to die from alcohol-related causes than NHW people.[154] AI/AN have a drug overdose mortality rate 2.2 times that of non-AI/AN people.[155] Opioids are involved in 78% of AI/AN overdose deaths, and stimulants are involved in 56% of AI/AN overdose deaths in the Northwest. Opioid-related overdose rates among NH-AI/AN people in the Northwest have increased by 400% since 2018.[156]

Hospitals and Clinics

Portland Area IHS recommends allocating 3% of FY 27 increases to the Hospitals and Clinics (H&C) budget line item to support the Community Health Aide Program (CHAP) expansion. Portland Area Tribes support increased funding for the CHAP expansion, authorized in the IHCIA under Section 1111.

The request is supported by Portland Area Tribes through the work that has been done on CHAP expansion in the Portland Area for the past six years. Portland Area Tribes have led the way in CHAP expansion. Both a Dental Health Aide Education Program and Behavioral Health Aide Program have been established with students in both programs. The Community Health Aide Program is currently in development. Increased funding is needed to support the education programs and the Portland Area CHAP Certification Board. Portland Area IHS is the first to establish a program and Certification Board.

Urban Health

Portland Area IHS recommends allocating 2% of increases in FY 27 to the Urban Indian Health budget line item, in part, to allow Urban Indian Organizations to purchase insurance for their users.

Dental Services

Portland Area IHS recommends allocating 1% of increases in FY 27 to the Dental Services budget line item.

Indian Health Professions Services

Portland Area IHS recommends allocating 1% of increases in FY 27 to the Indian Health Professions budget line item.

Maintenance & Improvement

Portland Area IHS recommends allocating 1% of increases in FY 27 to the Maintenance & Improvement budget line item.

Public Health Nursing

Portland Area IHS recommends allocating 1% of increases in FY 27 to the Public Health Nursing budget line item.

Community Health Representatives

Portland Area IHS recommends allocating 1% of increases in FY 27 to the Community Health Representatives budget line item.

154 Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Provisional Mortality on CDC WONDER Online Database. Data are from the final Multiple Cause of Death Files, 2018-2023, and from provisional data for years 2024 and later, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/mcd-icd10-provisional.html on Mar 5, 2025

155 NPAIHB Data Hub.

156 Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Provisional Mortality on CDC WONDER Online Database. Data are from the final Multiple Cause of Death Files, 2018-2023, and from provisional data for years 2024 and later, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/mcd-icd10-provisional.html on Mar 5, 2025.

CONCLUSION

The budget request outlined in this document represents a consultative process that began many years ago between Portland Area IHS, Northwest Portland Area Indian Health Board and Tribes.

The Portland Area's budget request demonstrates a commitment to maintain health programs by funding current services. The Portland Area recommends funding initiatives to address the health disparities that exist for AI/AN people.

Fully funding the budget will further the goal of the IHS and the Portland Area Tribes to elevate the health status of AI/AN people.

Hot Issues

ISSUE # 1
Indian Health Service Appropriations

BACKGROUND

Indian Health Service (IHS) is currently funded through discretionary appropriations. In FY 2024, IHS received advance appropriations which ensures continuity of care for AI/AN people who receive care at IHS. Prior lapses in annual appropriations and continuing resolutions jeopardized the health of AI/AN people and was harmful to the Indian health system.

RECOMMENDATIONS

Mandatory Funding

Move IHS funding from discretionary appropriations to mandatory appropriations. This would ensure adequate, stable and predictable funding annually. It is important to immediately move Contract Support Costs (CSC) and 105(l) lease costs to mandatory. Significant increases to CSC and 105(l) costs annually are impacting program increases, including medical inflation and population growth, to IHS and Tribal health programs.

Advanced Appropriations Funding

Continue advanced appropriations and expand to all IHS accounts to support federal and Tribal health programs formally plan and address emergent health issues comprehensively.

Reconcile Funding

Reconcile IHS funding with Tribal input to ensure that IHS funds are not rescinded or returned. Federally operated and Tribal health programs are underfunded so any rescission or return of funding is harmful to Tribes.

Medicaid and Medicare Reimbursements; 340B

ISSUE #2
Medicaid and Medicare Reimbursements; 340B Program

BACKGROUND

Medicaid, CHIP, and Medicare programs provide critical health coverage for AI/AN people and is a vital source of financing for health care for IHS, Tribally operated, and urban health programs (I/T/U) in Portland Area and across Indian country.

RECOMMENDATIONS

Community Health Aide Providers

Request that CMS broadly support reimbursement of Dental Health Aide Therapists (DHAT), Behavioral Health Aides/Practitioners, and Community Health Aides/Practitioners at the OMB Encounter Rate to ensure sustainability of these provider types in the system.

Medicare Outpatient Encounter Rate

Require HHS and CMS pay the Medicare outpatient per visit rate for services provided by IHS and Tribal health programs.

Traditional Healing and Alternative Care

Request that SAMHSA promptly approve 1115 Waivers that request reimbursement of traditional healing services. Tribes in the states of California, Arizona, Traditional Healing Tribes request Medicare and Medicaid reimbursement at the OMB Encounter Rate for traditional and cultural healing practices and activities. In addition, Tribes request that all types of alternative care, including new and innovative therapies that provide healing and well-being to AI/AN people be reimbursed at the OMB Encounter Rate. The Seattle Indian Health Board is collecting outcome data on the use of traditional healing practices that will support reimbursement of these services.

340B Program

Request that HHS and HRSA protect the 340B program and make changes to allow Direct Service Tribes to participate in the program. This is an important program for Tribal health programs in the Portland Area that ensures affordability of critical and life-saving pharmaceuticals.

ISSUE #3
Mental Health & Substance Use Disorder (SUD)

BACKGROUND

Mental illness and substance use continue to devastate many American Indian/Alaska Native communities in the Portland Area. Fentanyl related overdoses and deaths have increased dramatically. Of concern are Native youth who are particularly vulnerable to fentanyl/substance misuse and suicide ideation and attempts.

RECOMMENDATIONS

Prevention and Treatment Funding

Provide a 10% Tribal set aside of Substance Abuse Mental Health Services Administration (SAMHSA) funding to increase support prevention and treatment services available to Tribes with funding provided directly to Tribes through an interagency agreement between SAMHSA and IHS so that funds can be transferred to Tribes through Indian Self-Determination Education Assistance Act (ISDEAA) compacts and contracts. Prevention funding is a critical component to Tribes implementing the Icelandic Prevention Model.

Redirect SAMHSA State Block Grant funding directly to Tribes or transfer funds to the Indian Health Service to be allocated to Tribes through their ISDEAA compacts or contracts.

Comprehensive Opioid/Fentanyl Response

Request cross-collaboration of governmental agencies to comprehensively address the opioid/fentanyl crisis in Tribal communities; and federal and state agency support of a Tribally driven, multi-year plan, with the end goal of ending this crisis. The following federal agencies must be included in the collaboration: Department of Health and Human Services, Indian Health Service, Substance Abuse Mental Health Services Administration, Centers for Medicare and Medicaid Services, Centers for Disease Control and Prevention, Health Resources Services Administration, Department of Housing and Urban Development, Department of Interior, and Department of Justice.

Successful Models

Request that HHS, IHS and SAMHSA support opportunities for Tribes to replicate successful models to treat opioid misuse such as the Swinomish Tribal Community's Didgwalic Wellness Center "Integrated Care" model. Capital funds are needed to build facilities to replicate this model program in Tribal communities. In addition, Portland Area Tribes are interested in innovative interventions, including Narcan vending machines.

Suicide

Request that SAMHSA and IHS increase funding to reduce suicide rates and increase Tribal capacity to prevent suicide throughout Indian Country. Provide additional funding dedicated to suicide prevention, intervention, postvention and improving the reach of 988 and Tribal specific suicide prevention lifeline hubs.

National Tribal Behavioral Health Agenda

Request that SAMSHA update and fully fund the National Tribal Behavioral Health Agenda to improve the behavioral health of American Indian/Alaska Native people. This includes acknowledging and supporting the development of Tribally based, traditional Indigenous knowledge and cultural practices in prevention and interventions.

Behavioral Health Aides (BHA)

Request that SAMHSA and IHS partner with Tribes and support the Behavioral Health Aide (BHA) education program and services provided by BHAs. BHAs are a provider type under the Community Health Aide Program that is growing and intended to fill behavioral health provider needs in Tribal communities.

Inpatient Mental Health and SUD Treatment Programs, Aftercare and Housing

Request for HHS, IHS and SAMHSA to fund and/or increase access to culturally specific inpatient treatment programs and secure detoxification centers for American Indians/Alaska Natives using alcohol, methamphetamines, and/or opioids. Studies show that to be effective, a patient requires 180 days of inpatient treatment, as well as after care and housing.

Youth Residential Treatment Centers, Aftercare and Transitional Living Support

Request that IHS and SAMHSA consult with Tribes and Native youth on youth specific programs and funding sources that comprehensively address the needs of Native youth and provide a specific funding source to develop more Youth Residential Treatment Centers. Also needed are aftercare and transitional living support for both substance use and mental health services.

Youth Behavioral Health Agenda
Request for SAMHSA and IHS to work with Native Youth to develop a Youth Behavioral Health Agenda which includes addressing expansion of youth-friendly telehealth services and tailored mental health and alcohol and drug prevention messaging.

Traditional Healing
Request that HHS, IHS and other agencies increase funding sources for traditional healing practices.

Request that CMS expand Medicaid reimbursement of traditional healing services to all states and focus on Medicare reimbursement. Traditional healing among American. Indians/Alaska Natives is a powerful cultural practice that creates harmony and balance physically, mentally, emotionally and spiritually. It strengthens cultural identity, community support systems, and political empowerment, all of which have been identified as pathways to resilience for American Indians/Alaska Natives populations.

Tribal Boarding Schools
Request that the Department of Interior and HHS continue to provide funding and support for healing for boarding school survivors and their families. Historical trauma for American Indians/Alaska Natives is rooted in Indian Boarding Schools, which continues to impact Tribal communities today.

ISSUE #4
Community Health Aide Program (CHAP) Expansion

BACKGROUND
Northwest Portland Area Indian Health Board (NPAIHB), with the support of Northwest/Portland Area Tribes, are leaders in the lower 48 in CHAP expansion. In addition, the Indian Health Service and NPAIHB have established a Portland Area CHAP Certification Board; and NPAIHB has created CHAP provider education programs. NPAIHB has also successfully worked with the states of Idaho, Oregon and Washington and the Tribes to lay the foundation for integration of these providers in the Portland Area Indian health system.

RECOMMENDATIONS
CHAP Expansion
Increase funding for the national CHAP expansion at $60 million with $10 million for Portland Area to continue to expand CHAP. Recommend inclusion of Portland Area in CHAP education funding to support Tribal education programs for Dental Health Aide Therapists (DHAT) and Behavioral Health Aides (BHA).

IHS Scholarship and Loan Repayment
Request to IHS that CHAP providers, including DHATs, BHAs, and Community Health Aides (CHA) be eligible for IHS Scholarship and Loan Repayment Programs.

ISSUE #5
Regional Specialty Referral Center (Center)

BACKGROUND
There are no Indian Health Service hospitals in the Portland Area. Portland Area Tribes rely on Purchased and Referred Care (PRC) for all specialty and hospital care. American Indian/Alaska Native people who are not part of their State's managed care Medicaid program, or on Medicare, experience increased wait times due to limited providers and appointment availability.

As a result of Master Planning activities in 2005, three regional referral specialty centers were proposed to fill unmet needs within the Portland Area. The Program of Requirements and Program Justification Document were finalized in April 2016.

In 2022, IHS allocated funds to build the first Center in Puyallup (Washington State). The Portland Area Office, in consultation with the Portland Area Facilities Advisory Committee, a local Tribal advisory group, is moving forward on the first Center using Portland Area Tribes priorities for specialty care. The facility is anticipated to provide medical and surgical specialty care, specialty dental care, and specialty mental health/substance use care. The Centers will not impact Purchased and Referred Care (PRC) funding for Portland Area Tribes; instead, the Centers will maximize PRC funds for Tribes. This facility could provide services for approximately 50,000 users within the Portland Area as well as an additional 20,000 in telemedicine consultations.

The second and third facilities will be located in or around Portland, OR and Spokane, WA, respectively.

RECOMMENDATIONS
Increase Funding for First Center
Request that HHS/IHS increase funding for the first Center to ensure that it can be constructed given the inflation in building construction, and to ensure recruitment of experienced specialty providers and support for AI/AN who use the Center, including transportation and lodging for American Indians/

Alaska Natives who travel long distances to access Center services.

Fund Two More Centers
Request that HHS/IHS prioritize funding for the two other Portland Area Regional Specialty Referral Centers.

ISSUE #6
Staffing, Recruitment and Retention

BACKGROUND
Both Federally operated and Tribal health programs have difficulty with the recruitment and retention of qualified medical and behavioral health providers.

Direct Service Tribes expressed concerns about IHS vacancies and having to cover costs out of their Purchased and Referred Care (PRC) funding for services. For example, if IHS has a dental provider vacancy, a Tribe may pay for dental care using their PRC funding.

RECOMMENDATIONS
Indian Health Care Improvement Act Authorizations
Recommend full funding of IHCIA Sec. 112. Health professional chronic shortage demonstration program (25 U.S.C. § 1616p) and Sec.134. Methods to increase clinician recruitment and retention (25 U.S.C. § 1621t). Tribes also request expansion of Title 38 Physician and Dentist Pay (PDP) authorities to include market pay for all provider positions, including physician assistants. Also, request the same competitive advantage as the VA to grant higher levels of annual leave accrual to providers under Title 38 PDP.

Direct Service Tribes
Request that IHS reimburse Direct Services Tribes for services not provided by federal IHS staff due to staffing shortages and that are paid for by PRC funding. Create flexibility in how funding can be used when positions remain unfilled; and flexibility to compensate providers at higher rates or provide bonuses for provider recruitment and retention.

Provider Housing Pilot Project
Request IHS create a pilot project to support provider housing in the Portland Area as part of a comprehensive recruitment and retention program.

Reform Health Resources Services Administration Health Provider Shortage Area Scoring
Request of HRSA to incorporate Portland Area Tribes' recommendations to reform or change HPSA scoring for IHS and Tribal health programs. Portland Area Tribes have made countless comments and recommendations through the rule-making process and Tribal consultations with HRSA.

ISSUE # 7
Public Health Infrastructure

BACKGROUND
Indian Health Service is not fully funded to support Tribes' public health infrastructure. The pandemic highlighted the public health infrastructure needs of Tribes and shortfalls in Indian Health Service and Centers for Disease Control and Prevention funding.

Tribes need comprehensive funding to support public health infrastructure and their response to public health emergencies, including but not limited to, Tribal data sovereignty (data collection, surveillance, monitoring, and response), staffing and comprehensive public health departments.

RECOMMENDATIONS
Create a New Account
Request a new Indian Health Service account to support Public Health Infrastructure and fully fund the account.

Direct Funding to Tribes
Request that the Centers for Disease Control and Prevention (CDC) set aside direct funding for Tribal Nations for public health infrastructure or transfer funds to the Indian Health Service for distribution of funds through Indian Self-Determination Education Assistance Act (ISDEAA) compacts and contracts.

Tucson Area



PASCUA YAQUI TRIBE	TOHONO O'ODHAM NATION	TUCSON INDIAN CENTER
Enrolled Members: 21,376	Enrolled Members: 36,291	Urban Population: 44,817
Land base: 2,287 acres	Land base: 2.85 million acres	Metro Tucson

The Tucson Area is submitting a National Budget Increase as requested by the Tribal Budget Formulation Work-group at the 4.74% level over the FY 2024 National Budget Recommendations to achieve National Needs Based Funding amount of $53.8 Billion by 2026. The Tucson Area Office (TAO), Tohono O'odham Nation (TON), Pascua Yaqui Tribe (PYT) and the Tucson Indian Center (TIC) recommends program increase be distributed among the Tucson Area's Top Budget Funding Priorities.

The Tucson Area is the second Area to become predominately Self Governance within Indian Health Service.

The Tucson Area budget priorities are aligned with the FY 2027 National Budget when fully funded, these include and not limited to: Purchased/ Referred Care, Hospital & Health Clinics, Health Care Facilities Construction, New/Replacement Equipment, Mental Health, Community Health Based Programs, Alcohol & Substance Abuse, Public Health, Urban Program Services and Facilities, Long-Term Care/Assisted Services and Sanitation Facilities Construction.

We request that grant funded programs become a permanent funding for Tribes as part of the re-authorization and remove the competitive grants and award as 106(a) funding, such as: Special Diabetes Prevention for Indians (SDPI), Suicide Prevention Intervention and Postvention (SPIP), Domestic Violence Prevention Initiative (DVPI), and Cancer Prevention.

FY 2023 Omnibus Bill resulted in the passage of Advance Appropriations. The Tucson Area strongly recommends the Indian Health Service budget allocation be changed from discretionary appropriations to mandatory entitlements. We recommend all IHS funding be included in the Advance Appropriations: these include 105(L) Lease, Contract Support Cost (CSC), Indian Health care Improvement Funds, Sanitation Facilities Construction (SFC) and Electronic Health Record Systems (EHR).

Top Budget Priorities

Purchased/Referred Care

Purchased/Referred Care Services continues to be ranked as the highest budget priority based upon the increased cost of contracted specialty services, lack of funding, and limited scope of services provided at Tribal facilities. Arizona Tribes were disproportionately impacted by the pandemic; therefore, it is concerning with Long Term COVID-19 that members may need more specialty care services than anticipated in which such patient care would increase the costs of PRC. Moreover, with post COVID-19, patients have returned to normalcy and routine wellness care has identified an increase in diagnosis such as cancers, diabetes and other chronic illnesses. Forecasting medical care and medication costs has been difficult to project based upon the costs of inflation by the impact of the pandemic. Without additional funding the impact of COVID-19 vaccine, medication and supply costs has created a financial strain on our health care systems. In addition, the designation of Arizona as a state-wide PRCDA will also have a large impact on

PRC expenditures. In order to ensure that the health care services provided to American Indians living on the reservation are not curtailed, additional funding would be required. Increased funding would be necessary not only to pay for services provided to newly eligible PRC patients, but also for new staff to address the additional workload. It is extremely important for federal and state agencies to respect the government-to-government relationship through consultation with Tribes, as a failure to do so has adverse effects on access to care and the overall ability to provide quality health care services.

Hospitals & Health Clinics (H&HC) Dental Equipment

The Tucson Area recommends to preserve, protect and expand new services under the new provisions of the IHCIA. With a fully funded budget the access to quality health care would be possible and would provide funding to support expanding services in the IHCIA (for example sections 112, 123, and 124), which were authorized without appropriations.

Prevention and treatment of Type 2 Diabetes and the promotion of healthy lifestyles is a priority. SDPI funding has not been sufficient. Permanent reauthorization would address health problems such as amputations, blindness, end stage kidney disease and cardiovascular disease caused by Type 2 Diabetes.

Staffing continues to be a concern and challenge in providing quality health care, due to global issues, especially in rural areas, which continue to be a challenge that impacts operations in Tribal health care settings.

The lack of State reimbursement in Adult Dental Services cause the Tribes to supplement all non-emergency dental costs. Caps on dental services and benefits are limited to emergency services only. Dental equipment is costly and require frequent replacement. Due to inflation and supply chain challenges, PPE and sterilization supplies are difficult to acquire.

Equipment purchases and upgrades are needed throughout the facilities and in mobile units.

Health Care Facilities Construction

The Tucson Area continues to strongly support funding for new health care facilities in order for the Sells Hospital replacement to remain on the IHS Health Care Facilities Planned Construction Budget (HCFC priority list). The latest HCFC priority list shows construction funding required to begin the Sells Hospital replacement in FY 2024. We recommend that this funding schedule be maintained to ensure progression and completion of the construction of the Sells Hospital as outlined within the five-year plan. Maintaining aging facilities is costly and takes away from providing much needed health services.

New/Replacement Equipment

Tucson Area recommends funds for new and replacement equipment in order to provide quality medical service to diagnose and treat certain medical illnesses. Bio-medical life expectancy of current equipment has been surpassed and does not meet current health care needs or accepted standards of care. Much needed replacement equipment includes: CT scanner, exam room furniture and equipment, diagnostics and specialty instruments, central hospital sterilizers, and emergency response vehicles. As medical technology advances the current equipment is becoming obsolete at a faster pace.

Moreover, IT plays an integral part in the installation, operation and maintenance of new bio-medical equipment. New technology does not readily interface with the RPMS system. IT infrastructure is costly and require constant upgrades due to technological advances in medical and dental care. These funds would be used to purchase IT hardware and software such as: servers, software licensure, wireless and local area network connectivity, communication systems and upgrading the data infrastructure for mobile health care units.

Mental Health (MH)

There is a need to expand Public Health services to respond to the wide increase of mental health issues. Telehealth services have never been so critical at this time to meet the increased cases of mental health care treatment and awareness/ education to family and community. Mental Health Support Services, such as 24-hour Helplines and transportation to crisis centers have been impacted due to limited resources and licensed personnel. Additional funding would enable the social-behavioral workforce to better serve the population, provide adequate behavioral health training and community educational programs.

American Indians and Alaska Natives (AI/AN) fall victim to violent crime at more than double the rate of all other U.S. citizens and at least 70% of violent victimization experienced by American Indians and

Alaskan Natives is committed by non-Native and usually while they are intoxicated. Nearly one-third of all AI/AN victims of violence are between the ages of 18 and 24 years, and about one violent crime occurs for every four persons of this age.

To address these issues, recent increases in behavioral health funding has only been allocated through limited time sensitive competitive grants. We recommend the funding become a permanent fund for Tribes and remove the competitive grant process. These funds should be part of the Tribal compact. There are time constraints in the grant process to award funding which creates a barrier to address behavioral health crisis and interventions. Due to limited services available, many individuals are not able to receive timely services for mental illness or emotional disorders and may self-treat by using or abusing alcohol or drugs.

According to the CDC, the following factors increases the risk for numerous public health and social issues: young age, low income, low academic achievement, unemployment as well as a numerous other factors. The State of Arizona Chapter 14 Title 13 Criminal Code recognizes that adolescents can be charged for an array of sexual misconduct, yet, do not have adequate services available. In the State of Arizona there are no facilities to specifically address the needs of high-risk youth behavioral issues, which require costly out of state treatment.

We recommend direct funding to implement new specialized providers, therapists, clinicians and physicians to enhance services which include developing interventions for pre and post suicidal and other mental health preventative programs.

Community Health Based Programs

Community Health Representatives (CHR) provide an array of community-based services that target hard to reach medically underserved populations. The ultimate goal is to decrease the impact of future hospital/medical care costs and reduce readmissions. Current funds do not support our efforts. With the continuous shortage of PHNs, the CHRs fill the gaps that are critical to address the population's health needs in rural areas.

The Tucson Area recommends additional funds to support and expand CHR programs. CHRs are instrumental in providing preventative health screening services, wound care, community health education, delivery of medications, food handler training, home visits and the advocates for all health promotion and outreach. Without the fundamental services CHRs provide, Native Americans right to quality health care would suffer and most individuals would be unable to access their health care system.

Tribal communities appreciate the CHR program beyond the basic services of transport, delivery and home visits. They value the delivery of these services in a culturally competent manner. Since the pandemic CHR's have been critical to post pandemic activities. CHR's are more likely to be trusted members of the community. The CHR model continues to work for Tucson Area Tribes because it is rooted in the understanding that CHR's know their communities best and is a holistic approach to healing.

Provide funding for public health infrastructure to create a system to respond to public health initiatives and events, such as infectious diseases, sexually transmitted infections (STI) and cancer prevention. The funding would establish a surveillance system, testing and treatment.

Alcohol & Substance Abuse (ASA)

Tucson Area recommends to expand current services and fund new programs related to Behavioral Health under the IHCIA (Section 127). The high prevalence of Alcohol & Substance Abuse related to the opioid epidemic, which contributes to suicides and violence within the communities have also been magnified by fentanyl. Increased funding needs to include the entire continuum of treatment including: training of substance abuse professionals, prevention, medically monitored detoxification, outpatient detoxification, intensive outpatient treatment, inpatient rehabilitation, medical assisted treatment, aftercare programs and sober living houses. Treatment options must be as available as the substance misused.

Drug overdose deaths from opioid misuse are of significant concern to Tribal communities. The rates and patterns of use in Native American communities is often due to substance availability, finances, presence of substance-misusing peers and attitudes toward substance misuse.

The recent suspension and closure of sober living homes in the State of Arizona has negatively impacted Tribal members seeking treatment in a safe environment. This has displaced many Tribal members, causing them to lose trust in a health care setting. These fraudulent sober living homes were

targeting American Indians who are enrolled in the State of Arizona's American Indian Health Plan and billed for services not provided. In response to this issue the State of Arizona suspended and closed the fraudulent sober living homes, leaving these patients without shelter, food, transportation and most importantly treatment. Instead of receiving the care the patients needed, these fraudulent sober living homes provided individuals with alcohol, drugs and participated in other illegal activities. To rectify this issue, Tribes need funding to start their own Tribally run sober living home programs to ensure safe and reliable services.

Expand Urban Program

For FY 2026, the Tucson Indian Center joins with the other UIOs across the country to recommend maintaining the Tribal Budget Formulation Workgroup's request of a minimum of $965.3 million to fully fund the Urban Health line item.

This funding is necessary for the Tucson Indian Center to address health priorities for Natives in the Tucson urban area, including:

1. Ensuring Urban Indian Health funding keeps pace with population growth:
   - Although more than 2/3s of Native people reside in urban or suburban areas, the urban Indian health line item has not kept pace with this population growth.
   - Full funding is needed to ensure that we can continue to offer the same level of high-quality culturally competent health care to all patients who walk through our doors.
2. Providing funding for UIO facilities and infrastructure:
   - UIOs do not receive separate facilities funding and must use their line item for purchasing and improving facilities.
   - It is critical that funding for the urban Indian health line-item accounts for the cost of UIO facility needs, so that UIOs are not required to forego much-needed facilities repairs and expansions to protect services.
3. Expanding service offerings to Native patients in urban areas:
   - Like the rest of the I/T/U system, UIOs want to continue to expand their service offerings to serve more Native patients.
   - We need full funding to be able to meet the growing needs of our patients and ensure that they can receive complete care in a culturally competent setting.

In closing, the Tucson Indian Center emphasizes that even though we are presenting our recommendation for the Urban Health line item, UIOs support full mandatory funding for the entire I/T/U system. We endorse a budget in which the Indian Health Service, Tribal Facilities, and UIOs are all fully funded so that we can serve all Native people no matter where they live.

The National Urban Health Program is funded at approximately 7% of the documented need and 1% of the Indian Health Service Congressional Appropriation. In addition to the previously established health priorities and disparities, program expansion is justified by the increasing need for primary care, behavioral health care, community health care, and long COVID-19 health needs. Lastly, expansion is needed to eliminate or mitigate the pending COVID-19 award funding cliff. These non-recurring funds will be fully expended in 1-3 years from award date. Critical program services must continue to serve the Indian Community.

Long Term Care/Assisted Living Services

The Tucson Area request new funding to implement Long Term Care and Assisted Living Services (IHCIA Section 124). The existing services for both Tribes have limited capacity for assisted living and ancillary support services; the dire need for funding is required to cover and maintain services for the increasing elder population. Most importantly, additional funding would allow an increase in case management and in-home support services to include hospice care, allowing elders and vulnerable adults to maintain their independence.

Sanitation Facilities Construction

The Tucson Area requests additional SFC funding to continue meeting existing and future needs for essential water and sewer needs in consultation with Indian communities.

The Tohono O'odham Nation is the second largest reservation in the United States in geographical size, with a land base of 2.8 million acres (4,460 square miles), approximately the size of the State of Connecticut. The Tohono O'odham Nation operates 29 existing water systems and 24 sewer systems to serve 3,400 homes. Most communities are in remote rural areas with challenges to providing access to clean water and sanitation facilities. Currently, there are 11 homes that lack access to safe water or adequate sewer. These 11 homes are identified on the FY 2023 Sanitation Deficiency System (SDS) list as having no indoor plumbing or adequate sewer.

IHS funded 3 of 12 eligible projects in FY 2023, while adding 8 new projects to the list. For FY 2024, 17 eligible projects reside on the SDS list, along with 55 ineligible projects which do not currently qualify for IHS funding. Ineligible projects are those that do not meet IHS funding criteria, due to a lack of an eligible need (for example, projects to address future needs, replacement of adequate facilities, or projects to address efficiency upgrades, etc.) or due to a lack of eligible homes (for example, projects that serve only non-residential building units).

The 2021 Infrastructure Investment and Jobs Act (Pub. L. 117-58) will provide $3.5 billion to the SFC program over a span of five years (FY22-FY26). It is expected that these funds will address the majority of the nationwide backlog of projects, as listed on the FY 2021 SDS list.

Both the Tohono O'odham Nation and the Pascua Yaqui Tribe have robust housing programs, with the Tribes each constructing approximately 75-100 homes over the past five fiscal years (FY19-FY23). Homes that are constructed with other than HUD funding are eligible for SFC housing assistance to pay for the eligible costs of water and sewer connections and related facilities. The need for single family homes, rather than multigenerational homes is more of a necessity now with lessons learned and best practices from the COVID-19 pandemic. Tribal communities have been hit the hardest from the pandemic, due to lack of housing including homelessness which has always been an issue. The pandemic escalated this housing crisis and it has been a real challenge to isolate and quarantine with limited living space.

Hot Issues

Cancer Prevention and Education

ISSUE

Expansion of cancer prevention and education

BACKGROUND

The cancer rates are continuously increasing among members of the Tohono O'odham Nation. Queries using the electronic Resource and Patient Management System (RPMS) database at the Sells Health Care Center revealed the most common cancers continue to be liver, renal cell, pancreas, colon and lymphoma. Cancers of the kidney, cervix, and liver appear to be reported at higher rates among Tribal persons seen at the clinic than in the general Arizona population.

RECOMMENDATION

1. Cancer Prevention
2. Early Cancer Detection
3. Promote Survivorship and Quality of Life
4. Enhance Local Surveillance Data
5. Incorporate Best Practices and Determine Feasibility of Local Research
6. Establish permanent funding rather than a competitive grant
7. Palliative and hospice care

Continuous education to members is critical and we must together promote and support positive changes that improve healthy living through good nutrition, increase mental and physical activity, and prevention.

Behavior Health Infrastructure

ISSUE

Behavioral Health continues to be challenged with aged buildings, inadequate space to accommodate clients and qualified personnel for improved access to care services.

BACKGROUND

The Tohono O'odham Nation faces service delivery issues that are complicated by personnel shortages, limited health care resources and distances to received services. Behavioral Health has three (3) outpatient operational sites on the Tohono O'odham Nation that provide outpatient counseling/case management, psychiatry and administration. In addition, there are two (2) sites that specifically house a day treatment program for Severely Mentally Ill (SMI) clients. All buildings are old and need to be updated and/or replaced to meet the needs of the clients and personnel. Buildings lack adequate space for client privacy and storage space. Additionally, the need for qualified personnel continues to be an issue for the Tohono O'odham Nation. Staff require consistent education and training in order to advance their skills in culturally relevant evidence-based practices that provide appropriate interventions not only to individuals seeking counseling but for the community at large.

RECOMMENDATION

To address the inadequate buildings, space and lack of qualified personnel, appropriated funds for behavioral health service facilities and workforce development need to be set aside within the national budget to address all behavior health care shortfalls.

Aging Health Facilities and IT/ Infrastructure in Remote Areas

ISSUE

The need for new buildings to house much needed health facilities with the appropriate IT to support an Electronic Health Data Base for the Nation. The current Electric Health Record system RPMS has been challenging to acquire for all users to conduct data updates.

BACKGROUND

The Resource and Patient Management System (RPMS) is a suite of over 86 applications that allow data sharing, storage and evaluation covering the array of Health Information and Resource Management needed to provide comprehensive health care to Native American and Alaska Native patients.

From the onset, a goal predicated by Congress was to have Health Information Systems that would be able to easily commutate between all Health Care systems that Government Department used, Department of Defense (DOD), Veterans Affairs (VA) and Indian Health Services (IHS). Much effort in moneys, time and Human talents were expended in completing this task, with little success.

With that in mind, Tucson Tribes, ardent user of RPMS, needs to monitor the development of DOD, and VA endeavors closely.

RECOMMENDATION

Erect state-of-the-art buildings for health facilities and identify a timeline of exploring alternative Health Care system with a comprehensive approach to Tribe's needs, including aligning with the commercial package DOD and VA.

Provide funding to research different packages and IT support to link to the legacy system.

IT Electronic Health Records (EHR)

ISSUE

The need for on-going technical support and an Electric Health Record system when RPMS is no longer supported by IHS.

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