

APRIL 2023

Honor Trust and Treaty Obligations:

A Tribal Budget Request to Address the Tribal Health Inequity Crisis

**The National Tribal Budget Formulation Workgroup's
Request for the Indian Health Service
Fiscal Year 2025 Budget**

TRIBAL CO-CHAIRS

Amber Torres | *Walker River Paiute*

Victor Joseph | *Tanana*

Andrew Joseph, Jr. | *Confederated Tribes of the Colville Reservation*

Acknowledgments

FY 2025 National Tribal Budget Formulation Workgroup Area Representatives

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- » Victor Joseph, Executive Director, Native Village of Tanana
- » Alberta Unok, President/CEO, Alaska Native Health Board

Albuquerque Area

- » Beverly Coho, Member, Albuquerque Indian Health Board

Bemidji Area

- » Phyllis Davis, Council Member, Match-E-Be-Nash-She-Wish Pottawatomi Tribe
- » Dr. Leo Chugunov, Health Director, Sault Saint Marie Health Center

Billings Area

- » Tracy King, Board Member, Fort Belknap Community Council
- » Frank White Clay, Chairman, Crow Tribe

California Area

- » Michael Garcia, Vice Chairman, Ewiiapaayp Band of Kumeyaay Indians
- » Chris Devers, Tribal Representative

Great Plains Area

- » Peter Lengkeek, Chairman, Crow Creek Sioux Tribe
- » Avis Little Eagle, Councilwoman, Standing Rock Sioux Tribe

Nashville Area

- » Tihtiyas (Dee) Sabattus, Deputy Director, United South and Eastern Tribes
- » Adrian Compton, Tribal Administrator, Monacan Indian Nation

Navajo Area

- » Dr. Buu Nygren, President, The Navajo Nation
- » Carl R. Slater, Delegate, 25th Navajo Nation Council

Oklahoma City Area

- » Terri Parton, President, Wichita and Affiliated Tribes
- » Del Beaver, Second Chief, Muscogee Nation

Phoenix Area

- » Amber Torres, Chairman, Walker River Paiute Tribe
- » Jerome Kasey III, Vice-chairman, White Mountain Apache Tribe

Portland Area

- » Nickolaus Lewis, Councilmember, Lummi Nation
- » Andrew Joseph Jr., Councilmember, The Confederated Tribes of the Colville Reservation

Tucson Area

- » Wavalene Saunders, Vice-chairwoman, Tohono O' odham Nation
- » Peter Yucupicio, Chairman, Pascua Yaqui Tribe

**INDIAN HEALTH SERVICE
FY 2025 NATIONAL TRIBAL BUDGET REQUEST
DETAIL OF CHANGES
(DOLLARS IN THOUSANDS)**

Sub IHS Activity	FY 2023 Enacted (P.L. 117-328)	FY 2024 Current Services	Binding Obligations	Program Increase	FY 2025 National Recomm. Total
SERVICES					
Hospitals & Health Clinics	2,503,025	188,280	75,000	10,804,511	13,570,816
Electronic Health Record System	217,564	0	0	583,507	801,071
Dental Services	248,098	5,142	0	2,921,102	3,174,342
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Total, Clinical Services	4,433,191	+293,208	+75,000	+34,986,395	+39,787,794
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Total, Other Services	283,952	7,743	0	1,205,216	1,496,911
Total, Services	4,919,670	+316,203	+75,000	+38,649,247	+43,960,120
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Total, Facilities	958,553	+30,160	+100,000	+7,118,675	+8,207,388
TOTAL, SERVICES & FACILITIES	5,878,223	346,363	175,000	45,767,923	52,167,509
CONTRACT SUPPORT COSTS					
Total, Contract Support Costs	969,000	0	100,000	0	1,069,000
SECTION 105(l) LEASES					
Total Section 105(l) Leases	111,000	0	150,000	0	261,000
Special Diabetes Program for Indians	147,000	0	0	208,292	355,292
TOTAL, IHS	7,105,223	346,363	425,000	45,976,215	53,852,801



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Executive Summary

Tribal leaders on the National Tribal Budget Formulation Workgroup (NTBFW), serving all 574 federally recognized sovereign Tribes within the twelve Indian Health Service (IHS) Areas, met on February 14-15, 2023, to exercise their right to provide meaningful input on IHS budgets and policy in formulation of the President's FY 2025 Budget Request to Congress. Following thorough discussions, the Tribal FY 2025 budget priorities and requests were established and are further described in this publication.

This is a budget request to honor historic obligations that the United States has failed to meet for centuries. Tribal nations have a unique legal and political relationship with the United States. Through its acquisition of land and resources, the United States formed a fiduciary relationship with Tribal nations whereby it has recognized a trust relationship to safeguard Tribal rights, lands, and resources.¹ In fulfillment of this tribal trust relationship, the United States “charged itself with moral obligations of the highest responsibility and trust” toward Tribal nations.² Congress reaffirmed its duty to provide for Indian health care when it enacted the *Indian Health Care Improvement Act* (IHCA) (25 U.S.C. § 1602), declaring 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.” Unfortunately, those responsibilities and legal obligations remain unfulfilled and Indian Country remains in a health crisis.

Just Like our Life Expectancy – IHS spending is stuck in the Termination Era. The IHS budget may appear to have increased since 2009, but when you consider inflation and population growth, the IHS budget has remained relatively flat for decades. We saw this crisis play out in the worst way possible during COVID-19, and now we see it in the data. We cannot expect Tribal communities’ health to improve when they are consistently starved for resources. For comparison, the latest enacted regular appropriations for IHS totals about \$7 billion, or roughly 7 times less than the need-based estimate from the Workgroup for FY 2023. Imagine

having one day’s worth of food for a week: for generations. How could this be anything but termination policy?

Congress provides more than \$1 trillion in resources for federal health care each year, but it disproportionately under funds IHS. When comparing FY 2023 omnibus spending for IHS to other Department of Health and Human Services (HHS) spending, only 0.66 percent of the total funding is provided to IHS. While this analysis of HHS spending includes spending from other Appropriations Subcommittee jurisdictions, it underscores the purposeful inequity that continues to result in American Indians and Alaska Natives (AI/AN) with some of the worst health statistics. Surely, this cannot be the highest possible health status promised by the United States in the *Indian Health Care Improvement Act*.

The Workgroup is pleased to see progress on the historic IHS mandatory proposal in the President’s FYs 2023 and 2024 Budget Requests and is encouraged that the Administration’s expectation with this proposal is to continue to work collaboratively with Tribes and Congress to move toward sustainable, mandatory funding.

Tribal Nations were also elated to see the inclusion of IHS advance appropriations in the FY Consolidated Appropriations Act, 2023 (P.L. 117-328). IHS advance appropriations should be expanded to include all IHS accounts and must be sustained and increased until Congress fulfills its duty the way it was intended – as a mandatory obligation in performance of a bargained-for exchange. Until this solution is enacted, it is critical that Congress continue to prioritize advance appropriations for IHS through the discretionary appropriations process to ensure funding for healthcare services and critical facilities activities are not disrupted.

As sovereign and independent nations, the duty to provide for the health, safety, and wellbeing of our citizens, lands, and sacred natural resources means that IHS funding serves a unique role in Tribes fundamental duty as governments to their citizens. Unfortunately, systemic inequities are exacerbating harm to AI/ANs, which we see in statistic after statistic. As a result, emerging/rapidly increasing American crises are uniquely and acutely harming our people, such as the mental health and opioid and substance abuse crises fueled by new drugs like Fentanyl and the trauma of COVID-19 and recovery.

Many IHS programs are proven successful and result in cost savings for the federal government, such as the Special Diabetes Program for Indians (SDPI); yet, remain under resourced and uncertain. Unfortunately, the SDPI

1 *Worcester v. Georgia*, 31 U.S. 515 (1832).

2 *Seminole Nation v. United States*, 316 U.S. 286, 296-97 (1942).

program has been flat funded for 20 years and expires on September 30, 2023. This program has proven to be effective at reducing the prevalence of diabetes among AI/AN adults,³ 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.⁴ Tribal nations request permanent reauthorization of SDPI and a substantial increase for SDPI – it’s good governance that saves lives and money.

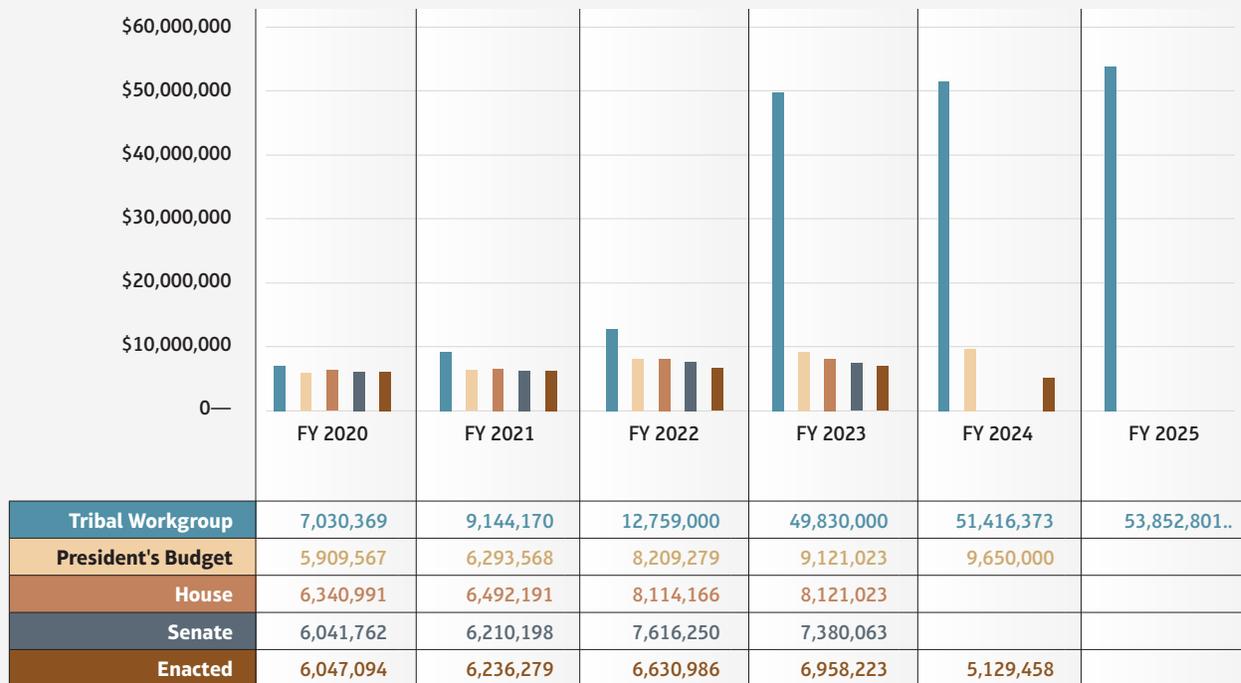
3 British Medical Journal: Prevalence of diagnosed diabetes in American Indian and Alaska Native adults, 2006-2017, available at: <https://drc.bmj.com/content/8/1/e001218>, accessed on: March 11, 2023.

4 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.

The United States can break the cycle of Tribal inequity. The United States can stop terminating our people each year with spending that breaks its obligation. Tribal nations seek no more than the duty affirmed and reaffirmed by the U.S. Constitution, treaties, statutes, court decisions, and federal administrative law. The United States is only as strong as its word to its people, and to honor its promise to the people, the United States must honor its promise to this land’s First People.

Since 2003, Tribal leaders, technical advisors, and other policy advisors have met each year during the annual National Tribal Budget Formulation work session to collaboratively develop an estimate of the cost to fully fund the obligations of the IHS. The IHS need-based cost estimate for Fiscal Year (FY) 2025 is \$53.85 billion.

INDIAN HEALTH SERVICE (Dollars in Thousands)



The Workgroup believes that accurate reporting of unmet obligations is necessary to show a clear picture of government performance in fulfilling its trust and treaty obligations. In past years, Tribal leaders on the Workgroup have complied with an exercise of budget formulation that is largely formulated based on models of OMB guidance to agencies for development of the President’s Budget Request to Congress. While the method may be an effective budgeting strategy within existing structures, it paints a picture of progress that pales in comparison to the actual cost of those obligations that are long overdue and prepaid by our ancestors.



Introduction:

A Tribal Budget Request to Address the Tribal Health Inequity Crisis

Treaties, Trust, and the Duty Owed

This is a budget request to honor historic obligations that the United States has failed to meet for centuries. Tribal nations have a unique legal and political relationship with the United States as defined by the U.S. Constitution, treaties, statutes, court decisions, and administrative law. Through its acquisition of land and resources, the United States formed a fiduciary relationship with Tribal nations whereby it has recognized a trust relationship to safeguard Tribal rights, lands, and resources.⁵ In fulfillment of this tribal trust relationship, the United States “charged itself with moral obligations of the highest responsibility and trust” toward Tribal nations.⁶ This bargained for exchange means that Tribal nations paid, in full, for the duties owed by the United States and that the United States has to duty to uphold its end of the exchange.

The United States’ long-standing and repetitive use of language regarding trust relationships and legal obligations is not by accident. In a trust relationship, a trustee owes certain fundamental duties to the beneficiaries, including a duty of loyalty to all beneficiaries, a duty to provide requisite resources, and a duty to act in good faith. The duty to provide requisite resources is not only one of quantity, but one of continuity and stability. Otherwise, the purpose of the trust relationship recognized by the United States for centuries is effectively meaningless.

Most recently, Congress reaffirmed its duty to provide for Indian health care when it enacted the *Indian Health Care Improvement Act* (IHCA) (25 U.S.C. § 1602), declaring that it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians—to ensure

⁵ *Worcester v. Georgia*, 31 U.S. 515 (1832).

⁶ *Seminole Nation v. United States*, 316 U.S. 286, 296-97 (1942).

the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy.” Unfortunately, those responsibilities and legal obligations remain unfulfilled and Indian Country remains in a health crisis.

Today, most Tribal lands are held in trust by the United States or have been completely taken from our Nations through the long history of U.S. war, removal, assimilation, reorganization, and termination. As a result, Tribes do not have the same asset base or tax base as other governments. Tribal nations rely on federal government funding and on economic development, but infringement on Tribal tax jurisdiction and drastically reduced land bases leave most Tribal nations in a position of unique reliance on annual appropriations for their healthcare infrastructure and delivery.

“For decades and generations, IHS has had a notorious reputation in Indian Country but it is all we have to count on. We do not go there because they have superior health care; we go there because it is our treaty right, and we go there because many of us lack the resources to go elsewhere.”

2016 STATEMENT OF VICTORIA KITCHAYAN,
TREASURER, WINNEBAGO TRIBAL COUNCIL, TO
THE SENATE COMMITTEE ON INDIAN AFFAIRS

The Health Status of Indian Country

The Centers for Disease Control and Prevention (CDC) now reports that life expectancy for American Indians and Alaska Natives has declined by nearly 7 years, and that our average life expectancy is now only 65 years—equivalent to the nationwide average in 1944.⁷ With a life expectancy 10.9 years less than the national average,⁸ Native Americans die at higher rates than those of other Americans from chronic liver disease and cirrhosis, diabetes mellitus, unintentional injuries, assault/homicide, intentional self-harm/suicide, and chronic lower respiratory disease.⁹ Native American women are 4.5 times more likely than non-Hispanic white women to die during pregnancy.¹⁰ The CDC also found that, between 2005 and 2014, every racial group experienced a decline in infant mortality except for Native Americans¹¹ who had infant mortality rates 1.6 times higher than non-Hispanic whites and 1.3 times the national average.¹² Native Americans are also more likely than people in other U.S. demographics to experience trauma, physical abuse, neglect, and post-traumatic stress disorder.¹³ Additionally, Native Americans experience some of the highest rates of psychological and behavioral health issues as compared to other racial and ethnic groups¹⁴ which have been attributed, in part, to the ongoing impacts of historical trauma.¹⁵ The chronic underfunding of the IHS is one significant contributing factor to this disparity.

7 U.S. Department of Health and Human Services, *Centers for Disease Prevention and Control, Provisional Life Expectancy Estimates for 2021* (hereinafter, “Provisional Life Expectancy Estimates”), Report No. 23, August 2022, available at: <https://www.cdc.gov/nchs/data/vsrr/vsrr023.pdf>, accessed on: October 13, 2022 (total for All races and origins minus non-Hispanic American Indian or Alaska Native).

8 *Id.*

9 See, U.S. Commission on Civil Rights, *Broken Promises: Continuing Federal Funding Shortfall for Native Americans* (hereinafter “Broken Promises”), 65, available at: <https://www.usccr.gov/files/pubs/2018/12-20-Broken-Promises.pdf>, accessed on: November 20, 2022.

10 *Broken Promises* at 65.

11 *Broken Promises* at 65.

12 *Broken Promises* at 65.

13 *Broken Promises* at 79-84.

14 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.

15 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.

The Resources Provided to the Indian Health Service

Although annual appropriations for IHS have increased significantly since 2009, after adjusting for inflation and population growth, the IHS budget has remained static in recent decades.¹⁶ In December 2018, the U.S. Commission on Civil Rights' *Broken Promises* report found that Tribal nations face an ongoing funding crisis that is a direct result of the United States' chronic underfunding of Indian health care for decades, which contributes to vast health disparities between Native Americans and other U.S. population groups.¹⁷ We saw this crisis manifest in the worst way possible during the COVID-19 pandemic, and now we see it in the latest data.

Supplemental appropriations enacted during the pandemic were historic investments for Indian Country. It cannot be lost to history that Congress' swift action saved lives, democracy saved lives, but it must also be clear that the IHS is so disproportionately underfunded by Congress that a historic investment in response to a global virus still provided less resources than the estimate of annual obligations for IHS services – an amount collaboratively developed each year by the IHS National Tribal Budget Formulation Workgroup (NTBFW). For comparison, the latest enacted regular appropriations for IHS totals about \$7 billion, or roughly 7 times less than the need-based estimate from the Workgroup for Fiscal Year (FY) 2023.

According to IHS data from April 2022, based on an estimate that excludes approximately two-thirds of the population that could be served by an appropriately funded IHS,¹⁸ actual IHS spending per user remains less than half of Medicaid spending per enrollee, less than half of Veterans medical spending per patient, and less than one-third of Medicare spending per beneficiary – even after including 3rd party revenue received by IHS.¹⁹ The Federal Disparity Index Benchmark, which assumes IHS users are provided services similar to those available to the U.S. population, recommends more than twice the investment per user than IHS receives²⁰ – again, an amount that excludes about

two-thirds of otherwise eligible Tribal citizens who may receive services as beneficiaries but have left the chronically underfunded IHS system.

Congress provides more than \$1 trillion in resources for the Department of Health and Human Services (HHS) each year, it just disproportionately under funds IHS. When comparing FY 2023 omnibus spending for IHS to other HHS spending, only 0.66 percent of the total funding is provided to IHS. While this analysis of HHS spending includes spending from other Appropriations Subcommittee jurisdictions, it underscores the purposeful inequity that continues to result in AI/ANs with some of the worst health outcomes. Surely, this cannot be the highest possible health status promised by the United States in IHCA.

Just Like our Life Expectancy - U.S. Spending Policy is Stuck in the Termination Era

Regardless of the Fund source or authorizing provision, Congress is making an annual budget policy decision much like the dark Termination Era policy that we pretend is behind us. Tribes and their citizens originally had a system of health care delivery imposed on them. Meanwhile, States and local governments violated Tribes' tax jurisdiction, effectively rendering Tribal nations without a way to fund basic infrastructure and governance in often isolated and drastically reduced or wholly taken lands.

As part of this imposed system, the resources provided to the IHS have been chronically underfunded and measurably unequal compared to investments in other U.S. populations. We see this systematic isolation, sovereign infringement, forced dependence, assimilation, and termination in the annual appropriations process each year. We feel it in our communities, and the outcomes and data have been placed before us. We cannot expect Tribal communities' health to improve when they are consistently starved for resources. Too often, Tribal nations are trapped in a federal funding structure operating on the assumption that only state governments are worthy of base funding, essentially, assuming that we do not exist as jurisdictional sovereigns.

¹⁶ *Broken Promises* at 67.

¹⁷ *Broken Promises* at 65.

¹⁸ The Indian Health Service estimates the population served as of January 2020 at 2.56 million; The U.S. Census Bureau estimates the AI/AN population as of July 2021 at 7.2 million.

¹⁹ Indian Health Service, *email correspondence to the National Tribal Budget Formulation Workgroup*, attachment "2021 IHS Expenditures Per Capital and other Federal Care Expenditures Per Capita – 4-27-2022," dated February 14, 2023.

²⁰ *Id.*



FY 2025 National Tribal Budget Recommendations

Since 2003, Tribal leaders, technical advisors, and other policy advisors have met each year during the annual National Tribal Budget Formulation work session to collaboratively develop an estimate of the cost to fully fund the obligations of the IHS. The IHS need-based cost estimate for FY 2025 is \$53.85 billion. The Tribal requests in this publication describe the national Tribal priorities for the FY 2025 IHS budget and justify the need for meaningful change in federal Indian policy, so that the United States may honor its treaty and trust obligations with spending that truly addresses the Tribal health inequity crisis.

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. After extensive analysis and intense consultation with Tribes, this analysis resulted for the first time in an actuarial-based IHS budget proposal totaling \$19.5 billion for FY 2005.

Over the years and with failure to produce necessary appropriations to fulfill the initial 10-year plan to achieve this goal, the per capita health funding and health disparities between American Indians and Alaska Natives (AI/ANs) and other populations have continued to widen.

Each year, the Workgroup updates the NBB using the most current available population and per capita health care cost information. The IHS need-based cost estimate for Fiscal Year (FY) 2025 is \$53.9 billion. For comparison, the latest enacted regular appropriations for IHS total about \$7 billion, or roughly 7 times less than the NBB from the NTBFW for FY 2023.

Step 1: The FY 2025 NTBFW methodology begins with the latest enacted amounts for IHS by line item. For the FY 2025 NTBFW Request, FY 2023 enacted amounts are the starting point.

Step 2: The FY 2023 enacted amounts are adjusted for an estimate of current services (or fixed costs) for the subsequent year, which includes federal pay, tribal pay, medical and non-medical inflation, and population growth. These estimates are provided by the IHS.

Step 3: Next, the amounts are adjusted for an estimate of binding obligations within the IHS budget, which includes staffing for newly completed facilities, health care facilities construction, contract support costs, and Section 105(l) lease cost agreements provided by the IHS.

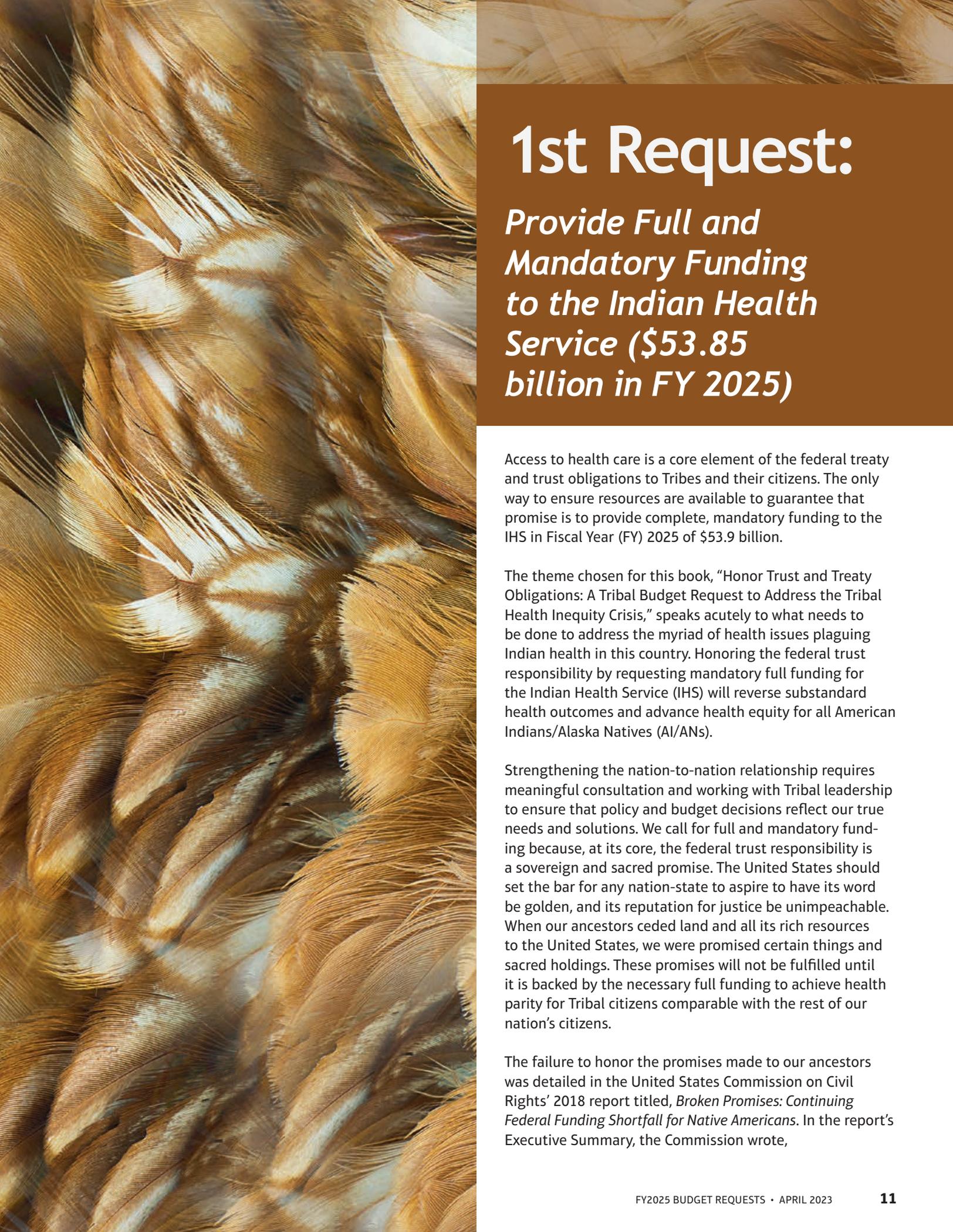
Step 4: The difference between the currently enacted amounts adjusted for fixed costs and binding obligations and the annually-adjusted NBB is provided in an IHS budget worksheet along with Area Budget instructions that were edited by the Workgroup to each of the IHS Areas for Tribes and Tribal organizations to allocate the remaining balance up to the NBB amount. The National Budget Worksheet is submitted along with an IHS Area narrative and list of hot topics to the IHS.

Step 5: Each year, the NTBFW convenes to review the Area submissions and come to an agreement on a National Tribal Request 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. Once an agreement is reached on NTBFW priorities, they are presented to the IHS Director for active discussion and engagement.

Step 6: After the agreement has been made by the Tribal leadership of the NTBFW, the NTBFW technical advisor team works to memorialize the agreement in an annual publication available to the public.

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1st Request:

Provide Full and Mandatory Funding to the Indian Health Service (\$53.85 billion in FY 2025)

Access to health care is a core element of the federal treaty and trust obligations to Tribes and their citizens. The only way to ensure resources are available to guarantee that promise is to provide complete, mandatory funding to the IHS in Fiscal Year (FY) 2025 of \$53.9 billion.

The theme chosen for this book, “Honor Trust and Treaty Obligations: A Tribal Budget Request to Address the Tribal Health Inequity Crisis,” speaks acutely to what needs to be done to address the myriad of health issues plaguing Indian health in this country. Honoring the federal trust responsibility by requesting mandatory full funding for the Indian Health Service (IHS) will reverse substandard health outcomes and advance health equity for all American Indians/Alaska Natives (AI/ANs).

Strengthening the nation-to-nation relationship requires meaningful consultation and working with Tribal leadership to ensure that policy and budget decisions reflect our true needs and solutions. We call for full and mandatory funding because, at its core, the federal trust responsibility is a sovereign and sacred promise. The United States should set the bar for any nation-state to aspire to have its word be golden, and its reputation for justice be unimpeachable. When our ancestors ceded land and all its rich resources to the United States, we were promised certain things and sacred holdings. These promises will not be fulfilled until it is backed by the necessary full funding to achieve health parity for Tribal citizens comparable with the rest of our nation’s citizens.

The failure to honor the promises made to our ancestors was detailed in the United States Commission on Civil Rights’ 2018 report titled, *Broken Promises: Continuing Federal Funding Shortfall for Native Americans*. In the report’s Executive Summary, the Commission wrote,

Since our nation's founding, the United States and Native Americans have committed to and sustained a special trust relationship, which obligates the federal government to promote Tribal self-government, support the general wellbeing of Native American Tribes and villages, and to protect their lands and resources. In exchange for the surrender and reduction of Tribal lands and removal and resettlement of approximately one-fifth of Native American Tribes from their original lands, the United States signed 375 treaties, passed laws, and instituted policies that shaped and defined the special government-to-government relationship between federal and Tribal governments. Yet the United States government forced many Native Americans to give up their culture. It did not provide adequate assistance to support their interconnected infrastructure, self-governance, housing, education, health, and economic development needs.

The time to right this wrong and bring health equity for all AI/ANs is now. The time to honor and live up to sovereign nation-to-nation treaty and trust obligations is now.

Mandatory appropriations for the full obligation owed to Tribal nations and their citizens under the Indian Health Care Improvement Act are consistent with the United States' treaty and trust obligations. Indian Health Service spending should be provided through mandatory direct appropriations with adjustments for inflation and population growth in an allocation mutually agreed to by Tribal governments.

The Workgroup applauds the President's FY 2023 and FY 2024 Budget Requests historic proposals to provide mandatory direct appropriations to the IHS. As part of this effort, the administration held Tribal consultations on moving the funds to mandatory, but using the President's Budget as a vehicle for formulating this request leaves Tribes and Tribal organizations in the dark until publication, as much of the information included in formulation of the President's Budget is embargoed until official release.

The amount provided, scope of authority, and mechanisms for growth adjustments are critical to an effective mandatory proposal. Support from Tribes and Tribal organizations is critical to its success, as it must garner the collaborative buy-in of the people it serves as beneficiaries. Yet, very little information was known about either the FY 2023 or FY 2024 proposals until their publication in the President's Budget.

The reauthorization of the IHCA expanded programs that seek to augment the HHS health care workforce, increase



the amount and type of services available at facilities funded by the IHS, and increase the number and type of programs that provide behavioral health and substance abuse treatment to American Indians and Alaska Natives.²¹ Unfortunately, many authorized provisions of IHCA remain unfunded that are high priorities of the NTBFW, such as long-term care for elders and other IHS expansions. These promises of IHCA remain illusory due to chronically underfunded and woefully inadequate annual spending by Congress.

The best policy solutions for Indian Country are developed through consensus-based collaborative government-to-government engagement that promotes Tribal sovereignty and self-determination. Without critical implementation data on unfunded portions of IHCA, the federal government is at a distinct disadvantage proposing how programs for Indian Country should be structured.

Clearly, a plan must be put in place to ensure that the intended outcomes of this law are realized. It is critical that additional funds are allocated so the full implementation of these programs can continue without compromising other critical services. Accordingly, the IHS National Tribal Budget Formulation Workgroup (NTBFW) requests that the IHS, Department of Health and Human Services (HHS), and the Office of Management and Budget (OMB) engage the NTBFW Mandatory Funding Workgroup to openly develop consensus with pen to paper on legislative text to fulfill the United States' full duty the way it was always intended – as a mandatory obligation in performance of a bargained-for exchange.

21 Congressional Research Service, *IHCA 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.

Expand and Sustain Advance Appropriations until IHS Funding is Mandatory

In an historic first, the FY 2023 Omnibus provides an advance appropriation for the Indian Health Service (IHS). Advance appropriations for the IHS mark a paradigm shift in the nation-to-nation relationship between Tribal nations and the United States by honoring basic year-over-year certainty and stability in the provision of the United States' Treaty and Trust obligations to provide for AI/AN health care.

Advance Appropriations are an interim measure until mandatory funding for IHS and other Tribal Health provisions can be achieved. With advance appropriations, AI/ANs will no longer be uniquely at risk of death or serious harm caused by delays in the annual appropriations process.

The advance appropriations in the FY 2023 Omnibus is not a final solution, as Tribes and Tribal organizations must work with the administration to promote a smooth implementation of the policy. As the process begins to normalize, both IHS and Tribes have the collaborative tools to produce reliable advance appropriation requests.

The advance appropriation enacted in the FY 2023 omnibus excluded certain accounts in the IHS budget and flat-funded the IHS accounts that it did include. While historic in its inclusion, a flat-funded IHS needs FY 2024 adjustments, at a minimum, for fixed costs and staffing for newly completed facilities, and should also include the [amounts requested by the Workgroup for FY 2024](#).

The Workgroup supports expanding IHS advance appropriations to all areas of the IHS budget and including increases from year to year that adjust for inflation, population growth, Indian Health Care Improvement Fund and other necessary program increases. The Workgroup strongly supports IHS advance appropriations inclusion each year, as the Workgroup continues to work with the administration and Congress for the advancement of mandatory direct appropriations for the IHS.

Make no mistake – IHS should be treated like an entitlement. Like programs such as Social Security and Medicare, Tribal Health was prepaid in full based on over ½ billion acres of Indian lands ceded in exchange for the Health provisions in treaties.

Current Services (Fixed Costs)

The Workgroup requests an increase of \$346.4 million over the FY 2023 enacted amount full fund increased costs associated with population growth, pay cost increases for workers, and medical and non-medical inflation for FY 2024. The \$346.4 million to maintain current services is spread throughout the appropriate IHS budget line items as provided by IHS and included in the Detail of Changes table above.

In past years, IHS funding increases have not been sufficient to cover these expenses, effectively resulting in a decrease in funding compared to the previous year. By including fixed costs for the next year, the Workgroup is making the budget policy statement that, at very least, and as a starting point, no IHS program should lose ground and have less purchasing and operating power than is currently enacted.

In addition to meeting current services for the IHS, employee pay costs must be increased to provided wages that incentivize workforce recruitment and retention in the IHS, Tribal, and Urban Indian (I/T/U) system. As part of a 2018 Government Accountability Office (GAO) report on IHS' ongoing challenges filling provider vacancies, it found that IHS clinics don't have enough doctors or nurses to provide quality and timely health care to American Indian and Alaska Native people.²² IHS data show an average vacancy rate for physicians, nurses, and other care providers of 25%.²³ Further, GAO found that IHS has trouble matching local market salaries.²⁴

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 healthcare workers. Although tribally operated sites have more flexibility in compensation

22 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: March 5, 2023.

23 *Id.*

24 *Id.*

packages and hiring processes, these programs are also hindered in recruitment and retention efforts due to funding limitations.

Additionally, the VA remains one of IHS's biggest competitors for retention of current healthcare 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.

No health system can run a quality program lacking one-fourth of the necessary staff. Further, the Workgroup feels strongly that commissioned officers, civil service, and Tribal employees should be exempt from any federal pay freeze that may be imposed in FY 2024 or FY 2025. We cannot allow pay scales for our health professionals to be so substandard that they are forced to look elsewhere to seek a fair wage.

Binding Obligations

The workgroup requests a total of \$1.50 billion for binding obligations in FY 2024 for staffing at newly completed facilities, Health Care Facilities Construction, and an estimate of Contract Support Costs 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, which is included in the total for Hospitals and Health Clinics. Construction of health care facilities is an ongoing process, with an annually published construction list of future projects, and constantly completed projects that were 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 the time of completion.

Health Care Facilities Construction

The Workgroup requests, at least, \$100 million over the FY 2023 enacted amount for planned Health Care Facilities Construction. This adjustment as a binding obligation to the currently enacted amount is a budget policy statement

from the Workgroup that, at a very minimum, the FY 2025 amount should maintain the schedule of planned health care facilities construction. This binding obligation adjustment is in addition to the Workgroup's request for Health Care Facilities Construction and is included in the FY 2025 grand total for Health Care Facilities Construction provided in the Detail of Changes table, above, and described under the Workgroup's explanation of program expansions, below.

Contract Support Costs

The Workgroup requests such sums as may be necessary to fully fund statutory and legally obligated Contract Support Costs (CSC) and that CSC should be provided through mandatory spending. This must be done as an interim step until the full IHS budget can be moved to mandatory funding. The estimated cost of CSC for FY 2025 by the IHS is \$1.07 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 and reconciliation requirements of the IHS-CSC Manual.

Approximately 60% of the IHS budget is operated by Tribes under the authority of the Indian Self-Determination and Education Assistance Act (ISDEAA). The Act 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 administering health programs to Tribes through the "Secretarial amount," which is the amount IHS would otherwise have spent to administer the health programs. In addition, Tribes are authorized to receive an amount for CSC that meets the statutory definition and criteria.

After adjustment to the FY 2025 estimate for CSC as part of binding obligations, the Workgroup does not provide any additional increases for CSC. In the event that the IHS budget continues to be provided through annual discretionary appropriations, the Workgroup supports that the appropriation continue in such sums as may be necessary, due to the mandatory nature of CSC obligations. However, inclusion of accounts that are mandatory in nature under discretionary spending caps has resulted in a net reduction on 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 all the IHS budget be provided as mandatory spending, but CSC and Payments for Tribal Leases are immediately prepared to be 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 Termination Era budgets.

Section 105(l) Lease Agreements

The Workgroup requests such sums as may be necessary to fully fund statutory and legally obligated Payments for Tribal Leases (or 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 2025 by the IHS is \$261 million. This estimate is provided to the Workgroup by the IHS. The Workgroup recognizes that this amount is subject to change based on the actual amount and description of leases with obligations in FY 2025.

The ISDEAA authorizes IHS to enter a lease for a facility upon the request of a Tribal nation or Tribal organization for the administration or delivery of programs, services, and other activities under the Act. Lease requests have grown exponentially as utilization of the program authority has developed, with many Tribal nations increasingly turning to 105(l) leases in response to the chronic underfunding of facility maintenance, repair, and replacement costs.

With every likelihood that this obligation, and therefore, IHS' estimate, will grow, Tribal Nations are concerned that 105(l) costs could have a detrimental impact on overall increases for IHS, including funds for patient care. It is with this in mind that the Workgroup continues to urge that all the IHS budget be provided as mandatory spending, but that CSC and Payments for Tribal Leases are immediately prepared to be 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.

Program Expansions

The Workgroup requests the resources and instructions outlined in this section as a critically needed infusion of resources across existing IHS line items, including the Special Diabetes Program for Indians (SDPI), totaling \$52.52 billion.

These national priorities identified and agreed to by Tribal leaders are the result of a year-long Tribal consultation process that includes discussion by individual Tribes and urban Indian health programs, meetings held by each IHS Area Office, and a final national session in which Tribal Leaders representing each region of the country come together to develop the national priorities for the Indian health care system.

This year's request builds upon prior progress that has been gained through efforts by IHS, Tribes and Urban Indian programs to improve the delivery and quality of health care and reduce the high level of health inequity for the AI/AN population.



Clinical Services

Hospital and Health Clinics - \$13.57 billion

For FY 2025, the Workgroup recommends an amount of \$13.57 billion for the Hospitals and Health Clinics (H&HC) line item. Sufficient funding for H&HC remains the top priority for FY 2025, as it provides the base funding for 605 hospitals, clinics, and health programs that operate on Indian reservations, predominantly in rural and frontier settings. This is the core funding that provides direct medical care services to AI/ANs. Increasing H&HC funding is critical, as it supports medical care services provided at IHS and Tribally operated facilities, including emergency care, inpatient and outpatient care, and specialized care, including for diabetes prevention, maternal and child health, youth services, communicable and infectious disease treatment, and women's and men's health. Importantly, H&HC funds provide the greatest flexibility to support the required range of services needed to target chronic health conditions affecting AI/ANs.

The demands on direct care services are a continuous challenge in our facilities. We experience constant and increased demand for services due to population growth and the increased rates of chronic diseases that result in growing patient workloads. In addition, rarely do the increases to the annual appropriated IHS budget adequately account for rising medical inflation year to year. This effectively means that, over time, IHS and Tribal health systems are losing funding. 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 to AI/AN health disparities.

Adding 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. As a result, any underfunding equates to limited health care access, especially for patients that are



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not eligible for, or who do not meet the medical criteria for, referrals through Purchased/Referred Care (PRC) to the private sector that shall be discussed in another section of this report. For many 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 IHClA. 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 largely unfunded. For Tribes, this is a huge disappointment. We renew our request to the federal government to keep its promise by funding IHClA authorities. Tribes also request that funding these new authorities should be in addition to the base level Hospital and Clinics funding.

Expand the Community Health Aide Program to all Tribes, including expansion in Alaska

The Community Health Aide Program (CHAP) was established in Alaska over 60 years ago. In 2010, based on the success of CHAP at addressing health disparities and social determinants of health in Alaska, Congress included language in the IHClA at Section 111 to make the program available to Tribal health organizations outside of Alaska. In 2015, Tribal leaders from the Portland Area saw the potential for CHAP and began to advocate for CHAP expansion into the Portland Area and nationally. CHAP in Alaska has always been underfunded and IHS was not funded for CHAP expansion; and therefore, until that time, IHS had not taken steps to make CHAP available outside of Alaska.

Tribal leaders and tribal health organizations in the Portland Area saw the need for Community Health Aides (CHA), Behavioral Health Aides (BHA), and Dental Health Aides (DHA) to address chronic health provider turnover and shortages, address important social determinants of health, increase access to primary care, and create professional wage jobs for their tribal citizens in their health programs. Tribes believe that CHAP providers could be successful in any setting and have been building CHAP infrastructure, including education programs since 2015.

The Portland Area has been instrumental in expanding CHAP nationally. As of 2023, there are 25 CHAP providers in the Portland Area and 20 on track to complete another level of their training by the end of 2023 and 4 students on track to

complete their training by the end of 2025. The Portland Area has three CHAP education programs. One Dental Health Aide Therapy Education Program and two Behavioral Health Aide Education Programs. The Community Health Aide Education Program is expected to accept their first cohort in the fall of 2023 in collaboration with 4 tribal health organizations. By the end of 2025, we expect the CHAP program in the Portland Area to be over 100 providers strong. The COVID pandemic has exacerbated provider shortages in Alaska and nationally and CHAP expansion is more important now than ever.

Community Health Aides are the only medical providers in smaller rural communities in Alaska and receive their training at certified CHAP training Centers in Alaska. Community Health Aides are trained to systematically assess all patients for their presenting conditions, using the Community Health Aide Manual (CHAM) and can treat certain conditions under standing orders from a referral physician, and / or after consultation with an assigned provider.

In Alaska, the Tribal health organizations receive limited resources from IHS for CHAP and many Tribal health organizations are using non-IHS resources to staff and outfit their training centers, pay for their staff to be trained and to update the CHAM. Further, a CHAP's medical scope of practice is clearly defined and is very different from the role of Community Health Representative (CHR). A Community Health Aide and a CHR are not interchangeable. Funding outside of Alaska is even more limited and not adequate to support a meaningful national expansion of CHAP.

Tribes in Alaska and across other Areas have made it clear that standing up a Community Health Aide Program will require additional financial resources. Tribes have also instructed that CHAP nationalization should occur without negative impacts to the already insufficient resources awarded to Alaska. For the first time, the FY 2020 budget included \$5 million for nationalization of CHAP. That funding was repeated in FY 2021, 2022, and 2023 but it does not provide enough funding towards the expansion of CHAP nationally. Since 2021, while not sufficient the Alaska Dental Health Aide Therapy Education Program has received limited funding, but the Washington Dental Health Aide Therapy Education Program has not received any funding. Both programs struggle and need additional funding to support their programs. That funding must be increased to include funding for the Dental Health Aide Therapy Education Programs educating students in Washington, Oregon, Idaho, and Alaska.

The Portland Area CHAP Program is focused on the certification of the education programs and providers in the

Portland Area as well as working with state agencies to ensure Medicaid reimbursement for services provided by CHAP Providers. Medicaid reimbursement is a necessary element to the success of the CHAP nationally. CHAP allows already stretched tribal health organizations to tailor their provider teams to meet the needs of their communities, more efficiently deliver a primary level of care, and free specialists and graduate level providers up to work at the top of their scope to increase access to specialty care.

In 2018, IHS established the CHAP – Tribal Advisory Group (CHAP-TAG). This unfunded mandate was tasked to determine how to establish a Community Health Aide Program in other regions, outside of Alaska. Under IHS guidance, the focus of the CHAP-TAG has been on implementing a policy, formatted as a chapter of the Indian Health Manual and published as circular 20-06 to establish a National Federal Certification Board and support Area Certification Board development and operation. The Alaska Area and Portland Area operate federal authorized certification boards. The Billings Area CHAP Certification Board is in development and expected to launch in 2023.

The Northwest Portland Area Indian Health Board established the CHAP learning collaborative to provide real time resources to other Areas to learn from CHAP implementation in the Portland Area and to establish a national learning collective to improve CHAP implementation nationally. IHS must take advantage of the 60 plus years of experience with CHAP in Alaska and the near decade of experience in the Portland Area and tap the expertise of the CHAP TAG and task the CHAP TAG to provide further guidance regarding the development of CHAP Training Centers and CHAP programs for areas outside of Alaska with the goal of utilizing CHAP to address social determinants of health, health equity, and access issues, and determine the funding needs to expand CHAP throughout the Nation.

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. The CHAP budget should be increased to \$60 million per year with \$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 must be made available through ISDEAA contracting and compacting mechanisms.

Electronic Health Records / Health IT - \$801.1 million

The Workgroup requests \$801.1 million to fully fund the modernization of the IHS Health Information Technology (HIT) in FY 2025.

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.

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 comprehensive health information solutions. Many of these systems have already undergone technology modernization and are many years ahead of the IHS HIT modernization. These modernization initiatives have been completely funded through non-federal resources and paid for at the expense of the Tribal and urban Indian health programs. It is unfortunate that these costs will likely never be compensated the way the current IHS modernization initiative is being financed by Congress for the federal government.

To date, none of the resources that the IHS has been provided for HIT modernization has been allocated to Tribally operated programs despite the fact that Tribes operate over 50 percent of the IHS programs. Tribal governments feel bilked by the Federal government in light of the fact that IHS is being funded for its HIT modernization while Tribal HIT modernization was paid for by Tribal resources. This despite the federal trust responsibility for the IHS to provide health care and to provide the necessary resources to accentuate that care.

Despite this unequal treatment in the allocation of resources between IHS and Tribal HIT modernization, the Tribal leaders and the NTBFW continue to support funding to fully fund the HIT modernization of the Indian health system—not just the IHS initiative. These HIT services are mission critical to support health care operations with comprehensive state of the art health information solutions. A fully modernized EHR is also important to the recruitment and retention of health professionals who covet to work in modern health facilities with state-of-the-art equipment.

These resources will support efforts to stabilize the aging IHS EHR while modernization is underway, and support the initial build activities for the EHR environment, as well as initial site transition planning. A properly resourced



IHS, Tribal, and urban Indian health program HIT program directly supports better ways to:

- » Care for patients;
- » Pay providers;
- » Provide essential referral services and coordinate patient care;
- » Recover costs;
- » Support clinical decision-making and reporting; and
- » Recruit and retain health professionals.

The current IHS EHR is over 50 years old, and the GAO identifies it as one of the 10 most critical federal legacy systems in need of modernization. Since FY 2020, the TBFWG and the President's Budget for IHS has supported a new budget line specifically for HIT. TBFWG also has recommended a meaningful investment in HIT systems to update the outdated IHS Resource Patient Management System (RPMS) and to also help support the investments that Tribes have already invested in their own HIT modernizations.

An adequately resourced IHS HIT program is critical to ensure quality and safe care as well as to save costs related to inefficient processes and unnecessary duplication of testing and procedures. The President's Budget request for FY 2025 must include substantial investments for both Tribal and IHS HIT modernization to address the changing technology and resource environment of health care. It cannot be stressed enough, that this funding must be provided for both the IHS and Tribal Health IT modernization efforts.

Dental Services - \$3.17 billion

The Workgroup recommends a total of \$3.17 billion for Dental Services. Many Native communities continue to struggle under the continued weight of oral health disparities. Oral Health is one of the 23 Leading Health Indicators

in Healthy People 2030, which identifies public health priorities to help individuals, organizations, and communities across the United States improve health and well-being.

The reasons for poor dental health in Tribal communities include geographic isolation that continue 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. In addition, missing teeth can impact a person's quality of life by lowering self-esteem and, for some, reducing employment opportunities. In addition, persons 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.²⁵

AI/AN children with dental caries, a common chronic bacterial infection leading to tooth decay, do not receive the necessary treatment. More than 70 percent of AI/AN children aged two to five years have a history of tooth decay, compared to 23 percent of White children.²⁶ 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.²⁷ 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.²⁸

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 because the infection spread throughout his body where he spent 3 weeks in the hospital.

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 PRC program. The patient also suffered permanent disfigurement of his nose when skin was pulled off his nose due to the tubes that had to be taped to his nose 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 emergency dental services to begin with, he could have prevented this illness and hospital stay, altogether. This is just one of many examples throughout Indian Country, dental funding is critical to the overall health of our tribal members.

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.²⁹ 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.³⁰

IHS and Tribal Dental Programs have long been challenged to meet the very high level of need for oral healthcare 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.³¹ Another potential reason is that the dental hygienist-to-population ratio within the Indian Health Service is 1:9,300 while the general population

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

26 Phipps KR, Ricks TL. The oral health of American Indian and Alaska Native children aged 1-5 years: results of the 2014 IHS Oral Health Survey. Available at: https://www.ihs.gov/doh/documents/IHS_Data_Brief_1-5_Year-Old.pdf, Accessed January 29, 2017.

27 Id.

28 Id.

29 1999 & 2010-2020 IHS oral health surveys, IHS National Dental Data Mart, 2019 national GPRA results, and National Health and Nutrition Examination Survey data.

30 Id.

31 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>

is at 1:2,000. Additionally, IHS cannot fill all vacant positions for dentists, with vacancy rates ranging between 10 percent-32 percent.³²

Overall, AI/ANs experience significantly more dental caries (tooth decay) 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 - \$4.47 billion

A history of genocidal practices, cultural assaults, and continuing oppression of AI/AN people has produced alarming rates of mental health disorders, suicide, violence, and behavior-related chronic diseases. Under-resourced mental health care and community barriers to service have reinforced these disparate rates. Legislative authority through the *Indian Health Care Improvement Act* can address resource disparities and constraints with the increased funding that is imperative in empowering present and future generations to live wholistic, healthy lives.

Tribal leaders request \$4.47 billion to fund quality mental health services in Indian Country for FY 2025. Such funds would increase 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.

Mental Health program funding also addresses adverse childhood experiences (ACEs) and historical traumas to break the cycles and conditions perpetuating or exacerbating poor mental health outcomes. An emphasis on traditional Tribal cultural values and practices will further improve the design and delivery of effective mental health prevention and intervention.

Lack of mental health services is evident across Indian Country. For instance, the Pine Ridge Indian Reservation announced a State of Emergency in 2017 after the Oglala Sioux Tribe reported the 9th suicide in six months. During that same period, 177 attempted suicide, and 168 threatened or expressed suicidal ideation.³³ That year, the suicide rate on Pine Ridge Indian Reservation was almost twice as high (1.7) as the rate for South Dakota.³⁴ This unacceptable

scenario spotlights the ongoing and imperative need for long-term, consistent funding that facilitates systematic changes to service availability and offers increased cultural and traditional-based models of care for AI/AN with mental health needs.

According to research, AI/ANs prefer not to seek mental health services through Western models of care due to a lack of cultural sensitivity. Furthermore, studies suggest that AI/AN are not receiving the services they need to help reduce the disparate statistics.³⁵ Historical displacement trauma of AI/AN and consequential suffering continue to negatively impact individuals and families today. This cycle of generational trauma often results in dysfunction within the family system, contributing to substance abuse, domestic violence, and child abuse. Improving cultural awareness and responsiveness of services is recognized as imperative to increasing healthcare access for communities with trauma.³⁶

Increased funding in mental healthcare would allow for the expansion of and integration of mental health services into primary healthcare clinics so that there is a focus on both physical and mental health, resulting in prevention and/or early intervention. Tribal members are identified in primary care settings as having a history of trauma and other mental health issues.³⁷ Thus, funding should also emphasize the infusion of a Trauma-Informed Care (TIC) model in AI/AN primary healthcare facilities. Transforming organizational and staff approaches by implementing strengths-based TIC encourages patient autonomy, creates trusting relationships, and establishes inclusive services.

Mental health resources must also consider the many AI/AN cultures built on connections to large, extended kinship networks. Although these networks can enhance resilience and social support, the high mortality rates in AI/AN populations result in frequent loss of kin and hold some Tribal communities in constant mourning. In addition, many AI/AN uphold traditional responsibilities to protect homelands and make up the highest rate of military enlistment among

35 Beals, J., Novins, D.K., Whitesell, N.R., Spicer, P., & Mitchell, C.M., & Manson, S.M. (2005). Prevalence of mental disorders and utilization of mental health services in two American Indian reservation populations: Mental Health disparities in a national context. *American Journal of Psychiatry*, 162, 1723-1732. Heilbron, C. L., & Guttman, M. A. J. (2000). Traditional healing methods with first nations women in group counseling. *Canadian Journal of Counseling*.

36 The National Child Traumatic Stress Network. (n.d.). *Culture and Trauma*. Retrieved February 28, 2023, from <https://www.nctsn.org/trauma-informed-care/culture-and-trauma>

37 The National Child Traumatic Stress Network. (n.d.). *Culture and Trauma*. Retrieved February 28, 2023, from <https://www.nctsn.org/trauma-informed-care/culture-and-trauma>

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

33 NewsCenter1 Staff. (2020 August 24). *Oglala Sioux Tribe president declares state of emergency in response to recent suicides*. [Video file]. Retrieved from <https://www.newscenter1.tv/ogla-sioux-tribe-declares-state-of-emergency-in-response-to-suicides/>.

34 CDC. (2022). Suicide mortality by state: 2017. Retrieved from <https://www.cdc.gov/nchs/pressroom/sosmap/suicide-mortality/suicide.htm>

any racial or ethnic group in the country.³⁸ High enlistment rates for military service result in high combat exposure risk and ensuing mental health conditions.³⁹

There are severe barriers to mental health access in the United States. Mental health facilities are critically understaffed, waitlists to see a mental health provider can take weeks, and transportation is a significant challenge. In 2021, the ratio of the national population to mental health providers was 350 persons per provider. The situation is even worse in heavily rural areas, such as South Dakota, where, in the same year, there were approximately 500 persons per single provider.⁴⁰ The lack of mental health providers is even direr at healthcare entities operating in rural areas and/or serving AI/AN communities. As a localized example, the Oyate Health Center in Rapid City, SD, serves urban and rural AI/AN populations. As of February 2023, the health center had three mental health therapists available for a service population of over 23,000. That equates to one provider for approximately 7,625 persons.

Moreover, the COVID-19 pandemic has posed an unprecedented threat to mental health, especially among the long-under-served AI/AN community. It has led to extended appointment waitlists, disrupted continuation of care, and exacerbation of mental health issues. Nationally, waitlists for mental health services are 72% longer than before the pandemic, and in 2022, two-thirds of psychologists reported an increase in symptoms' severity among patients.⁴¹ Within the Great Plains Area alone, a 2022 survey of 1,379 AI/AN in the region indicated that half (45.6%) of respondents' mental health got somewhat or much worse than before the COVID-19 pandemic started. When asked what might prevent the participants from accessing mental health services, many provided reasons such as "Appointments are booked out months in advance" and "Wait time is months down the road."⁴²

Mental health emergency services are generally provided through local hospital emergency departments. Inpatient



services are usually purchased from non-IHS facilities or provided by state or county mental health hospitals. Frequent lack of sufficient mental health hospital beds for patients requiring further hospitalization puts pressure on emergency departments to provide care beyond initial stabilization resulting in the costliest method of care and patients receiving an inappropriate level of care. Additionally, mental health care following psychiatric hospitalization is critical to healthcare outcomes. Without adequate support and outreach, patients experience barriers decreasing their success in accessing post-hospitalization continuing care services.

There are approximately 7.2 million AI/ANs in the United States, representing about 2.1% of the U.S. population.⁴³ In the past year, 19% of AI/ANs (or an estimated 1.4 million) reported mental illness, and 26% of those individuals were under 18.⁴⁴ The insufficient mental health resources available have led to a disproportionate number of suicides, higher depression rates, acts of domestic violence, ACEs and drug and alcohol addiction in this population. Among AI/AN, suicide is the 9th leading cause of death, at a rate almost 1.5 times higher than the suicide death rate among non-Hispanic white people (23.9 per 100,000 compared to 16.9 per 100,000). When adjusting for age, the suicide death rate for AI/AN males aged 15-19 is 68.4 per 100,000.⁴⁵ There are alarming rates of PTSD, depression, anxiety, violence, ADD/ADHD, and substance abuse among AI/AN under the age of 18. Funding access to directly respond to this high-risk age population is vital to the next generation's

38 Bassett D, Buchwald D, & Manson S (2014). Posttraumatic stress disorder and symptoms among American Indians and Alaska Natives: A review of the literature. *Social Psychiatry and Psychiatric Epidemiology*, 49, 417–433. 10.1007/s00127-013-0759-y

39 Department of Veterans Affairs. (2012). *American Indian and Alaska Native service members and veterans*. Washington, DC: Author.

40 County Health Rankings & Roadmaps. (2021). Mental health providers. Retrieved from: <https://www.countyhealthrankings.org/explore-health-rankings/county-health-rankings-model/health-factors/clinical-care/access-to-care/mental-health-providers?year=2022&county=46093>

41 APA. (2022) Increased need for mental health care strains capacity. Retrieved from <https://www.apa.org/news/press/releases/2022/11/mental-health-care-strains>

42 Lanoue, B., Jackson, .S, Wang, C. (2022). Mental health status change during the pandemic among the American Indian community [Unpublished raw data]. Great Plains Tribal Leaders' Health Board.

43 U.S. Census Bureau, Native American Heritage Day: November 25, 2022 (reporting for American Indian or Alaska Native alone or in combination for 2021 in comparison to the total estimated population), Press Release Number CB22-SFS.160, available at <https://www.census.gov/newsroom/stories/native-american-heritage-day.html>, accessed on: March 6, 2023.

44 Mental Health America. (2023). Native and Indigenous communities and mental health.

45 Centers for Disease Control and Prevention. (November, 2022). *Suicide Prevention: Disparities in Suicide*. Retrieved March 1, 2023 from [https://www.cdc.gov/suicide/facts/disparities-in-suicide.html#:~:text=3-,Suicide%20is%20the%209th%20leading,death%20among%20AI%2FAN%20people.&text=Non%2DHispanic%20AI%2FAN%20people,people%20\(2.0%20per%20100%2C000\).&text=The%20suicide%20rate%20among%20non,34%20is%2068.4%20per%20100%2C000](https://www.cdc.gov/suicide/facts/disparities-in-suicide.html#:~:text=3-,Suicide%20is%20the%209th%20leading,death%20among%20AI%2FAN%20people.&text=Non%2DHispanic%20AI%2FAN%20people,people%20(2.0%20per%20100%2C000).&text=The%20suicide%20rate%20among%20non,34%20is%2068.4%20per%20100%2C000)

future economic, mental, and physical well-being. Best approaches to treatment in AI/AN communities need to integrate spiritual, psychological, and physical well-being; individual and group wellness; and treatment and prevention. In addition, programs focusing on life skills and interpersonal social-emotional learning programs to promote healthy relationships and conflict resolution are imperative in decreasing suicide rates. Also, the need for postvention, such as establishing survivor support groups, is critical to interrupting or reducing the potential of suicide contagion.⁴⁶

AI/AN continue to experience significantly higher rates of ACEs than other populations in the country. Data from 2009–2017 showed an average ACEs score among AI/AN that was 2.32 times higher than scores among non-Hispanic whites.⁴⁷ ACEs often correlate to unidentified/unhealed traumatic experiences that directly impact health outcomes for AI/AN. In particular, because of historical and intergenerational trauma, indigenous people have higher rates of diabetes, COPD, kidney disease requiring dialysis, cancer, substance use disorders, and dental issues. According to the National Center for Health Statistics, AI/AN populations have higher death rates and lower life expectancy than white, Hispanic, and Black populations.⁴⁸

There has been a call for increased funding for AI/AN mental health programs to support infrastructure development and capacity in tele-mental health, workforce recruitment, and training. Telehealth mental health services may reach patients who would not otherwise receive treatment and, through that engagement, may improve the use of additional mental health services. The benefits of telehealth include improving access to services, reducing travel costs and time, and increasing patient comfort and willingness to engage and disclose.

Mental health funding allocated through time-limited competitive grants is an inefficient funding mechanism that does not support long-term program sustainability, thus creating a lack of trust in the AI/AN population and resistance to engage in services. Unpredictable short-term funding systems are a barrier to effectively addressing mental

health challenges. There must be a continuity of mental health resources that are allocated equitably to improve the current state of mental health circumstances.

Without adequate funding, limited resources will fall short of tribal needs and the proposed implementation of cultural and asset-based approaches to these. A significant funding increase for mental health services is needed to allow AI/AN communities to build upon their inherent strengths and resiliency in the face of such psychological crises. This request will enable AI/AN to mitigate health-related complications, prevent the cost of unhealthy lifestyles, educate communities on mental health issues, and affect their sovereign right to self-determined health care.

Alcohol and Substance Abuse - \$4.86 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.

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).⁴⁹ 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

46 Leavitt, R. A., Ertl, A., Sheats, K., Petrosky, E., Ivey-Stephenson, A., & Fowler, K. A. (2018). Suicides Among American Indian/Alaska Natives - National Violent Death Reporting System, 18 States, 2003-2014. *MMWR. Morbidity and mortality weekly report*, 67(8), 237-242. doi:10.15585/mmwr.mm6708a1

47 Giano, Z., Camplain, R. L., Camplain, C., Pro, G., Haberstroh, S., Baldwin, J. A., Wheeler, D. L., & Hubach, R. D. (2021). Adverse Childhood Events in American Indian/Alaska Native Populations. *American journal of preventive medicine*, 60(2), 213–221. <https://doi.org/10.1016/j.amepre.2020.08.020>

48 Elizabeth Arias, Ph.D., Betzaida Tejada-Vera, M.S., Kenneth D. Kochanek, M.A., and Farida B. Ahmad, M.P.H. Provisional Life Expectancy Estimates for 2021. *Vital Statistics Rapid Release*, 23(August 2022), 1-16.

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



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. A 2004 Bureau of Justice Study on American Indians and Crime found that alcohol is involved in nearly half of the violent crimes experienced by AI/AN and is involved in more than 6 in 10 violent crimes committed by AI/ANs.⁵⁰

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.⁵¹ 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 2016-2017.⁵² The overall rate of overdose deaths for AI/ANs increased by 13 percent between 2015-2017. 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.⁵³

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.⁵⁴

50 <https://bjs.ojp.gov/content/pub/pdf/aic02.pdf>

51 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>

52 <https://www.cdc.gov/drugoverdose/pdf/pubs/2019-cdc-drug-surveillance-report.pdf>

53 <https://www.cdc.gov/mmwr/volumes/66/ss/pdfs/ss6619.pdf>

54 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.

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. Native Americans experience some of the highest rates of psychological and behavioral health issues as compared to other racial and ethnic groups⁵⁵ which have been attributed, in part, to the ongoing impacts of historical trauma.⁵⁶ 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.

Local adaptations of culturally sensitive treatment protocols are needed to address the significant diversity among Native Americans, 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 Native Americans seeking help for substance abuse, and

55 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.

56 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.

1ST REQUEST

these individuals may experience better outcomes when traditional healing is incorporated with other treatment approaches.

There are also needs for funds to provide new approaches that incorporate alternative treatment modes such as behavioral health, alternative holistic therapy, physical therapy, and alternative pain treatment therapy to curtail 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 the 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.

Of utmost importance is funding that aids prevention and education and promotes healthy choices that align with cultural traditions. 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.⁵⁷ 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 program 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 each Tribe's self-determination tenets. 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 and ensure the continuity of the program and care our struggling Tribal members and their families need.

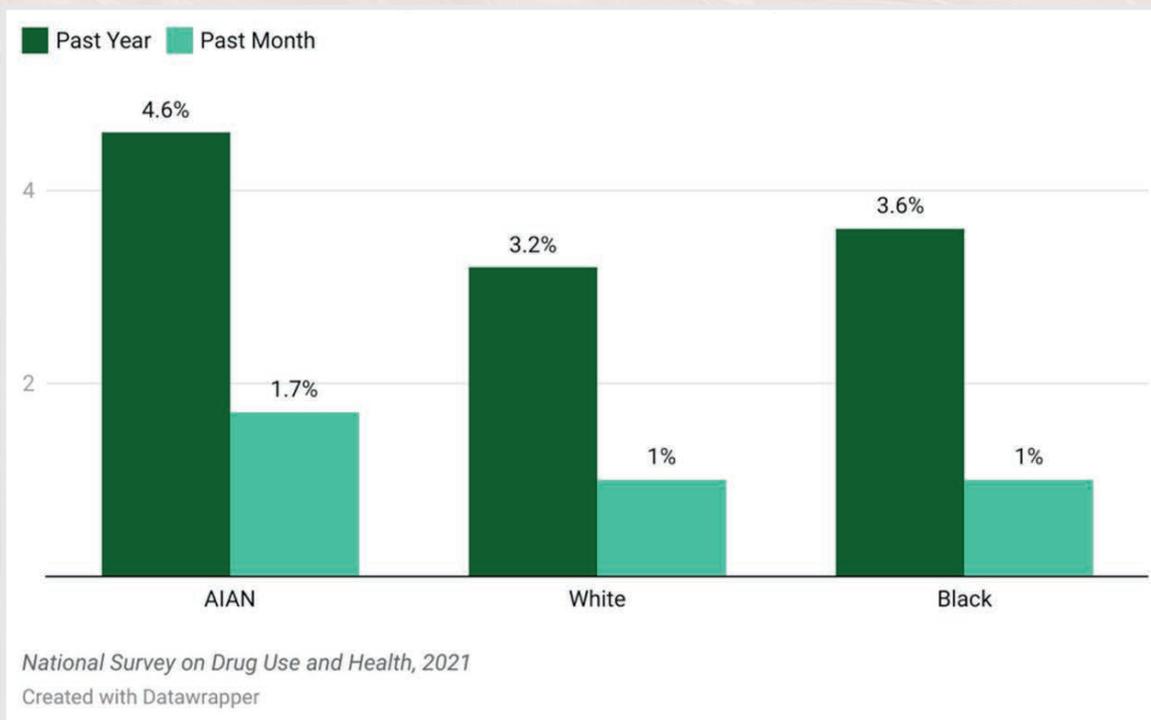
⁵⁷ Rosay, André B., "Violence Against American Indian and Alaska Native Women and Men," *NIJ Journal* 277 (2016): 38-45, available at <http://nij.gov/journals/277/Pages/violence-againstamerican-indians-alaska-natives.aspx>.

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.

AI/AN people in the United States have higher rates of illicit drug use, opioid misuse, and misuse of prescription drugs compared to other racial groups. For example, nearly 28% of AI/AN’s reported using illicit drugs within the past month compared to 15% of among Non-Hispanic Whites 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 Non-Hispanic Whites 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 Non- Hispanic Whites and African Americans, respectively. In general, AI/ANs had higher past month and past year opioid misuse compared to other racial groups (Figure 2.0).

Figure 2.0 – Opioid Misuse by Race⁵⁸



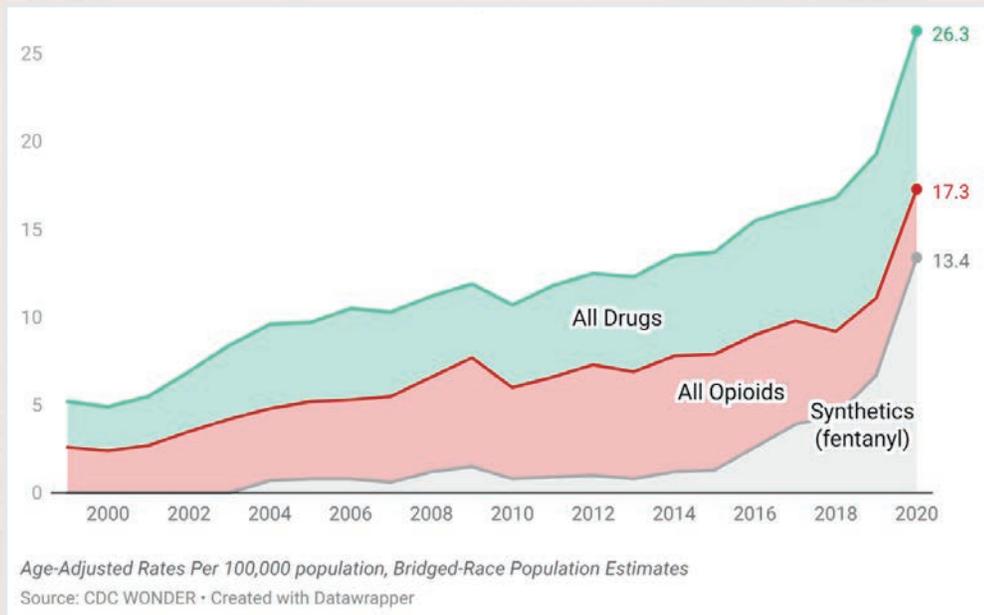
The rate of drug overdose deaths, specifically for opioid and fentanyl deaths, were disproportionately higher among AI/ANs in the U.S. relative to other racial groups. For example, from 2020 to 2021 AI/ANs experienced a 33.8% increase in all drug overdose deaths compared to a 14.5% increase among the total U.S. population for the same period. Additionally, deaths related to overdoses from opioid and fentanyl have increased significantly for AI/ANs.

Specifically, the rate of opioid overdose deaths has consistently increased over time for both AI/ANs and the total U.S. population; The U.S. opioid overdose rate is 24.7 (per 100,000) compared to 24.1 (per 100,000) for AI/ANs. However, this rate for AI/ANs represents a nearly 174% increase in opioid overdose deaths from 2018 compared to a 69% increase for the total U.S. population.

58 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.

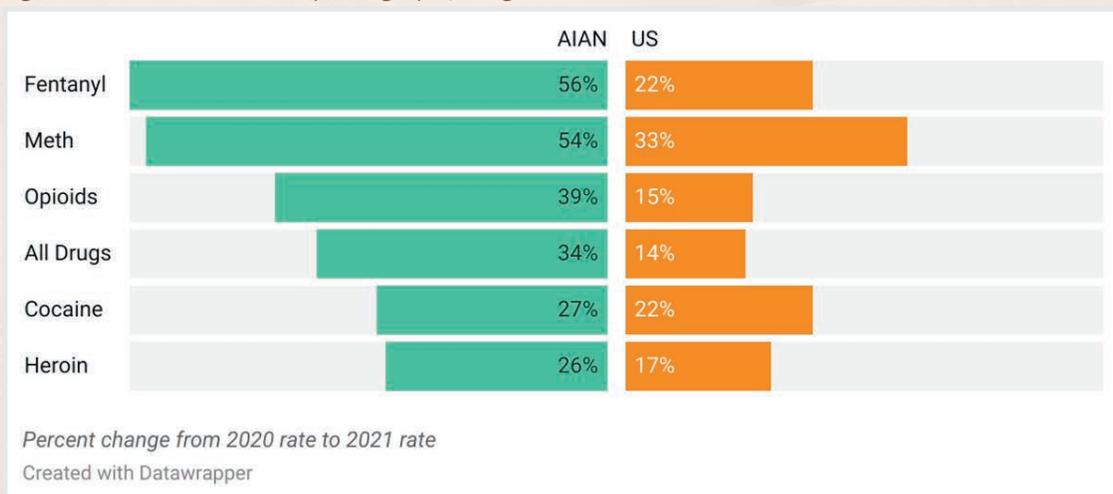
Lastly, synthetic opioid overdose deaths (i.e., fentanyl) have increased significantly over time for both AI/ANs and the total U.S. population. AI/ANs experienced a 117% increase in synthetic overdose deaths from 2018 compared to a 59% increase for the total U.S. population. Moreover, opioids and synthetics, such as fentanyl, are accounting for a larger proportion of all drug-related overdose deaths among AI/ANs every year (Figure 2.1).⁵⁹

Figure 2.1 U.S. Overdose Deaths Among AI/ANs



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 2.2).

Figure 2.2 Overdose Deaths by Category of Drug⁶⁰



59 Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Mortality 1999-2020 on CDC WONDER Online Database, released in 2021. Data are from the Multiple Cause of Death Files, 1999-2020, 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.html>;
Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Mortality 2018-2021 on CDC WONDER Online Database, released in 2023. Data are from the Multiple Cause of Death Files, 2018-2021, 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-expanded.html>.

60 Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Mortality 2018-2021 on CDC WONDER Online Database, released in 2023. Data are from the Multiple Cause of Death Files, 2018-2021, 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-expanded.html>.

CURRENT FUNDING

IHS, Tribal and urban Indian health programs are 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 urban Indian organizations were funded under this program. All IHS, Tribal and urban Indian health programs must be fully funded to address this crisis in their community, with an option for Tribes to receive funds in their Indian Self-Determination and Education Assistance Act (ISDEAA) (P.L. 93-638) 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. 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 IHS, Tribal and urban Indian programs 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 - \$9.14 billion

“Don’t get sick after June” is a well-known and timeworn saying in Indian Country. Historically, this expression referred to the month when IHS ran out of money each federal fiscal year, but the contemporary experience of IHS-eligible beneficiaries in need of secondary or tertiary levels of care through the IHS PRC program is equally disheartening. For FY 2025, the Workgroup recommends a total of \$9.14 billion for the Purchased/Referred Care (PRC) program.

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 our systems. Much of the secondary care and nearly all the tertiary care 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.

There is a limited number of IHS-funded hospitals in existence, with the Portland and California IHS Areas completely lacking the presence of a single IHS-funded hospital to provide inpatient, high-acuity, emergency, and specialty care services to IHS-eligible beneficiaries. If IHS or Tribally operated health facilities do not have the resources or capacity to provide needed care, they may contract for health services from private providers through the PRC program.

PRC funds are used to purchase essential health care services, including inpatient care, emergency ambulatory care, transportation, diagnostic imaging, physical therapy, laboratory, nutrition, and pharmacy services. However, PRC funds are insufficient to pay for all necessary care and, therefore, generally pay for only the highest priority costs, such as emergency care and transportation to that care. IHS and Tribally operated facilities tend to be located primarily

in rural areas where patients and providers must travel long distances, and where other health care providers are not available. IHS informed the GAO that the agency provides services almost exclusively in locations designated by the Health Resources and Services Administration (HRSA) as Health Professional Shortage Areas, or extreme shortage areas, meaning they lack a sufficient number of primary care physicians.⁶¹ Rural communities continue to face a number of systemic and long-standing health care challenges, with fewer specialty care physicians, mental health professionals, and acute care hospitals compared to urban areas. 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, and all PRC requests are categorized according to an antiquated medical priority level system designed to ensure that the program funds services for the most serious medical conditions. IHS has established five medical priority levels. Funds permitting, PRC programs first pay for all of the highest priority services, and then all or some of the lower priority services. Therefore, not all requests for PRC program funding are approved. Even IHS characterizes the results of the underfunded PRC program as a “rationed health care system.”⁶² 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. The ongoing series of PRC denials for IHS-eligible tribal citizens to access health care is a dismal failure of the United States to fulfill its treaty and trust obligations. For example, a patient may not be eligible under Priority 1 or 2 for further testing for a medical concern. Too often, this results in serious diseases, like cancer, not being identified while at a treatable stage.

Tribal health programs have been increasingly relying on third-party collections from payers like Medicare, Medicaid, and private insurance to pay for ongoing operations, including staff payroll and facility maintenance.⁶³ For many Tribes 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 healthcare operating budgets. While Medicaid Expansion has improved the ability of many facilities to approve PRC requests for

higher medical priority levels, this is not so across-the-board. The ability for Tribes to address levels of care that provide the greatest return with regards to health status and quality of life improvement is highly restricted, creating significant challenges for individual American Indians and Alaska Natives as well as their communities.

Although the public health emergency is scheduled to end on May 11, 2023, the adverse impacts of the COVID-19 pandemic continue to reverberate in Indian Country as tribal governments and urban Indian organizations have experienced lost revenue, increased operating costs, and reduced services. During the height of the pandemic, many Tribal health programs experienced third-party reimbursement shortfalls ranging from \$800,000 to \$5 million per tribe per month, with annual third-party reimbursement collections plummeting 30-80 percent below pre-pandemic levels — losses for which it will likely take Tribes years to recoup.⁶⁴

When there is no annual increase to PRC or consideration of population growth and medical inflation, tribes are forced to cut health services. For the Portland and California IHS Areas without an IHS-funded hospital, the health care delivery consequences are crippling. Through the 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 increases to PRC, which has only happened three times— in FY 2010, 2012, and 2014. As long as the PRC program remains severely underfunded, thereby restricting access to comprehensive health care services, health equity for American Indians and Alaska Natives will remain out of reach.

Year after year, PRC funding remains a top budget priority and persistent access to care issue for Tribes across the country. AI/AN communities face significant inequity in health care and health status compared to other U.S. populations. Their health outcomes are adversely impacted by wholly inadequate access to comprehensive health services through the underfunded PRC program. 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 moral and legal responsibility to address this crisis in health equity.

61 U.S. Government Accountability Office, *GAO-18-580 Indian Health Service: Agency Faces Ongoing Challenges Filling Provider Vacancies*. August 2018. Available at: <https://www.gao.gov/products/GAO-18-580>.

62 Indian Health Service. *Purchased/Referred Care (PRC): History*. Available at: <https://www.ihs.gov/prc/history/>. Last accessed March 8, 2023.

63 GAO. *GAO-19-612 Indian Health Service: Facilities Reported Expanding Service Following Increases in Health Insurance Coverage and Collections*. September 2019. Available at: <https://www.gao.gov/assets/gao-19-612.pdf>.

64 Witness statement of former IHS Director Rear Admiral Michael Weahkee before the U.S. House of Representatives, Committee on Appropriations, Subcommittee on Interior, Environment, and Related Agencies. June 11, 2020. Available at: <http://docs.house.gov/meetings/AP/AP06/20200611/110779/HHRG-116-AP06-Wstate-WeahkeeR-20200611.pdf>.



Indian Health Care Improvement Fund - \$3.77 billion

In FY 2025, the workgroup recommends a total of \$3,77 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 2021 IHS spent only \$4,140 per user nationwide compared to the average national healthcare spending of \$10,680.⁶⁵ However, some IHS areas and Tribes are not even funded at the IHS national average of \$4,140 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 IHCA 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 funding level needed to address the current health status and resource deficiencies for each IHS Service Unit, Indian Tribe, or Tribal organization.

⁶⁵ Indian Health Service, *email correspondence to the National Tribal Budget Formulation Workgroup*, attachment "2021 IHS Expenditures Per Capital and other Federal Care Expenditures Per Capita - 4-27-2022," dated February 14, 2023.

To date, Congress has only provided \$437.4 million for distribution to IHS Service Units, Indian Tribes, or Tribal organizations through the IHCIF since FY 2018. 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.

The National Tribal Budget Formulation Workgroup continues to advocate for full funding for the IHS via a mandatory appropriation; yet, capturing the full health need has been a hurdle. However, in its FY 2023 Congressional Justification, the IHS proposed the use of the IHCIF 2018 "level of need" analysis to close the funding gap over five years at \$11.2 billion. This was the first ever congressional justification that attempted to address the full funding need of the IHS. The problem was that the funding increases were proposed to be "distributed proportionally across the IHS funding lines"; in doing so, historical inequities will only grow.

In FY 2018, a joint IHCIF Tribal/Federal Workgroup met to review and update the existing IHCIF data and develop recommendations for IHS to consider and make a final determination on the allocation methodology. The final report was due to the IHS Director in July 2019; yet no report has been released. The NTBFWG suggests the workgroup complete the report soon and forward it to the IHS Director so a final determination can be made.

The Workgroup explicitly requests the following:

- » Finalize the IHCIF report.
- » Adopt the recommendations on the new allocation methodology for better articulation of the IHCIF in the future through Tribal consultation.
- » Update the IHCIF allocation methodology data and release it to all Tribes annually.

Increased and equitable distribution of the IHCIF will ensure greater access to high-quality, culturally appropriate care and services across the IHS/Tribal/Urban system.

Preventive Health Public Health Nursing - \$966.3 million

The Workgroup recommends \$966.3 million 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. For example, one small Tribe in Alaska serving just under 400 citizens only received \$2,053 in FY 2021 for PHN services. 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 - \$611.6 million

The Workgroup recommends \$611.6 million for the Health Education program. Since the COVID-19 pandemic was declared a national emergency, the national Health Education programs have redeployed health educators and reoriented their activities to face the pandemic head on. Health Education programs are an integral component of culturally appropriate primary, secondary, and tertiary prevention, as well as, bridging primary care with community health outreach and preventive education. The goal of the Health Education program is to help Indian 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 healthcare 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 offered 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, colorectal screening. Health Educators are extremely valuable in Native communities by raising awareness of lifestyle choices and decisions, they help prevent countless sick days for workers and students, also assist individuals to restore or maintain optimal health, and they guide individuals to practice sanitary and hygiene habits that prevent crippling and deadly diseases from being transmitted and spread. Health Educators are a vital source to interpret health education messages from English to a Native language, i.e., breaking the chain of infection, prevention measures on new and emerging diseases, detailed provider instructions during patient visits and medication tutoring; the availability of Native speaking staff trained in Medical Interpretation will become compromised, including bridging the generation gap between elders and youth.

Health Education supports the IHS Strategic Plan FY 2019-2023, Goal 1 Objectives 1.2 Build and strengthen and sustain collaborative relationship, 1.3: Increase access to quality health care services and Goal 2 Objective 2.1: Create quality improvement capability at all levels of the organization, 2.2.: Provide care to better meet the health care needs of AI/AN communities, 3.1: Improve communication within the organization with tribes, urban Indian organizations, and other stakeholders, and with the general public, and 3.2: Secure and effectively manage the assets and resources.

Community Health Representatives - \$1.04 billion

The Workgroup recommends \$1.04 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 of 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.

CHR 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.

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.

CHR are part of the direct provision of health services to Native Americans and are authorized in in IHCA. 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.

Alaska Immunization - \$55.2 million

The Workgroup requests \$55.2 million to fully 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 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.

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 recently 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.

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.

Other Services

Urban Indian Health - \$965.3 million

The United States has a trust responsibility to maintain and improve the health of American Indians and Alaska Natives no matter where they live.⁶⁶ To meet this obligation in urban areas, the federal government contracts with 41 Urban Indian Organizations (UIOs), which operate over 77 facilities in 38 urban areas nation-wide. UIOs were created in the 1950s by American Indians and Alaska Natives 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 Termination⁶⁷ and Relocation⁶⁸ policies.

In 1976, UIOs were formally incorporated into the Indian healthcare system, also referred to as the IHS/Tribal/UIO or I/T/U system, through passage of IHClA. Today, the 41 UIOs are a fundamental and inseparable component of the I/T/U system, providing a wide range of culturally focused health care and social services to American Indians and Alaska Natives living 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.

The Workgroup recommends \$965.3 billion for the IHS Urban Health line item. Because UIOs receive direct funding through a single line item – Urban Health – only an increase to this line item will ensure increased federal

funding for services at UIOs as well as facilities costs and other expenses. UIOs 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. Due to historically low funding levels for urban Indian health, UIOs are chronically underfunded. Full funding of UIOs will directly benefit urban AI/ANs that rely on UIOs to access care.

Full funding of the urban Indian health line item is necessary to address the growing American Indian and Alaska Native population in urban areas. Although more than 70% of AI/ANs reside in urban or suburban areas, historically only 1% of the underfunded IHS budget is spent on urban Indian health care. This growing population will require UIOs to increase access to care by hiring additional staff, expanding services, and opening new facilities to meet the growing need. For example, as of 2021, UIOs reported needing at least \$200 million to fund construction and renovation projects nation-wide. In the last year alone, six UIOs opened new facilities, and an additional 16 UIOs plan to open new facilities in the next two years.

Unfortunately, since 2000, most of the increases in funding for the Urban Indian Health line item have been absorbed by medical inflation. When accounting for inflation, the line item only increased by approximately 3.7% between FY2000 and FY22. 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 American Indians and Alaska Natives, 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 populations. Such additional funding includes funding from programs such as IHS's Behavioral Health Integrative Initiative (BH2I) and the SDPI. As UIOs work to provide for a growing population of urban Indians, their continued eligibility for grant or funding initiative opportunities, including BH2I and other behavioral health initiatives as well as SDPI, 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.

⁶⁶ See 25 U.S.C. § 1601(1); Sen. Rpt. 100-508 (1988).

⁶⁷ Act of August 15, 1953, Public Law 83-280, 67 Stat. 588.

⁶⁸ Act of August 3, 1956, Public Law 84-959, 70 Stat. 986.



Indian Health Professions - \$255.7 million

The Workgroup requests \$255.7 million for the Indian Health Professions program. IHS and Tribes continue to struggle to recruit and retain qualified medical professionals to work in facilities serving Indian Country. This is an on-going issue and comprehensive efforts are needed to “grow our own” AI/AN health professionals. Broader efforts to encourage and support AI/ANs entering health careers are needed including accessing federal and state scholarships, loan repayment programs and working with educational institutions.

IHS and Tribal providers have long contended with provider shortages, which has made providing care to patients extraordinarily difficult. The provision of health care is a fundamental element of the federal trust responsibility, which was upheld by the Eighth Circuit Court of Appeals in *Rosebud Sioux Tribe v. United States*. In that case, the Court discussed the duty of the government to provide “competent physician-led health care.” The Court found that this duty did exist and that it had been strengthened by the Snyder Act and the Indian Health Care Improvement (IHCA). Funds must be appropriated to honor this promise and ensure that “competent physician-led health care” can be provided throughout Indian Country.

The federal government must also 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 Urban Indian Organizations that receive funds through Title V of the IHCA 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 to access providers.

Indian Health Professions program increases would help to increase funding for scholarships, loans and expand loan forgiveness options to individuals seeking to work in Tribal communities. Regarding the CHAP implementation in the lower 48 states, a portion of the recommended amount should be made available for scholarships for students seeking a career as a CHAP mid-level provider. 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 a major need for training in or near Tribal communities. 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.

Tribal Management Grants - \$8.8 million

The Workgroup requests \$8.8 million for the Tribal Management Grant (TMG) program. Under the authority of the ISDEAA the program was established to assist all federally recognized Indian Tribes and Tribally sanctioned organizations (T/TO) to plan, prepare, or decide to assume all or part of existing IHS, functions, services, and activities (PFSAs) through an ISDEAA Title I contract and to assist established contractors and compactors further develop and improve management capabilities. This grant award is an important resource for Tribal capacity building and technical assistance when needed.

There are four types of awards designed to assist tribes which are: Planning, Evaluation and Feasibility are 1-year grants. Health Management Structure is a 3-year grant.

- » Planning grants awards up to \$50,000. Awardees establish goals and performance measures for current health programs or to design their health programs and management systems.
- » Evaluation funds awards up to \$50,000 and determine the effectiveness and efficiency of a program or if new components are needed to assist T/TO improvements to its health care delivery system.
- » Feasibility funds award up to \$70,000 to analyze programs to determine if T/TO management is practicable.
- » Health management structure (HMS) grant awards up to \$300,000. HMS projects include the design and implementation of systems to manage PFSAs, such as Electronic Health Records (EHR) systems, billing, and accounting systems management, along with health accreditation review and recommendations for correction of audit material weaknesses.

Although the IHS has made this discretionary competitive grant program a lesser priority than direct health services, there is a high level of interest and awareness by Tribes and Tribal organizations to explore their sovereign right to assume all or parts of their own health delivery systems. TMG's are available to Tribes and Tribal Organizations to pursue planning and feasibility studies and or evaluation of health management structure framework.

Direct Operations - \$239.7 million

The FY 2024 total budget request is \$101.87 million. The Direct Operations budget supports the IHS to carry out duties related to its role as the lead federal agency charged with carrying out the treaty and trust obligations of the United States. It provides agency-wide leadership, oversight, and executive direction for health delivery systems located on or near Indian reservations and within Tribal villages, as well as for 41 urban-centered, nonprofit urban Indian organizations providing health care services at 59 locations throughout United States. The IHS is the only HHS agency whose primary function is direct delivery of health care. IHS provides services both directly, or indirectly through contracts/compacts with Tribes/Tribal Health Organizations, to 2.6 million citizens of 574 federally recognized Tribes. Direct Service Tribes (DST) opt to receive primary health care services from the Indian Health Service. These services include direct patient care such as internal medicine, pediatrics, women's health, and dental and optometry services. There are 18 tribes that are strictly DST and just over 200 Tribes/Tribal Health Organizations which contract or compact a portion of their programs and services while also relying on the IHS to directly manage the others. Funds are used to promote the efficient and effective administration and oversight of national functions such as: human resources (HR), financial management, acquisitions, internal control and risk management, health care and facilities planning, health information technology, Contract Disputes Act claims analysis, and other administrative support and systems accountability. These types of direct operations performed at the Headquarters and Area Office levels provide the foundation necessary to carry out the Agency mission.

The IHS Headquarters (HQ) provides overall program direction, authorities, and oversight for the 12 IHS Areas and 170 Service Units. HQ staff formulate policy and distributes resources; also provides technical expertise to all components of the Indian health care system, including I/T/Us. Headquarters also hosts the Resource and Patient Information. RPMS which is a decentralized integrated solution for management of both clinical and administrative information in I/T/U healthcare facilities. HQ also provides data management including collection of national statistics



and performing public health surveillance, identifying trends, and projecting future needs. The IHS Headquarters works in partnership with HHS and sister agencies to formulate and implement national health care priorities, goals, and objectives for AI/ANs within the framework of its mission. The IHS Headquarters also works with HHS to formulate the annual budget and necessary legislative proposals and respond to congressional inquiries.

By delegation from the IHS Director, the 12 Area Offices distribute resources, carry out policies and internal controls, monitor and evaluate the full range of comprehensive healthcare and community-oriented public health programs, and provide technical support to local Service Units and I/T/U staff. They ensure the delivery of quality health care through the 170 Service Units and participate in the development and demonstration of alternative means and improvement models to support health services management and delivery. Program increases for Direct Operations will allow the enhanced implementation of quality and patient safety measures and will enable the agency to be responsive to deficiencies cited in the previous GAO High Risk Report. A funding increase will enable the operational support necessary for carrying out the functions of the new Office of Quality (OQ). The OQ provides for quality systems integration and address quality assurance, patient safety, business intelligence, risk management, and quality improvement. Funds will also be used to strengthen the agency's capacity for oversight in key areas such as workforce management and development, finance, acquisitions, and other evolving areas identified by Tribal and agency leadership. This will increase the efficiency and effectiveness of Headquarters programs focused on policy management and compliance, competency training, evaluation, data analysis and reporting, and accountability. The non-inherent federal function portion of Direct Operations funds are available for Tribal Shares distribution if a Tribe or Tribal

Health Organization exercises its right to assume management of federal functions under ISDEAA Title I or Title V. The funding history for Direct Operations has only shown moderate growth despite growing responsibilities and demands of the health industry and rising inflation. From FY 2018 – FY 2020 funding remained flat at \$72 million and rose to \$82 million in FY 2021 and \$95 million in FY 2022. In FY 2021 and FY 2022, the IHS Direct Operations had the added burden of administering COVID related activities and resources.

Self-Governance - \$27.5 million

The Workgroup requests \$27.5 million to support and expand Self-Governance training and technical support through the Office of Tribal Self-Governance (OTSG), OTSG is responsible for a wide range of agency functions that are critical to honoring the IHS's relationship with AI/AN nations, Tribal organizations, and other AI/AN groups, under authorization of Title V of the ISDEAA, as amended 25 U.S.C. § 5381 et seq., 42 C.F.R. Part 137.

Title V authorizes Tribes and Tribal Consortia to enter Self-Governance compacts, self-determination contracts and related funding agreements to assume federal programs, functions, services, or activities (PFSA), and associated Tribal Shares, placing the accountability of PFSA service provision with Tribal nations. This request supports expansion of the implementation of the IHS Tribal Self-Governance program, funding for Planning and Negotiation Cooperative Agreements to assist Indian Tribes to prepare and enter the IHS Tribal Self-Governance program, and funds Tribal shares needs in IHS Areas and Headquarters for any AI/AN Tribes that have decided to participate in the IHS Tribal Self-Governance program.

Today, Indian Tribes and Tribal organizations administer over one-half of IHS resources through ISDEAA self-determination contracts and Self-Governance compacts. There is a growing interest by Tribes to explore Self-Governance as an option to exercising its self-determination rights. The Self-Governance budget supports activities, including but not limited to: government-to-government negotiations of Self-Governance compacts and funding agreements; oversight of the IHS Director's Agency Lead Negotiators (ALNs); technical assistance on Tribal Consultation activities; analysis of IHCIA authorities; Self-Governance planning and negotiation of Cooperative Agreements; and supporting the activities of the IHS Director's Tribal Self-Governance Advisory Committee which advises the IHS Director on Self-Governance policy decisions.

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 ALNs, Tribal technical advisors and financial expertise are required to successfully advance Tribes wanting to assume administration of their health systems. The budget supporting Planning and Negotiation Cooperative Agreements assist Tribes to secure expertise, and IHS to ensure staff are available to respond to technical assistance requests. There are two types of cooperative agreements to assist Tribes in attaining Self-Governance:

The Planning Cooperative Agreement provides resources to Tribes entering Title V compacts and to existing Self-Governance Tribes interested in assuming new or expanded PSFAs. 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 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.

The Negotiation Cooperative Agreement provides resources to Tribes to help defray the costs related to preparing for and conducting Self-Governance program negotiations. The design of the negotiation process enables a Tribe to set its own 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 OTSG. These cooperative agreements provide funds to support Tribal and federal negotiation teams, who work together in good faith to enhance each Self-Governance agreement.

Recommendations by the Tribal Self Governance Workgroup as part of the National Tribal Budget Formulation Workgroup devote substantial resources to the budget formulation process each year. This workgroup is representative of all Direct Service and Self Governance Tribes as well as Urban Indian programs across the Nation. It is paramount that Tribes are honored by working together with IHS to raise the physical, mental, social, and spiritual health of AI/ANs to the highest level.

Facilities

Maintenance and Improvement - \$2.75 billion

The Budget Formulation Workgroup is proposing \$2.75 billion to fully fund facility Maintenance and Improvement (M&I) in FY 2025. M&I funding is consistently ranked 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. 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.

The IHS Facilities Appropriations Advisory Board (FAAB) provided the following data on the M&I program in the Facilities Appropriations Information Report dated January 30, 2020:

The M&I program funding is distributed through a formula allocation methodology. The report discusses that the current level of appropriations for M&I funding is \$168.95 million, which is a 123% increase from 2017, but prior to that, M&I appropriations remained flat at about \$53 million annually. Consequently, the Backlog of Essential Maintenance Alteration and Repair (BEMAR) Report, updated annually, cites the need is now about \$767 million. This is the result of insufficient funding needed to keep pace with preventive, routine, and unscheduled emergency work in the vast number of aging IHS and Tribal facilities which now average approximately 40 years old, nationwide, with some facilities significantly older. The report notes that maintenance costs increase as facilities and systems age. Available funding levels have been impacted by:

- » Age and condition of equipment that necessitates more repairs and/or replacement;
- » Lessened availability of service/repair parts for aging equipment and limited vendor pool in remote locations;
- » Increases in supportable space. Between 2015 and 2019, supportable space increased 7 percent;
- » Increased costs due to remote locations;
- » Costs associated with correcting accreditation-related deficiencies;
- » Increasing regulatory and/or executive order requirements; and
- » Environmental conditions impacting building and equipment efficiency and life.

The FY 2025 Tribal M&I budget request will bring the Indian health care system closer to addressing critical backlogs and will support maintenance and improvement objectives

including exceeding environmental standards and ensuring compliance with accreditation standards of The Joint Commission (TJC), or other applicable accreditation bodies. 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 - \$2.17 billion

The IHS Sanitation Facilities Construction (SFC) Program, an integral component of IHS disease prevention 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, adequate sanitation infrastructure remains critical as tribal governments continue to respond to the COVID-19 pandemic.

Water and sanitation 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 the quality of life of Indian people.

All AI/AN communities and homes should have adequate access to running water and adequate sanitation services. 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 and stored in drums, and honey buckets or outhouses in place of toilets. It 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.

As with other infrastructure issues in Tribal communities, the need to complete sanitation projects remain great. The IHS FY 2023 Congressional Budget justification reported that the total sanitation facility needs reported through Sanitation Deficiency System (SDS) increased approximately



\$0.27 billion or 8.7 percent from \$3.09 billion to \$3.36 billion from FY 2020 to FY 2021. All IHS Areas reported high numbers of homes that require sanitation improvements and sanitation needs were concentrated in the Alaska, Navajo, Great Plains, and California Areas. **Sufficient resources for the SFC line item aid the prevention of communicable and environmentally related diseases such as pneumonia, influenza, and respiratory syncytial virus by providing for these necessities:**

- » Water, Wastewater and Solid Waste Facilities for existing AI/AN homes and/or communities.
- » Water, Wastewater and Solid Waste Facilities for newly identified AI/AN Tribal Housing Projects.
- » Special or Emergency Projects.

The magnitude of the sanitation facility needs and cost increase is due to the underlying challenges of construction cost inflation, population growth, an increasing number of regulations and failing infrastructure. Failing infrastructure is presumably the largest factor, which is a result of the infrastructure age and inadequate operation and maintenance.

Under the IHCA, 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. However, resources have not been appropriated specifically for this purpose often leading to total system failure before the Agency acts to correct problems, which disrupts access and erodes success of the program.

Without adequate funding and flexibility, tribal members 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.

On November 15, 2021, President Biden signed the Infrastructure Investment and Jobs Act (IIJA), which appropriates \$3.5 billion over five years (FY 2022-2026) for the IHS Sanitation Facilities Construction program. At the time of the IIJA, it was estimated that these funds were sufficient to address the current estimate for all known deficiencies.

Since passage of the IIJA, the economics of dealing with supply chain issues, rising prices, and shortage of skilled labor have had a profound impact on the costs of construction projects. Over the last year, Tribes, states, territories, and local governments have begun work to improve over 65,000 miles of road and 1,500 bridges; invest in 600 airport infrastructure projects; purchase 15,000 new buses, ferries, and subway cars; and buy 75 new locomotives and 73 intercity train sets for Amtrak. All this activity has had a very significant impact on construction costs that have now affected the IHS Sanitation Facilities Construction program. It is now estimated that the total IHS sanitation facilities need will exceed \$4 billion.

Despite the sizable investment that the IIJA will provide to meet sanitation needs, it is clear that additional funding will continue to be needed to support extreme inflation costs associated with these types of projects and an ever-growing need for operation and maintenance costs to support the federal investment that has been made in these projects and maximize their useful life.

In the absence of external financial assistance, 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 the 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 expedite the need for total replacement – driving up costs overtime. The unprecedented amount of funding for construction and repair of these facilities through the IIJA underscores the need to protect that investment and ensure sustainable operation of these systems. In order to accomplish this mission, Workgroup requests the following:

- » Direct as much funding as possible directly to projects. 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.
- » Add an Operation and Maintenance account for the SFC program funded at \$100 million annually.
- » 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

At an average age of approximately 37 years,⁶⁹ 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 facility; oftentimes to modular units, in order to provide additional space for primary health care services. These conditions create difficulties for staff and patients, increases wait times, and inefficiencies within the health care system become problematic.

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.

Still, in other Areas, there are no IHS facilities and Tribes and Tribal organizations are uniquely reliant on specific lines of the IHS budget, while not able to access others. The solution is not going to develop overnight, but outdated and insufficient health care facilities drive up 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. There are 6 remaining projects on the list which are currently estimated to cost \$286 million. Once those projects are funded, IHS is required to implement a new priority system which is outlined in IHCA. 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 projects may be effective is for essential specialty health care. The lack of essential specialty care that is otherwise taken as granted for everyday Americans forces IHS beneficiaries into the grossly underfunded and overburdened Purchased/Referred Care Program, to pay out of pocket, or, often, to go without. As previously mentioned in the Dental Services section, above, sometimes specialty services go untreated until they become life-threatening and 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 Purchased /Referred Care program.

An important provision of the law under the new priority system is the establishment of an Area Distribution Fund (1) 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

⁶⁹ 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.

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 impacts on our lands in the construction process.

Facilities & Environmental Health Support - \$514.8 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 \$514.8 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-borne 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 - \$239.7 million

The Workgroup requests \$239.7 million for the IHS Equipment program. The Tribal Leaders along with the IHS are committed to the quality of care. It is a tribal and agency priority to provide the highest-level healthcare delivery system 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 electronic health records increases, the need for compatible equipment replacing 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.

Special Diabetes Program for Indians - \$355.3 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 Indian Self-Determination and Education Assistance Act (ISDEAA or '638') contracts or compacts or through direct service provided by IHS.

Although Tribes are thankful for the current SDPI funding which was established by Congress in 1997 to combat the disease that has ravage our tribal nations, the funding amount since 2004 has remained stagnant at \$150 million. Today there are over 300 SDPI programs that serve approximately 780,000 American Indians and Alaskan Natives. 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 experienced disruption of delivery of care amid the COVID-19 pandemic that continues today.

This pandemic has impacted AI/ANs who already live with pre-existing health conditions at risk 3.5 – 4.5 times higher than the general population. Many programs experienced budgetary cuts, reduction in ability to purchase necessary diagnostic equipment and even furlough healthcare

providers. Permanent funding would ensure the implementation of diabetes outreach, education, and prevention for Tribal Patients. A recent 3-year extension of SDPI funding is helpful in providing short-term resources. But our current strategic planning is hindered due to the lack of guaranteed funding after the year 2023. If the SDPI funding after 2023 is not renewed or 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. 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 renal failure, 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 practice of competitive grants, allow for greater flexibility in how tribes receive these funds, through contracts or compacts and to eliminate practice of mandatory sequestration which reduces overall federal funds for that Fiscal Year and negatively impacts all tribes who receive SDPI resources. This also has a direct impact on program planning and implementation if funds are "piece-mealed" out to Tribes.

Conclusion

Congress provides about 7 times less than the estimated need for IHS by the National Tribal Budget Formulation Workgroup, an amount that currently excludes authorized but unfunded provisions in the *IHCIA*. Imagine having one day's worth of food for a week: for generations. How could this be anything but termination policy?

Tribes' unique history and relationship with the United States can be seen in the IHS budget and how AI/ANs access care throughout the IHS, Tribal, and Urban Indian (I/T/U) system, but all IHS Areas are united in their request that all the authorities in the *IHCIA* be fully funded through mandatory direct appropriations.

The Workgroup is pleased to see progress on the historic IHS mandatory proposal in the President's FY 2024 Budget Request and is encouraged that the Administration's expectation with this proposal is to continue to work collaboratively with Tribes and Congress to move toward sustainable, mandatory funding.

IHS advance appropriations should be expanded to include all IHS accounts and must be sustained and increased until Congress fulfills its duty the way it was intended – as a mandatory obligation in performance of a bargained-for exchange. Until this solution is enacted, it is critical that Congress continue to prioritize advance appropriations for IHS through the discretionary appropriations process to ensure funding for healthcare services and critical facilities activities are not disrupted.

As sovereign and independent nations, the duty to provide for the health, safety, and wellbeing of our citizens, lands, and sacred natural resources means that IHS funding serves a unique role in Tribes fundamental duty as governments to their citizens. Unfortunately, systemic inequities are exacerbating harm to AI/ANs, which we see in statistic after statistic. As a result, emerging/rapidly increasing American crises are uniquely and acutely harming our people, such as the mental health and opioid and substance abuse crises fueled by new drugs like Fentanyl and the trauma of COVID-19 and recovery.

Many IHS programs are proven successful and result in cost savings for the federal government, such as SDPI; yet, remain under resourced and uncertain. Unfortunately, the SDPI program has been flat funded for 20 years and expires on September 30, 2023. This program has proven to be effective at reducing the prevalence of diabetes among AI/AN adults,⁷⁰ 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.⁷¹ Reauthorize and increase the SDPI – it’s good governance that saves lives and money.

The United States can break the cycle of Tribal inequity. The United States can stop terminating our people each year with spending that breaks its obligations. Tribal nations seek no more than the duty affirmed and reaffirmed by the U.S. Constitution, treaties, statutes, court decisions, and federal administrative law. The United States is only as strong as its word to its people, and to honor its promise to the people, the United States must honor its promise to this land’s First People.

70 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.

71 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, accessed on: March 11, 2023.





2nd Request:

Permanently Exempt Tribes, Tribal Programs, and Urban Indian Organizations from Budget Cuts, Sequestration and Rescissions

As outlined by Tribal leaders throughout the Indian Health Service (IHS) National Tribal Budget Formulation Workgroup's (NTBFW) request and supported by numerous federal reports and findings, the IHS is chronically underfunded, with current estimates about 7 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 it would devastate Tribal nations and their citizens.

Under the Budget Control Act of 2011, the IHS was not exempt from the automatic across the board cuts – unlike federal programs that serve the health of our nation's populations, such as Social Security, Medicare, Medicaid, the Children's Health Insurance Plan (CHIP), and the Veterans Administration (VA). Although the American Taxpayer Relief Act reduced the level of the sequester reduction for the IHS from 8.2% to 5.1% for FY 2013. Even at that revised level, the IHS budget suffered a devastating cut of \$225 million.

Several Members of Congress publicly stated that this was clearly an oversight, and that IHS should not have been held to the full sequester.⁷² Nevertheless, IHS, Tribal, and Urban Indian (I/T/U) programs were left with an impossible choice – either deny services or subsidize the federal trust

72 Capriccioso, Rob, *A Miscalculation on the Sequester Has Already Harmed Indian Health*, Tulalip News (March 11, 2013), available at: <https://www.tulalipnews.com/wp/2013/03/11/a-miscalculation-on-the-sequester-has-already-harmed-indian-health/>.

responsibility. In fact, many did close their doors for several days per month and others were forced to only deliver PRC for Priority I, emergent or acutely urgent care 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.

While there is not currently an automatic rescission or sequestration measure in effect on IHS discretionary spending, sequestration on mandatory spending impacts the highly-successful and cost reducing SDPI. The SDPI program is currently funded through FY 2023 at \$150 million annually, but is subject to a mandatory sequestration of \$3 million, reducing the SDPI funding level from \$150 million to \$147 million. Making forced cuts to one of the most successful health programs for Native communities ever,⁷³ while other health spending is exempt, demonstrates the inequity facing Indian Country. This flat funding has been further strained when a determination by the Department of Health and Human Services opened the grant program up to additional eligible grantees in 2022.

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. 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 2024 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. Congress must ensure that any budget cuts – whether automatic or explicit – hold IHS and our people harmless. We cannot balance the budget on the backs of the First Americans.

⁷³ Indian Health Service, *Changing the Course of Diabetes: Charting Remarkable Progress* (2020), available at https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/SDPI2020Report_to_Congress.pdf



3rd Request:

End the practice of competitive grant-making where not required by statute, and, as appropriate, distribute funds to tribes through Indian Self-Determination and Education Assistance Act (ISDEAA) agreements contracts and compacts, making such funds eligible for Contract Support Costs and eliminating burdensome grants administration

Tribal governments are not grantees; they are sovereign nations that expect the highest level of respect from and a direct relationship with the federal government. Grant programs harm the relationship between Tribal nations and the federal government and do not uphold the federal trust responsibility. The health needs of Indian people are chronic and multi-faceted; such needs must be addressed through committed, stable funding. In contrast, grant programs are temporary, unreliable, non-recurring, and unable to address the ongoing critical needs of Tribal communities.

Under the grant making process, some Tribes may receive awards and benefit from occasional increases, while other Tribes do not. This creates two categories of Tribes — those that have the technical experience and financial resources

to secure competitive awards, and those that do not. Many Tribes without the capacity to secure competitive grant funding have the highest needs but do not benefit from these programs. There are too many restrictions and requirements to federal grants including excessive reporting, limitations on use of funds, and timelines, which all detract from patient care. Grants also create additional administrative burden and costs for Tribes receiving these grants.

If these funds were put into ISDEAA agreements, the Tribes would be eligible to receive additional contract support cost (CSC) funds which would assist to alleviate this administrative burden and cost. Unfortunately, only indirect costs are allowed with grant funds and these amounts must be subtracted from the total grant award. This results in far less funding for the provision of health services and care for patients. There are many administrative requirements, yet 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 now appropriates CSC based on actual need.

As independent sovereign nations, Tribes have diverse and unique community needs. One community may struggle most with opioid addiction, others may continue to fight alcohol and methamphetamine addictions. Grants limit qualifying needs to a single problem, and Tribes are left without access to funds to meet their community's most pressing needs. Tribes are often subject to the whims of federal agencies, particularly around grant making. As was also the case with COVID-19 emergency funding, many federal agencies treated Tribal nations as project grantees instead of sovereign nations, resulting in grant opportunities that were ill-fitted to serve AI/AN people. Too often, Tribal nations are trapped in a federal funding structure operating on the assumption that only state governments are worthy of base funding, essentially, assuming that we do not exist as jurisdictional sovereigns.

Despite the Workgroup's repeated requests for the United States to end the practice of grant-making, including within the IHS, it continues to take place. For example, under the American Rescue Plan Act resources (\$210 million) to the IHS for "public health workforce activities," \$47 million of which was for "Public Health Capacity Building in Indian Country" was distributed through competitive grants. IHS stated that such a competitive grant approach allows the IHS to "track the outcomes and performance of these funds to demonstrate the effectiveness of critical investments". Another example was the reissuance of the IHS Behavioral Health and Domestic Violence Prevention programs (formerly Methamphetamine and Suicide Prevention

Initiative (MSPI) and Domestic Violence Prevention Initiative (DVPI)). Each of these grants require separate administration, including semi-annual progress and quarterly financial reporting as well as compliance with the standard and burdensome HHS grants management policies and procedures.

The decision to distribute a new round of program funding through a granting mechanism is despite the NTBFW and tribal consultation feedback where the grant-making process was strongly opposed. The IHS decided to issue 6 grant announcements, some of which were new. Tribes competed for each of these separate grants even though all experience 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 included awards to Tribes in all 12 Areas. For example, the newly branded "Domestic Violence Prevention" program awarded 37 grants; of those, 27 awards were provided to tribes across only 8 Areas and 10 Urban health centers. IHS proposes that competitive grants reach the neediest communities, but this is not true. Instead, many of the neediest tribes have no capacity to apply for, much less administer, such programs.

Across Indian Country, the high incidence of heart disease, suicide, cancer, substance abuse, diabetes, and cirrhosis are well documented. Grants used to address any Indian health issue limits funding for and restricts access to culturally appropriate care. Increasing resources through direct funding for behavioral health issues to combat alcohol and substance abuse, including opioids, methamphetamines, and other addictions, is needed to break the cycle and reduce the disease and cost burden currently experienced by our Tribal communities.

Federal treaty and trust obligations to fund healthcare and public health in Indian Country cannot, and must not, be achieved through the competitive grant mechanism. By the 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 Tribes to operate under. That is unacceptable.

Funding for all ongoing health services in FY 2025 should be distributed using a fair and equitable formula directly through self-governance contracts and compacts rather than through any new grant mechanism or existing grant program. This will ensure sufficient, recurring, and sustainable funding with additional funds for contract support.

4th 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 is funded 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 Indian Self-Determination and Education Assistance Act (ISDEAA), Urban Indian Organizations, and to federal service unit facilities. At issue is the ability of the federally operated healthcare 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 Purchased / Referred Care (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, as directed by the Tribes who receive services from that share of the IHS funding.



5th Request:

Preserve Medicaid, Medicare, and the State Children's Health Insurance Program

Medicaid

More than 40 years ago, Congress authorized the Indian Health Service (IHS) and Tribal facilities to bill Medicaid for services provided to Medicaid-eligible American Indians and Alaska Natives (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.”

Medicaid plays an integral role in ensuring access to health services for AI/AN peoples and provides critical funding support for the Indian health system overall through third party revenues. 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 doesn't 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 if in-network.
- » 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.

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

- » Revisit the Four Walls interpretation. Provide reimbursements for services furnished by IHCPs outside of an IHS or Tribal Facility.
- » Encourage states to increase Medicaid telehealth reimbursement for IHCPs to the OMB encounter rate.
- » Shield IHCPs from state benefit cuts and enrollment limitations.
- » 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 Tribes to develop a methodology for calculating Medicaid disproportionate share hospital (DSH) payments that considers the uniqueness of the Indian health care system.
- » Clarify that states cannot mandate AI/ANs into managed care plans, including those enacted through waivers. This exemption cannot be bypassed using the HHS Secretary’s waiver authority.
- » Work with states to help them file Section 1115 waivers to obtain Medicaid reimbursement for traditional practices.
- » Encourage Tribal consultation at the state level and enforce State Plan Amendment (SPA) requirements for Tribal consultation.

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:

- » Direct sponsorship of Medicare Part B premiums for Tribal citizens. Currently, to cover Medicare Part B premiums, Tribes must reimburse the beneficiary for their premium payment. For a person who cannot afford that premium, paying it and waiting for reimbursement results in undue financial hardship. Employers and unions can sponsor premiums and, by extending the same opportunity to Tribes, it would both recognize Tribal sovereignty and streamline the payment process for the Tribe and beneficiary.
- » CMS should create a Tribal Graduate Medical Education (GME) program. Alternatively, CMS should create a Tribal set-aside within the existing GME program for Tribal facilities and remove administrative impediments to participation in GME funding by Tribe-operated hospitals.
- » Expand Medicare reimbursement of audio-only telehealth and communications technology-based services. This includes expanding the ability to provide direct supervision via audio-only means, increasing flexibility in the Medicare definition of telemedicine services, and removing other restrictions on telehealth.
- » Simplify and streamline reimbursement for Medicare Part D by ensuring that claims from IHS and Tribal facilities are reimbursed at the highest possible rate—not a discounted rate—by Pharmacy Benefit Managers (PBMs). This can be accomplished by adopting the Part D Indian Addendum developed by IHS and Tribes.
- » 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/IHS all-inclusive encounter rate. This automatic deeming and rate-setting should not supersede rates that an IHCP has negotiated and prefers over the OMB/IHS all-inclusive rate.

- » Authorize reimbursement for traditional healing services through Medicare.
- » Include Pharmacists, Licensed Professional Counselors (LPCs), Certified Community Health Aides and Practitioners (CHAPs), Behavioral Health Aides and Practitioners, Dental Health Aide Therapists (DHATs), and other providers as eligible provider types under Medicare for reimbursement to IHS, Tribal health programs, and Urban Indian Organizations, for all Medicare-covered services that are within the scope of their licensed or certified practice under applicable state, federal, or Tribal laws.
- » Authorize payment at the OMB encounter rate for services furnished by all authorized medical and behavioral health practitioners working in Indian health programs, including pharmacists, licensed marriage and family therapists (LMFTs), licensed professional counselors, and masters-level, bachelors-level, and below-bachelors-level practitioners such as Behavioral Health Aides and peer support specialists.
- » Create a dental benefit under Medicare that does not require enrollment in managed care.
- » Exempt AI/AN people from all Medicare penalties or cost-shares, as they are in the Medicaid program. Eliminate Medicare Part B premiums and deductibles for IHS-eligible people.
- » Ensure parity in Medicare reimbursement for IHCPs. Ensure that Medicare is reimbursing all IHCPs at the OMB/IHS all-inclusive rate.
- » 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 Children's Health Insurance Program (CHIP) have substantial effects on the quality of provision of care through the IHS. As a champion within the U.S. Department of Health and Human Services (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:

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

Respecting and upholding Tribal sovereignty must come first and foremost in any public health work in Indian Country. As sovereign governments, Tribal nations have inherent authority and responsibility to meet their citizens' healthcare and public health needs.

Respecting Tribal sovereignty, in large part, means honoring self-determination – supporting Tribes to make decisions for themselves on the best way to set priorities and design programs tailored to the needs of Tribal communities to advance health equity. In addition, Tribal sovereignty opens options and potential approaches to health equity that may differ from other communities or populations. For example, Tribal sovereignty allows Tribes to use Tribal law as a powerful tool for protecting public health and advancing health equity in Tribal communities. Ensuring sufficient flexibility and support for Tribes to design their public health priorities and interventions is both more effective in advancing health equity and more respectful of Tribal sovereignty.

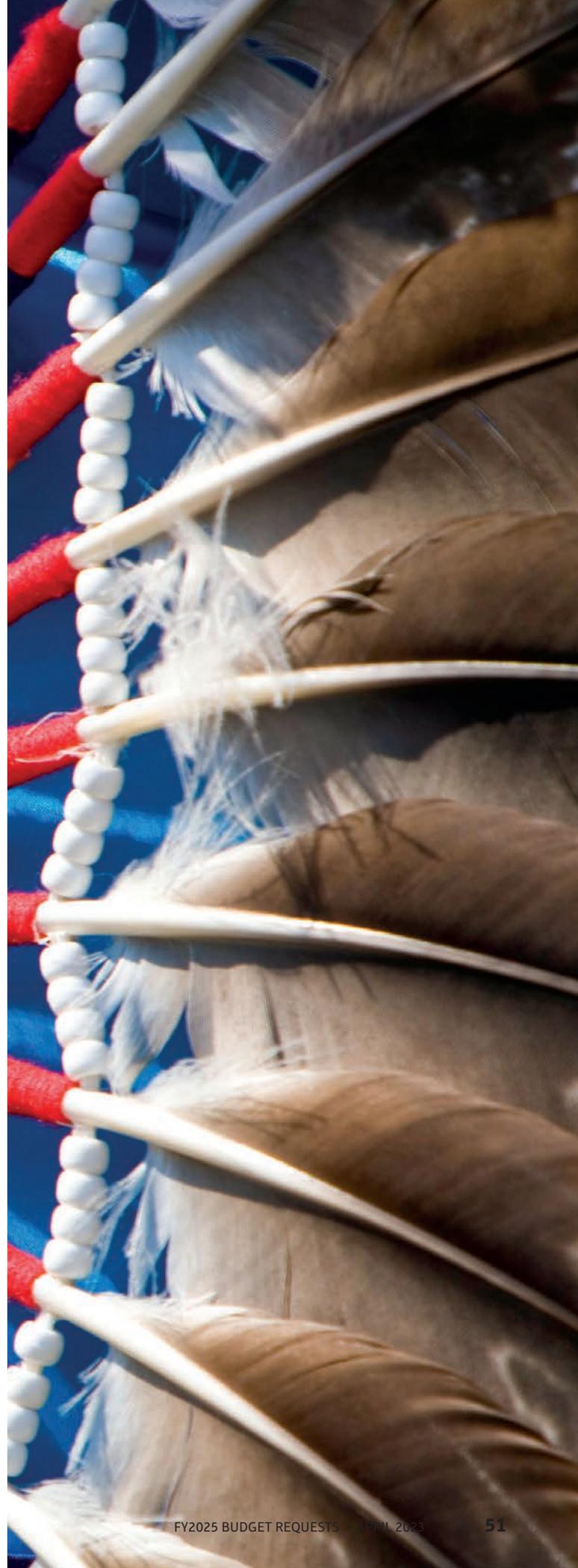
Like all sovereign nations, Tribes maintain nation-to-nation relationships with the U.S. government. Therefore, any federal public health programs and health equity initiatives must flow through the appropriate diplomatic channels that respect the authority of Tribal governments. Because of the central importance of Tribal sovereignty, implementing federal public health initiatives in Tribal communities necessitates special

attention to the significant nuances and complexities that arise at this intersection of jurisdictions.

As discussed by this Workgroup in the Program Expansions section of this request for years, many IHS programs support or could better support Tribal public health Infrastructure. Further, the IHCIA includes authorities to support Tribes in their development of public health capacity if they were provided adequate resources. However, the United States treaty and trust obligations are not singularly contained within one agency of the federal government, and the IHS cannot be expected to carry that burden exclusively on its back.

The Department of Health and Human Services (HHS) offers public health funding, but all too often, we see funding and partnerships structures from grant notices that focused around states and local governments, but not Tribes. HHS must entirely rethink these structures to appropriately build in Tribal nations as it works to improve the public health of the whole country. As we know all too well from the COVID-19 pandemic, public health challenges do not end at a particular geographic or jurisdictional border.

HHS can advance health equity for AI/ANs by ensuring, most importantly, dedicated resources for Tribal public health capacity and infrastructure development; flexibility and Tribal control in public health programs for Indian Country; accepting the federal government's responsibility to ensure good health and well-being for AI/AN people; conducting meaningful Tribal consultation; implementing equitable funding structures; and recognizing that the answers for health equity lie within our communities, and not in Washington, DC or any State capitol.





7th Request:

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

The IHS National Tribal Budget Formulation Workgroup thanks the Biden-Harris Administration for its historic dedication to Office of Management and Budget (OMB) engagement and involvement in the development of Tribal health budget priorities. To have a more effective process, Tribes must have the opportunity to meet directly with the Office of Management and Budget (OMB) to ensure that they clearly understand the budget priorities put forward by the Tribes.

The Workgroup is also encouraged to see the establishment of the first-ever Tribal Advisor to the OMB Director. Unfortunately, disaster has a way of bringing persistent issues to the forefront and underscoring the importance of institutional expertise on Tribal budgets, law, and policy. When COVID-19 hit the United States, a lack of Tribal expertise and coordination across agencies led to a checkerboard of policy and programs that lacked consistency and clarity when it mattered most.

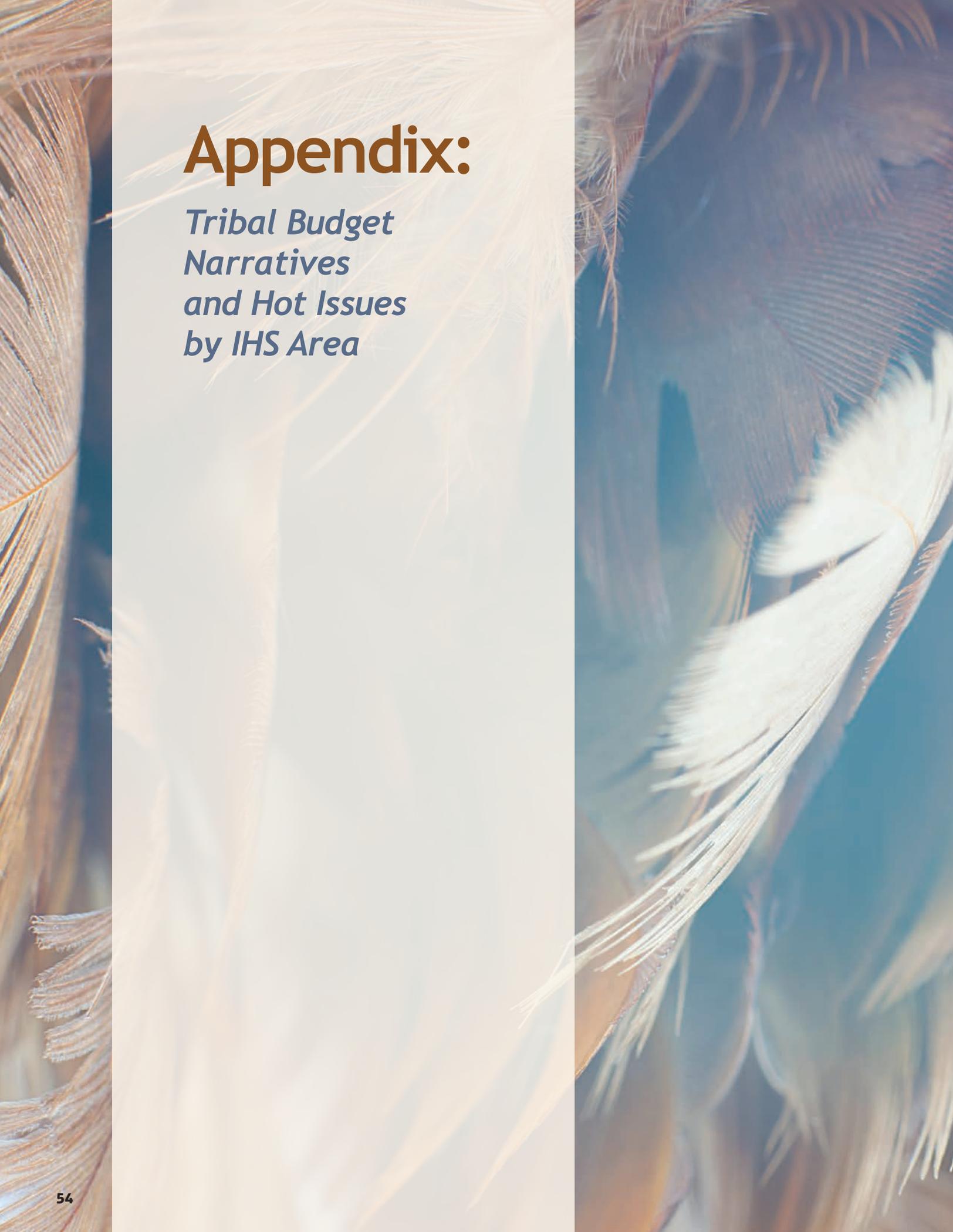
This Administration has also had historic legislative success that underscores the importance of a Tribal Advisor to the OMB Director and ongoing engagement from OMB in the IHS budget formulation process. The Infrastructure Investment and Jobs Act included \$3.5 billion for IHS Sanitation Facilities Construction over five years, an investment into a multi-site, multi-year, and multi-phase infrastructure initiative with complex

jurisdictional and regulatory hurdles to timely execution. As cited by the Workgroup, the soaring cost of construction has already made this budget inadequate, and the investment does not include funds for the operations and maintenance of existing or newly completed facilities.

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). This will ensure consistency for Indian policy in all government matters, and consistency across various Presidential Administrations. The TAC will be able to provide a wide-ranging perspective to OMB as they look to craft budgets and policies that have countless impacts on AI/AN people and Tribal Nations.

The commitment from this Administration is historic, but the United States will not realize the efficiency of this expertise unless the position has the continuity to build on its work from administration to administration. The treaty and trust obligations to the Tribes cannot be compartmentalized, and having OMB expertise present and participating in meaningful national budget formulation is a step toward honoring those obligations.





Appendix:

*Tribal Budget
Narratives
and Hot Issues
by IHS Area*

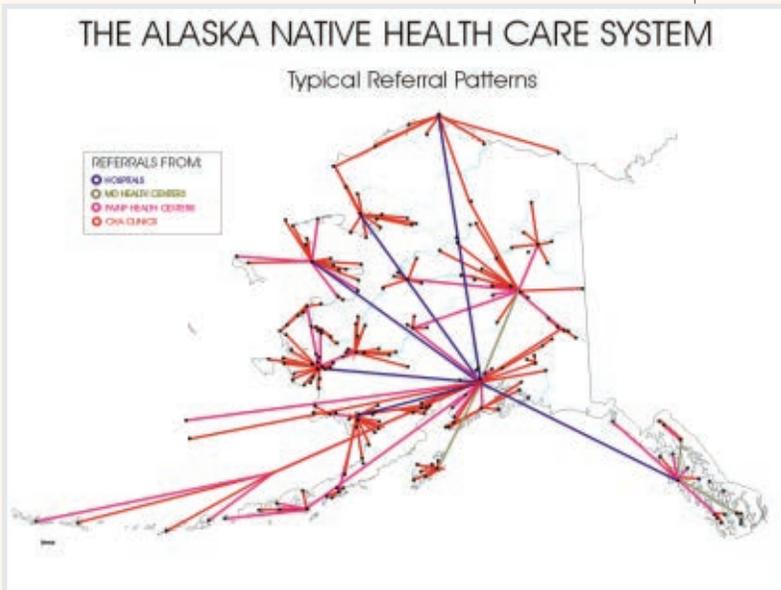
ALASKA AREA

Alaska Area Narrative

THE ALASKA AREA OFFERS THE FOLLOWING BUDGET RECOMMENDATIONS FOR FISCAL YEAR 2025.

Profile of the Alaska Area

In the Alaska Area, Tribes and Tribal Health Organizations (T/THOs) work together and support the Alaska Tribal Health System, which is a comprehensive system of health care that serves all 229 federally recognized Tribes in Alaska and over 188,000 Alaska Native and American Indian people. The Alaska Tribal Health System is a dynamic system administered by and for Alaska Native people. This system has risen to many challenges and has made great strides through both ingenuity and necessity. The system consists of several levels of service, including Village Clinics, Sub-Regional Services, Regional-Hub Services, Statewide Services, and Tribal Care Coordination. Alaska T/THOs work together to ensure all Alaska Native and American Indian people receive the highest quality of healthcare.



Its size and reach are reflected in the map highlighting the typical healthcare referral patterns. In many rural areas of Alaska, T/THOs are the only healthcare providers available. Therefore, they serve the general population. The Tribal and governmental systems represent a larger portion of both facilities and service providers in Alaska than in any other state.

This is a finely-tuned network that provides services through:

- » 180 village clinics and small primary care centers
- » 25 sub-regional mid-level care centers
- » 7 regional hospitals
- » Alaska Native Medical Center tertiary care

Budget Recommendations

Current Services & Binding Obligations: \$771,363,000

Severe and chronic underfunding of the Indian Health Service has resulted in the loss of purchasing power and the diminution of infrastructure, programs, and services. The IHS Current Services and Binding Obligations must be preserved with increases to ensure no loss of services, maintenance of current programs, and to protect existing infrastructure.

MEDICAL INFLATION

The Current Services request also includes \$5,820,000 million for Non-Medical Inflation and \$112,825,000 million for Medical Inflation. As a component of the Consumer Price Index (CPI),

The index for all items less food and energy rose 5.7 percent over the past 12 months. The medical care index rose 0.1 percent in December after declining in the previous 2 months. The index for hospital services increased by 1.7 percent over the month. The physicians' services index and the prescription drugs index both rose 0.1 percent in December.⁷⁴ The actual inflation rate for different components of the IHS health care delivery system is much greater.

Recruitment of healthcare staff for remote areas in Alaska has never been easy, but over the course of the Pandemic, healthcare organizations in Alaska are faced with significantly higher rates for Locums Providers and have to significantly increase salaries for many clinical functions in order to recruit and retain a workforce. Salaries for providers and nurses have increased between 18-37% since 2019, as reported by some Tribal health organizations. Additionally, the cost of pharmaceuticals and other supplies has also increased significantly.

Further, fiscal years 2021 and 2022 saw the highest levels of inflation in 40 years. These cost increases have also been met with significant increases in labor costs at a time of high

74 <https://www.bls.gov/news.release/cpi.nr0.htm>

turnover and burnout for existing staff, requiring higher and higher funding levels to operate facilities and 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 the cost of living in rural areas.

JOINT VENTURE CONSTRUCTION PROGRAM AND STAFFING PACKAGES

Important for binding obligations, Alaska Area recommends that all new and joint venture facilities should receive funding for staffing packages funding in advance of the facility's completion. It takes considerable time to recruit appropriate personnel. From an operational standpoint, waiting for a facility's staffing package to be awarded until the facility opens makes it extremely difficult to recruit expanded personnel when supportable space is increased and leaves new functional facilities immediately understaffed.

Because of inadequate funding related to staffing, multiple tribal organizations in the Alaska Area are at a point where their ability to carry out health care services is significantly compromised. Compounding interest alone drives up the cost of such projects by millions of dollars when facilities cannot provide and be reimbursed for services. In entering joint venture construction agreements, IHS agreed to request funding from Congress on the same basis as IHS requests funding for other facilities.

Hospitals & Health Clinics: \$15,300,000

The Alaska Area recommends a \$15.3 billion program increase for the Hospital & Health Clinics (H&HC) major line item budget account to support sustainable public health infrastructure – in Alaska, Tribal health is Public Health. The H&HC funds ensure that comprehensive, culturally appropriate public healthcare services are available. This is the core budget line item that makes available medical care services for Alaska Native and American Indian people, including the services which support our public health activities 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, and 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 Alaska Native and American Indian people, such as diabetes, maternal and child health, and communicable diseases – including the current triple pandemic of influenza, RSV, and COVID-19.

The demands on the IHS H&C line item are continuously challenging for providers. In our facilities, we experience constant and increased demand for services due to the significant population growth, significant costs of travel, and the increased rate of chronic diseases that result in overwhelming patient workloads. This is exacerbated by rising medical inflation, difficulty in recruiting and retaining providers in rural healthcare 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 care needs.

Dental Services: \$6,834,572

The Alaska Area recommends a program increase of \$6.8 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 Alaska Native and American Indian children. Funds are used for staff salaries and benefits, contracts to support dental services, dental lab services, training, supplies, and equipment. These funds are needed primarily to improve preventive and basic dental care services, as many 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 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, and 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 health.

Immunization Alaska: \$273,383,000

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 the vaccine for preventable diseases. COVID-19 and now the triple pandemic of influenza, RSV, and COVID variants show that funding and supporting 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, delivering access and health equity in our state.

Eighty percent of Alaskan Native communities are located off the road system, and 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 eight 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.

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 the vaccine for preventable diseases in Alaska Native communities.

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.

Maintenance & Improvement: \$2,733,828,000

The Alaska Area recommends a \$2.7 billion program increase for the Maintenance and improvement (M&I) line item. M&I is the primary source for maintenance, repair, and improvements for facilities that house IHS-funded programs, whether provided directly or through P.L. 93-638 contracts/compacts.



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, care delivery, and patient health is compromised. In order to provide the level of care necessary to ensure a minimum standard of patient care, more resources must be provided at the facility and clinic levels.

Furthermore, with proper maintenance and improvements to facilities, investments are protected by extending the usability of the facilities. With currently provided resources to build new facilities projected to require many of our facilities to last for over 250 years, increased M&I funding is the only way to ensure facilities can continue to operate until they are replaced.

Sanitation Facilities Construction: \$2,460,446,000

The Alaska Area recommends a \$2.5 billion program increase for the Sanitation Facilities Construction program. The Alaska Area further recommends that the 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. The Alaska Area recommends \$100 million for this to be funded out of the sanitation line item. In order to address the sanitation crisis in our communities, we urge the Indian Health Service to empower Tribes to establish a path to service for unserved and underserved communities and be ready to respond to climate threats to sanitation facilities. The Sanitation Facilities line item and the Sanitation Facilities Construction Program (SFCP) help meet that need.

Tribal Self Governance and partnership between Tribes/THOs and IHS play a critical role in ensuring access to clean water and sanitation infrastructure. Through the authorizing statute for the Indian Health Service, the Indian Health Care Improvement Act (IHCA) (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).

During the pandemic, we were told to socially distance ourselves and wash our hands to keep COVID-19 from spreading, but for thousands of homes in Alaska Native villages, without access to clean running water or sewer, this was impossible. Roughly 20 percent of rural Alaska Native homes still lack in-home piped water across 32 communities. This creates significant health risks for our communities. We thank Congress and the Administration for providing \$3.5 billion in funding to support water and sanitation through the Infrastructure Investment and Jobs Act. With a backlog of almost \$3 billion (approximately \$1.7 billion of that in Alaska), the IHS Sanitation Deficiency System list (SDS) cannot keep pace with the need, and this new funding will help address this. But the difficulties continue, as rising prices, labor costs, and seasonal challenges continue to drive up the cost of delivering water and sanitation. IHS must continue to advocate for SFCP funding to support these needs. Furthermore, as systems have aged and the SDS list has not been updated, there is a growing amount of unidentified deficiencies which will require continued maintenance and improvement. We urge the Administration to prioritize Sanitation Facilities Construction funding.

Furthermore, cost caps imposed by the IHS continue to impact access to most funding, thus decreasing project priority and limiting the amount of funding for those projects. HHS should direct IHS to eliminate cost caps to allow piped water and sewer for these unserved and underserved communities. The provision of Indian sanitation facilities is a very important component of the overall effort required to reduce waterborne disease outbreaks, a goal highlighted in Healthy People 2020 “Topics & Objectives” for Environmental Health. Safe drinking water supplies and adequate waste disposal facilities are essential preconditions for most health promotion and disease prevention efforts, as well as being a major factor in the quality of life of Indian people.

Alaska has clinics (where temperatures can drop to -30 degrees or colder) that have instructions posted in outhouses on how to capture a urine sample. It is unfathomable in this day and age, and with the vast wealth of this nation, we have communities suffering in these developing world conditions. Furthermore, with the existing water and wastewater systems all over the state of Alaska and across the nation, many are failing or out of regulatory compliance. 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 provide for much needed infrastructure necessary to promote public health, leading to increased risk of skin and respiratory infection and costly community outbreaks of communicable disease.

The IHS SFCP, an integral component of the IHS disease prevention activity, has carried out authorities since 1960 using funds appropriated for Sanitation Facilities Construction to provide potable water and waste disposal facilities for Alaska Native and American Indian people. As a result, the rates for infant mortality, the mortality rate for gastroenteritis, and other environmentally related diseases have been dramatically reduced by about 80 percent since 1973. IHS physicians and health professionals credit many of these health status improvements to IHS’ provision of water supplies, sewage disposal facilities, development of solid waste sites, and provision of technical assistance to Indian water and sewer utility organizations.

Funding is needed to address sanitation emergencies and climate change impacts. The coronavirus pandemic has not only highlighted the inequities in public health with a lack of access to clean water but resulted in delays for critical community infrastructure projects. Climate threats (fall storms) 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 cleanings, was also delayed due to the COVID-19 pandemic. Heavy equipment and adequate Arctic storage facilities are needed in all of our communities for snow removal during winter months and year-round, ongoing maintenance to keep water/sewer/honey bucket services. Resources need to be provided to address sanitation crises for villages that depend on single water tanks or standalone washeterias. Further, as the Arctic heats up, 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 that damage facilities.

OPERATION AND MAINTENANCE (O&M)- \$100 MILLION

The 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” (25 U.S.C. 1632(b)(2) (C)). The IHCA also states, “the financial and technical capability of an Indian tribe or community to safely operate and maintain a sanitation facility shall not be a prerequisite to the provision of construction of sanitation facilities by the Secretary” (25 U.S.C. 1632(d)). IHS should request funding to support the creation of a new Operation & Maintenance (O&M) line item

within the Sanitation Facilities Construction Program which also holds all other funding harmless.

The IHS, in collaboration with the Alaska Native Tribal Health Consortium (ANTHC) and the State of Alaska (SOA), estimated O&M expenses and gaps at American Indian (AI) and Alaska Native Village (ANV) utilities included in the IHS data system. The finding showed that the estimated funding gaps in O&M expenditure for all AI and ANV-operated water and wastewater utilities are between \$55.2 and \$238.3 Million annually.

In 2008 the Infrastructure Task Force (ITF) identified insufficient O&M funding, including support of Tribal capacity development, as a barrier to increasing access to safe drinking water and wastewater disposal in Indian country⁷⁵. Understanding O&M expenses of Tribal drinking water and wastewater systems is necessary to understand the financial capacity of Tribally operated utilities. Financial capacity directly affects a Tribe's ability to provide an adequate supply of drinking water and maintain drinking water regulatory compliance, provide reliable and compliant wastewater services, and ensure the longevity of the infrastructure that has been funded by extensive national investment.

The Indian Health Service is required under the Indian Health Care Improvement Act (IHCIA) to report on all sanitation deficiencies, including deficiency level 1 needs related to routine replacement, repairs, or maintenance. The IHS is also authorized under IHCIA to provide operations and maintenance assistance and emergency repairs to tribal sanitation facilities when necessary to avoid a health hazard or to protect the Federal investment in sanitation facilities.

Roughly 20 percent of rural Alaska Native homes still lack in-home piped water across 30 communities. This continues to create significant health risks for our communities.

Total Recommended Program Increases: \$1,812,264 (in thousands)

⁷⁵ Meeting the Access Goal: Strategies for Increasing Access to Safe Drinking Water and Wastewater Treatment to American Indian and Alaska Native Homes March 2008. <https://www.epa.gov/sites/production/files/2015-07/documents/meeting-the-access-goal-strategies-for-increasing-access-to-safe-drinking-water-and-wastewater-treatment-american-indian-alaska-native-villages.pdf>



Alaska Area Hot Issues

Achieving Health Equity Requires Full and Mandatory Funding

Issue: Full Mandatory Funding for Indian Health Service

Background: Fulfilling the trust responsibility requires that the United States fully fund all necessary health care and public health services for American Indian and Alaska Native people and do so through mandatory funding. The full funding level deserves a thoughtful, measured, and Tribally-driven approach to developing appropriate recommendations. Tribal Health was prepaid in full based on over a half billion acres of Indian lands ceded in exchange for the "health" provisions in treaties.

Recommendations:

- » Request full funding for and implement the remaining provisions of IHCIA.
- » Support a Tribal workgroup to identify full funding needs for the Indian healthcare system.
- » Work with Tribes and provide needed data as part of a Tribally driven study to determine strategies for IHS mandatory appropriations.

Issue: Contract Support Costs Mandatory Funding

Background: Congress provided that Contract Support Costs be fully funded by including an indefinite discretionary appropriation for this account. However, this line item continues to take up a large percentage of the IHS discretionary budget, thereby leaving little room to expand other services given tight discretionary appropriations caps. Mandatory appropriations for Contract Support Costs will ensure that other areas of the IHS budget are held harmless by these costs and true increases in critical services line items can move forward. This will enhance care for AN/AI people and reduce health disparities.

Recommendations:

- » Reclassify Contract Support Costs as mandatory appropriations, including continuing Contract Support Costs funding as a separate appropriation with an indefinite amount to fulfill ISDEAA legal obligations.
- » Amend the IHS Contract Support Costs policy in light of the recent *Cook Inlet Tribal Council* decision to clarify the ISDEAA's duplication provision only requires a dollar-for-dollar offset. IHS should also delete current footnotes suggesting this issue remains in dispute.
- » Amend IHS Contract Support Costs policy to reflect the new 9th Circuit *San Carlos Apache Tribe* decision ruling that IHS must pay contract support costs on the portion of Tribal health programs funded with third-party revenues and should delete current footnotes suggesting this issue remains in dispute.

Sustainable Investments in Critical Infrastructure

Issue: Joint Venture Construction Program and Staffing Packages

The Joint Venture Construction Program (JVCP) is a very successful partnership between the Indian Health Service and the Tribal Health Organizations that allows for badly needed healthcare facilities to be built without using capital funds from the IHS. JVCP remains a cost-effective mechanism to address the healthcare facilities shortage separate from the IHS Facilities Construction Priority System. The JVCP program has increased access to care in communities with dire healthcare needs. The Alaska Area recommends that the JVCP be expanded to allow stand-alone specialty care facilities when not developed as part of an in-patient or outpatient facility (e.g., in-patient or outpatient behavioral health facilities, dialysis centers, long-term care, and other specialty care services). All new and joint venture facilities should receive staffing package funds in advance of the facility's completion. It takes considerable time to recruit appropriate personnel. From an operational standpoint, it does not make sense for T/THOs to wait for a facility's staffing package funding until after the facility opens, which leaves new functional facilities immediately understaffed. Because of inadequate funding related to staffing, multiple tribal organizations in the Alaska area are at a point where their ability to carry out health care services is significantly compromised. Beyond reducing access to health care services, it puts these Tribal Organizations in danger of being unable to service the debt incurred in constructing joint venture facilities. Compounding interest alone drives up the cost of such projects by millions of dollars when facilities are unable to provide and be reimbursed for services.

Additionally, the IHS is to discontinue the practice of requesting "less than" the full amount (derived from IHS's own calculated staffing costs) of necessary staffing funds from Congress. When the IHS requests and subsequently receives less than the amount it needs to meet its contractual commitments to individual Tribal providers, funds must be diverted from other areas to make up for the difference. Before IHS requests and before Congress funds discretionary increases in other IHS accounts, contractually committed staffing packages should be paid in full.

Recommendations:

- » Alaska Tribes recommend that IHS routinely and regularly offer a new cycle for the IHS JVCP applications.
- » In FY 2019, ten JVCPs were selected in phase one of the final application process. Five projects were selected to continue to phase two. The Alaska Area recommends that IHS proceed with the second five selected applicants in FY 2025 and request funding for the staffing packages from Congress.
- » Alaska Tribes recommend allowing applications for construction projects already started that are being developed in accordance with IHS design/construction criteria. This is especially relevant in Alaska, where the construction season is extremely short, and materials are particularly expensive. They must be shipped via barge, which might only arrive 1 or 2 times yearly. For these reasons, Alaska Tribes must plan years in advance.
- » *Alaska Tribes also recommend including dedicated behavioral health facilities in the JVCP solicitations, given the high priority of substance abuse issues and the need for residential treatment centers.*
- » Remove 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. IHCIA requires that the tribe lease facility to IHS for 20 years at no cost under the JVCP. The joint venture (JV) facility is eligible to receive a share of IHS's perennially insufficient Maintenance and Improvement (M&I) funding but is not eligible for a lease under section 105(l) under the ISDEAA. A facility should not be denied full funding simply because it was selected for the JVCP. Enabling 105(l) leasing would protect the Tribe's and IHS's investment over the years.

Issue: Clinic Lease Programs

Village health clinics supported by the IHS Village Built Clinic (VBC) Lease Program have a long and unique history in Alaska and provide the only local source of health care in many rural areas. VBC leases are vital to the provision of services by Community Health Aides/Practitioners, Behavioral Health Aides/Practitioners, and Dental Health Aides; the program provides the foundation for the healthcare system in villages in rural Alaska. The VBC Lease Program is also similar to the

section 105(l) leases in that it has long been underfunded and is crucial to Tribal clinics keeping their doors open to serve patients. Alaska Tribes recommend the VBC Lease Program be treated similarly to section 105(l) leases, and provided full, indefinite funding for the program through mandatory appropriations. The 105(l) lease program and the VBC Lease Program are vital funding sources for facilities.

Recommendations:

- » Provide Mandatory Appropriations for VBC Leases.
- » Fully fund VBC Leases by including VBC leases under the Payments for Tribal Leases account of the IHS budget.
- » Transfer 105(l) lease payments account from discretionary to mandatory appropriations and continue 105(l) lease payments funding as a separate appropriation with an indefinite amount to fulfill ISDEAA legal obligations.

Issue: Sanitation Facilities

Roughly 20 percent of rural Alaska Native homes still lack in-home piped water across 32 communities. The impacts of the lack of sanitation and clean water infrastructure remain an ongoing public health crisis. Difficulties with addressing the sanitation crisis continue as rising prices, labor costs, and climate challenges continue to drive up costs. IHS must continue to advocate for SFCP funding to support these needs.

As systems have aged and the SDS list has not been updated, there is a growing amount of unidentified deficiencies which will require continued maintenance and improvement. Cost caps and ineligible cost contributions imposed by the IHS continue to impact access to most funding, thus decreasing project priority and limiting the amount of funding going to those projects. Safe drinking water supplies and adequate waste disposal facilities are essential preconditions for most health promotion and disease prevention efforts, as well as being a major factor in the quality of life of Indian people.

Alaska has clinics (where temperatures can drop to -30 degrees or colder) that have instructions posted in outhouses on how to capture a urine sample. It is unfathomable in this day and age, and with the vast wealth of this nation, we have communities suffering in these developing world conditions. Many existing water and wastewater systems are failing or out of regulatory compliance. Funding is needed to address sanitation emergencies and climate change impacts. The coronavirus pandemic has not only highlighted the inequities in public health with a lack of access to clean water but resulted in delays for critical community infrastructure projects. Climate threats (fall storms) continue to damage essential public infrastructure (water storage tanks, distribution lines, sanitation roads), and aging public infrastructure impacts water quality.

Delaying a water/sanitation construction project for a year, whether for regulatory or other reasons, increases project costs from 10% to 25%. The range of cost increase is correlated with what phase of the project the delay occurs. If the delay occurs before pre-planning, material takeoff, and equipment mobilization occurs, project cost increases should be near 10%, mostly due to the inflation of material prices.

Materials for water/sewer construction projects have increased in price from 20% in electrical components, 50% for plumbing components, and over 100% for lumber in the last year, increasing most overall construction project costs by 10% or more. The further along in the project planning, material takeoff, and equipment mobilization phases, the “more costly” the delays will be. This could increase the cost by up to 25% for smaller projects as many of these expensive efforts will need to be completed again upon actual construction startup.

Recommendations:

- » Empower Tribes with funding through Tribal Self-Governance to establish a path to service.
- » Remove IHS Sanitation Deficiency System Cost Caps.
- » Reform IHS Sanitation Deficiency System ineligible cost match requirements and 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 operational costs.
- » Recommend establishing local and/or regional utility management and operations systems. This will support the creation of operator standards, education, and training materials and criteria which are culturally competent and reflective of Native educational styles.
- » IHS administrative set-aside should be minimal. Use IHS administrative funds to conduct community and homeowner education and outreach.
- » Fund operational costs for new communities.
- » Allow and fund local climate and environmental threat monitoring in project communities and through a statewide network. Alaska is the only Arctic and Sub-Arctic state, and it is experiencing warming trends at twice the rate and having a greater impact than in most other parts of the United States on sanitation and facilities infrastructure.

Issue: Operation and Maintenance

Tribes recommend that IHS create and fund the operation and maintenance (O&M) of sanitation infrastructure. An unprecedented amount of funding provided by Congress for the construction and repair of sanitation facilities through the IJA underscores the need to protect federal investments and ensure the maximum life-cycle and sustainable operation of



these sanitation systems for as long as possible. Tribes must be provided O&M costs so that the projects will continue to be successful for decades to come. O&M costs should also be used for existing systems to keep projects that are already completed off of the SDS list in the future.

O&M funding for sanitation facilities systems should be made available through ISDEAA self-governance mechanisms. In the absence of external financial assistance, Tribes are often forced to use their limited funds to support O&M. In many instances, the support may not happen at all because the Tribes may not have the resources to carry out these functions. Continued dependence on this practice will continue to shorten the useful life of existing sanitation projects or cause their breakdown.

Under the Indian Health Care Improvement Act (IHCA), the 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. However, resources have not been appropriated specifically for this purpose.

The IHS, in collaboration with the Alaska Native Tribal Health Consortium (ANTHC) and the State of Alaska (SOA), estimated O&M expenses and gaps at the Tribal village utilities in the IHS data system. The finding showed that the estimated funding gaps in O&M expenditure for operated water and wastewater utilities to be between \$55.2 and \$238.3 million annually. Understanding O&M expenses of Tribal drinking water and wastewater systems is necessary to understand the financial capacity of Tribally operated utilities. Financial capacity directly affects a Tribe's ability to provide an adequate supply of drinking water and maintain drinking water regulatory compliance, provide reliable and compliant wastewater services, and ensure the longevity of the infrastructure that has been funded by extensive federal investment.

Recommendation:

The new O&M line item should be funded on an annually recurring basis and not take funding away from existing funding for SFC projects or IHS line items

Issue: Maintenance & Improvement

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. In order to provide the level of care necessary to ensure a minimum standard of patient care, more resources must be provided at the facility and clinic levels.

With proper maintenance and improvements (M&I) to facilities, investments are protected by extending the usability of the facilities. With currently provided resources to build new facilities projected to require many of our facilities to last for over 250 years, increased M&I funding is the only way to ensure facilities can continue to operate until they are replaced.

Recommendations:

- » Provide adequate funding for M&I funds as the primary source for maintenance, repair, and improvements for facilities that house IHS-funded programs, whether provided directly or through P.L. 93-638 contracts/compacts.
- » 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 life of such facilities.
- » In order to provide the level of care necessary to ensure a minimum standard of patient care, more resources are needed at the facility and clinic levels.

Issue: Small Ambulatory Grants Program

In many of the rural communities in Alaska and indeed in many rural American communities, the only access to health care is the Tribal health program in those communities. In Alaska, with 80% of its communities off the road system spread across over 660,000 square miles, these communities are, in effect, islands, and therefore Alaska Tribes recommend that the eligibility of 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 Indian Health Care Improvement Act. This section allows IHS to award grants to Tribes and/or Tribal Organizations to construct, expand, or modernize small ambulatory healthcare facilities.

Recommendation:

Support continued appropriations for the Small Ambulatory Grants Program and award funding to construct, expand, or modernize small ambulatory healthcare facilities.

Building Parity & Expanding Tribal Self-Governance

Issue: Tribal Self-Determination is Health Equity

The federal government recognizes 574 Tribes as distinct, independent political entities whose inherent sovereignty predates the United States but has been limited in certain circumstances by treaty and federal law. Almost half of the federally-recognized Tribes are in Alaska, with 229 Alaska Tribes. Tribal governments have many of the same responsibilities as state and local governments but often do not have access to the same sources of revenue to support these responsibilities. In addition to serving Tribal members who reside on lands under a Tribe's jurisdiction, the Tribe may also provide services or benefits to enrolled Tribal members who do not reside on or near these lands and others in the community, such as Tribal members from other Tribes and those who are not American Indian or Alaska Native people.

In December 2022, the GAO conducted a report and recommended that Congress consider enabling funding agencies to use existing mechanisms and structures, such as self-governance compacts, to distribute emergency relief funds. For example, using existing mechanisms, such as contracts and compacts, can enable agencies to more quickly distribute funds to recipients and mitigate administrative burdens for agencies and tribes. By allowing the agencies to use existing mechanisms to distribute funds, Congress would better ensure that they distribute these funds more quickly and with a minimal additional administrative burden on tribal recipients and agencies. This also allows agencies to maintain accountability using the funds through existing reporting mechanisms. Additionally, GAO found that increasing federal capacity and expertise for working with tribal recipients could improve the federal administration of future funding for tribal recipients. In accordance with a 2021 presidential memo, each selected agency is implementing an action plan that includes building capacity and expertise better to meet the unique needs of tribes and tribal communities.

Tribal Self-Governance has been the most successful Indian Policy the US Government has ever pursued. Within the Department of Health & Human Services, the ability to self-determine and self-govern is limited to the programs of the Indian Health Service. It is time to expand self-governance to other programs in HHS. Inherent in the government-to-government relationship between Tribal Nations and the federal

government is that the United States works directly with Tribes as sovereign equals in all governmental functions, including emergency preparedness and response.

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. Not only are these investments the right thing to do because of the trust responsibility and treaty obligations, but they're also good investments. Tribal programs, when given the resources, can be innovative and have remarkable health outcomes. Tribal governments have repeatedly advocated for a government-wide expansion of Tribal self-governance. Self-determination and self-governance policies honor the inherent sovereignty of Tribal Nations by affording local Tribal control over program and policy implementation, thus allowing for the creation of tailored programs uniquely developed to address community priorities. Not only does this improve the efficiency and effectiveness of program operations, but it is also a proven method that leads to health equity and better socioeconomic outcomes for Tribal communities.

Tribes are often subject to the whims of federal agencies, particularly around grant-making. As we have seen with COVID-19, many federal agencies have no idea about Tribal Nations, resulting in grant opportunities that are often ill-fitted for serving Tribal people.

Recommendations:

- » A formula-based allocation of funding directly to Tribes is the best way to honor the trust responsibility and ensure that all Tribal nations, not just the ones who have access to the resources needed for competitive grant writing, are able to access funding.
- » The Federal government has a constitutional obligation to fulfill this trust responsibility, and because of this trust responsibility, federal spending for IHS should be mandatory, not discretionary.
- » The IHS should be exempt from broad-based cuts in discretionary spending and budget rescissions.
- » Federal trust obligations to fund healthcare 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.

Issue: Parity in Modernization of Health Information Technology

IHS announced for the first time that it would be distributing a portion of the \$6 billion multi-year EHR Modernization budget request in accordance with existing processes for Programs, Functions, Services and Activities (PFSAs) definition and shares distribution. While this is welcome news, we understand that the Agency is limited by the Code of Federal Acquisition Regulations (CFAR) in its ability to work with non-federal entities during the acquisition process. Tribes recommend that the IHS begin working with Tribes on the process of determining PFSAs and shares distribution in preparation for future appropriations.

Alaska Tribes have invested millions of dollars of their own resources in modernizing their electronic health records management system. Tribes and THOs who have already converted from the RPMS system to more efficient technological solutions should be financially supported just as the IHS is being funded for its modernization. If IHS is seeking financial support from Congress for its modernization through the IHS appropriation and budget formulation process, it must include a proposal to fund those Tribes that have invested their own resources for modernization as well as ongoing maintenance.

Recommendations:

- » Work with Tribes on the process of determining PFSAs and shares distribution in preparation for future appropriations and provide financial resources for the modernization efforts that have already been carried out by Tribes and THOs and recognize the lack of parity for Tribes and THOs who had to move away from RPMS for the safety and benefit of our patients.
- » Honor and respect Tribal communities and stakeholders - appropriate HIT solutions should include participation from Tribal HIT experts and representatives who are given authority to represent Alaska Tribes on HIT issues.
- » Support Tribes while creating an opportunity to continue to innovate around HIT solutions for rural and resource-constrained communities - IHS must commit to creatively integrating ongoing evaluation of any HIT interventions.

Issue: Non-Competitive Funding for Behavioral Health

A more effective way to distribute behavioral health resources to Tribes is through self-governance contracts and compacts to ensure sufficient, recurring, and sustainable funding. Using existing funding allocation methodologies will allow Tribes to better plan for greatly needed services for their citizens, especially for Methamphetamine treatment and domestic violence services and prevention. This will also alleviate the burden on Tribes to use valuable staff time to apply for grant funding and

grant reporting and allow them to use their limited resources to treat behavioral health concerns instead.

Many communities face high rates of depression, substance abuse, domestic violence, and diabetes; these challenges have been exacerbated by the COVID-19 pandemic. The historical trauma associated with forced relocation, the removal of children sent to boarding schools, and the prohibition of our spoken language, religious ceremonies, and cultural traditions all compound the traditional social and economic factors associated with current negative health disparities.

Alaska Tribes have consistently listed behavioral health as a main priority. Necessity has required flexible thinking and drove the replication of the Alaska Tribal Health System's highly successful CHAP training model in creating an innovative Behavioral Health Aide (BHA) Model, which focuses on prevention, intervention, treatment, case management, and aftercare services in our rural communities. The trained and certified BHAs are an essential component of our care teams, providing local outreach and remote services for those who are affected by trauma, substance use, and mental illness. Traumatized individuals or those with substance use and/or mental health disorders often experience difficulty trusting others, including behavioral health providers, at the outset of their healing processes. Many BHA's grew up in the communities in the region they serve and are uniquely positioned to support rural communities, as they are familiar with the historical trauma and the unique challenges community members face.

Staff turnover, partially caused by the highly stressful nature of the job and remote locations with high costs of living, make recruitment and retention very challenging and therefore establishing trust with the vulnerable individuals needing care. Alaska's behavioral health programs statewide struggle with hiring Masters level qualified and licensed providers necessary to improve the quality, quantity, and consistency of the behavioral health workforce in Alaska. The BHA program helps address these challenges.

Alcohol and Substance Abuse has grave impacts that ripple across Tribal communities, causing upheaval and adverse experiences that begin or perpetuate a cycle of abuse, breaking the social fabric of our traditions and ties to one another. Stigmatization and lack of understanding of the disease of addiction make addressing the challenge even more difficult. The problems range from individual social and medical health loss to community distress, from unintentional injury to domestic violence to suicide and/or homicide.

Recommendations:

- » Increasing resources, in non-grants, for behavioral health to combat alcohol and substance abuse, including opioids, methamphetamines, and other addictions, are needed to break the cycle and reduce the disease and cost burden currently experienced by our Tribal communities.
- » Culturally relevant, community-based psychological and behavioral health services are necessary to improve outreach, education, appropriate intervention, and treatment for depression, unresolved childhood trauma, and other risk factors contributing to suicide, violence, and other mental health disorders.
- » Increase the availability of alcohol treatment services and improve outpatient support for those returning to villages after in-patient/residential treatment.
- » Issue: Increase funding for Behavioral Health Workforce Development
- » We strongly advocate for increased funding to assist with the recruiting, retaining, and training of culturally-responsive Alaska Native behavioral health providers. This includes funding programs that support Alaska Native students studying within the field of psychology through initiatives such as Alaska Native Community Advancement in Psychology as well as those training to serve as certified BHAs.

Issue: Permanent Authorization of the Special Diabetes Program for Indians

Special Diabetes Program for Indians (SDPI) is a remarkably successful program. This unique program prioritizes culturally informed care and has reduced the incidence of type 2 diabetes in our communities and saved lives and scarce health resources. Yet, SDPI continues to be imperiled by flat funding. Considering inflation and population growth, the current funding levels are not sustainable. Unfortunately, the President's Budget for FY 2023 only recommended funding at \$150 million, despite recommending large program increases in many other areas. Though the program has been reauthorized at this level through FY 2023, the Committees of jurisdiction could recommend additional funding. Reauthorization delays for SDPI and delays in the passage of annual appropriations can create program disruptions that make it hard for programs to retain staff, plan, and budget spend-down.

SDPI continues to be imperiled by flat funding. Considering inflation and population growth, the current funding levels actually represent an effective decrease in funding. Additionally, reauthorization delays for SDPI and delays in the passage of annual appropriations can create program disruptions that make it hard for programs to retain staff, plan, and budget spend-down. In addition, recent reports following preliminary studies of the incidents of "repeat COVID" have demonstrated an increased incidence of associated diabetes and pre-diabetic patient.

The SDPI program must not be subject to mandatory Sequestration deductions, which reduce available amounts of meaningful funding annually. Current programs should be held harmless from inflation erosion, and the additional funds will allow for Tribes not currently funded to develop programs that have shown to be highly effective in reducing the devastating impact that diabetes has in Tribal communities.

Tribes are implementing evidence-based approaches that are attesting to the improvement of quality of life, lowering treatment costs, and yielding better health outcomes for Tribal members. However, disparities still exist. This year, in particular, our programs felt the strain resulting from the shorter authorization periods, flat funding, and more Tribes needing access to SDPI funds. The effectiveness of the SDPI programs is well documented, saving the Federal Government millions as it reduces the number of patients with end-stage renal disease and the need for dialysis services and thus improving the quality of life of Tribal members across the nation.

It is time to transition the SDPI from a grant program and implement it as standard practice through permanent reauthorization and recurring funding for all Tribal and IHS programs. Interrupting the progression of diabetes has the potential for far-flung impacts, including the risk of developing Non-alcoholic Fatty Liver Disease (NAFLD) and obesity. NAFLD, for example, "has a strong, multifaceted relationship with diabetes and metabolic syndrome, and is associated with increased risk of cardiovascular events, regardless of traditional risk factors, such as hypertension, diabetes, dyslipidemia, and obesity."⁷⁶

Recommendations:

- » \$250 million for SDPI and permanent renewal with automatic annual funding increases tied to the rate of medical inflation and request the total funding be permanently added to the IHS base funding. This request is more important than ever, as some of our THOs have seen a doubling of the number of pre-diabetic patients in their communities during the pandemic.
- » Inclusion to allow SDPI to be a self-governed program, allowing funds to be sent to Tribes through ISDEAA funding mechanisms at their discretion. Without self-governance, the limited funding of the SDPI program continues to limit available services due to reductions in administrative costs.
- » Hold the Special Diabetes Program for Indians (SDPI) harmless from mandatory sequestration.
- » SDPI funding to be awarded in ISDEAA contracts and compacts.
- » IHS to repurpose administrative funds set aside for programmatic uses to serve more patients.

76 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6747357/>

Investing in Essential Providers & Workforce Expansion

Issue: Commissioned Personnel Support Staffing

Commissioned Corp Staffing is a critical workforce support for the Indian healthcare system. However, the number of Commissioned Corps Officers in the Alaska Area has been on the decline. Since 2015, the Alaska Area has gone from 436 Officers down to 205 Officers in 2020. Further, the number of Officers in Alaska was 498 in FY 2012. These Commissioned Corps declines have been worsened by a large number of existing officers. Some Co-signers have reported declines in Commissioned Corps Officer staffing by upwards of 68% at their organizations.

Recruitment of new Officers to replace leaving staff has also been difficult. The time it takes for individuals to complete the commissioning process has become exceedingly long. We have heard from some THOs that it is taking as long as two years for providers to complete the commissioning process. This amount of time is too long for many providers to wait to complete the process, and Tribes and THOs often do not have the resources to retain providers during this process. The Commissioned Corps also no longer begins the commissioning process for individuals currently in school. New graduates cannot wait extended periods with student loans, and the Corps loses recruits to other opportunities due to this.

Recommendations:

- » Reduce processing time for new Commissioned Corps Officers.
- » Allow recruits to begin the commissioning process during the final years of their education.
- » Provide additional funding to increase the pool of Commissioned Corps Staffing to support Tribes and THO staffing needs.
- » Complete a study, including exit interviews where practical, to gather the reasons why staffing is declining. Share the results with the Tribes and THOs and look for ways to partner in order to protect this valuable resource.

Issue: Tribal Public Health & Pandemic Response

We are bearing witness to and experiencing the alarming changes to our everyday lives resulting from this unprecedented pandemic. In a matter of weeks, COVID-19 reshaped the very fabric of our economy, our society, the way we conduct business, relationships, and our personal livelihoods – in some ways, permanently. We are continuing to face profoundly uncertain and challenging times.

In 2020 and 2021, multiple COVID-19 outbreaks occurred in our rural communities lacking sufficient water and sanitation facilities. At the peak of the COVID-19 outbreaks, the

Yukon-Kuskokwim Delta region saw COVID-19 positivity rates which were the highest COVID-19 rates in the country. Forty percent of homes in this region do not have in-home water or sewer connections. In order to counteract the spread of the virus in these environments, many villages closed their communities to the outside world; in Alaska Native communities, the impacts and trauma of the 1918 Spanish Flu outbreak weighed heavily and played a large part in these considerations.

The pandemic continues to have devastating impacts on already chronic and pervasive health staffing shortages. Ranging from physicians to nurses to lab technicians to behavioral health practitioners –the Pandemic is compounding staffing shortages that already stubbornly persist across Alaska. In addition, many Tribes do not have adequate housing for healthcare professionals, which further complicates recruitment efforts. Numerous reports from the U.S. Government Accountability Office and the Department of Health and Human Services (HHS) Office of Inspector General (OIG) have documented how IHS and Tribal facilities struggle to keep providers when competing with mainstream healthcare entities that can easily offer higher wages and better working conditions. More has to be done to make meaningful strides toward reducing essential provider vacancies.

For instance, as reported by the HHS OIG, both IHS and Tribal administrators have noted that staffing shortages have forced IHS hospitals and clinics to turn patients away due to limited capacity. Chronic underfunding of the Indian health system means that hospitals and clinics have less money to hire qualified physicians at competitive salaries. Further, limited funding for personnel can delay the physician hiring process as overburdened staff juggles multiple competing priorities and responsibilities. At the end of the day, these challenges harm the patient most – many of whom encounter long delays in scheduling appointments and having to travel hundreds of miles just to access their closest health center.

T/THOs around the country are reporting significant difficulties retaining staff and filling vacancies. What was initially considered a challenge has now become a workforce crisis in need of immediate remedy and commitment to overcome longstanding problems exacerbated by the triple pandemic (COVID-19, RSV, Flu). The lack of adequate staffing means our patients suffer from delayed or complete loss of needed services. T/THOs without adequate levels of personnel cannot deliver the same volume of services, much less respond to growing demands.

Recommendations:

- » Recognize that Tribal Health is Public Health by ensuring adequate resources and policy flexibility for Tribal health.
- » All federal public health funding programs should include Tribes or Tribal Health Organizations (THOs) as eligible

entities and provide direct Tribal funding set-asides. Tribal set-asides further the fulfillment of the federal trust obligation for health, but also, without a set-aside, Tribes will more than likely not receive meaningful public health funding. Many Tribal public health departments do not have the capacity to compete with state and local governments for competitive public health grants. The consequence is that Tribes, especially in rural areas, are routinely left behind in the development of public health infrastructure.

- » Ensure resources and flexibility are available to address staffing shortages and healthcare facility capacity.

Issue: Increasing the Number of Tribal Engineers

Ongoing support of adequate sanitation infrastructure has never been more critical than it is now. One of the greatest obstacles after sanitation facilities are built is ensuring that community members are trained through culturally appropriate methods to maintain these systems and keep those skills and knowledge in our Tribal communities. Identifying all sanitation needs across such an expansive state the size of Alaska is challenging, given the limited amount of engineering resources currently provided. It is imperative that all sanitation needs be captured to ensure proper reporting to Congress and equitable distribution of funding to the Alaska Area. Many IHS Areas, including Alaska, struggle with this due to limited funding and resources. IHS should provide additional funding to expand the number of engineers to identify need, manage very complex projects from design through construction, and assist in providing operational and maintenance support to Tribes upon completion. With increasing requirements, these engineers can support program policies and procedures for rural sanitation projects. These additional resources can be deployed locally where they can ensure that Tribal citizens are provided with a continuous supply of clean, uncontaminated water for drinking, living, and recreational purposes.

Environmental, water, and sanitation programs in Alaska operated by THOs are generally understaffed but are charged with providing critical support for the operation of health infrastructure (e.g., sewage lagoons, water plants, and washeterias), as well as supporting the emergent and immediate response to disaster events impacting local health and water/sanitation infrastructure. Because of increasingly frequent disasters, these programs need additional staff to assess the risk to the systems from environmental threats in order to protect the existing infrastructure and to respond to ongoing crises and emergencies (e.g., extreme weather, erosion, permafrost degradation, wildfires, and disease outbreaks).



Recommendations:

- » Provide budget support to address understaffing by increasing the number of engineers serving Tribal health organizations to help address sanitation deficiencies, manage complex projects, provide operational and maintenance support, assess environmental risks, and respond to emergencies.
- » IHS should provide additional funding to expand the number of engineers to identify need, manage very complex projects from design through construction, and assist in providing operational and maintenance support to Tribes upon completion.

Issue: Indian Health Professions Scholarship & Loan Repayment

We commend and thank IHS for adding Dental Therapists as eligible health professionals for loan repayment. However, we recommend that all Community Health Aides and Practitioners (CHA/Ps) providers—not just dental therapists—be added as eligible health professionals for the 437-scholarship program, in addition to an eligible category for loan repayment. CHAP providers are frontline workers in many Tribal communities and will be more important across the IHS system as the CHA/P program is expanded nationally.

Indian Health Professions scholarships and loan repayments are critical in order to meet the recruitment and retention needs facing Tribal health programs. The shortage of providers is one of the greatest barriers to access to care. One solution that invests in Tribal individuals and health programs is to “Grow Our Own.” This also has the added benefit of building capacity, reducing turnover, and helping support culturally appropriate approaches.

Recommendations:

- » Add CHA/P as an eligible health professionals for the 437-scholarship program.
- » Alaska Tribes advocate for expanding the Indian Health Professions scholarship program to extend opportunities



for individuals interested in pursuing successful community-based alternative career paths such as Community Health Aide/Practitioners, Behavioral Health Aide/Practitioners, and other alternative provider-extender certified programs. As this country faces shortages in all health professions, these alternative provider-extender models provide an effective way to ensure access to care in remote communities with chronic provider shortages. Scholarships are a way to finance the training and certification so that rural communities can afford to recruit and retain these essential providers.

- » Increase award for IHS Loan Repayment Program from \$20 thousand to \$40 thousand per provider per year to support recruitment and retention of qualified providers.
- » Make the IHS Loan Repayment Program awards tax-exempt, similar to the NHSC Loan Repayment and Scholarship Programs, to support provider recruitment and retention.
- » IHS should partner with Tribes and THOs to refresh any promotional materials, web content, or other media to help leverage the IHS Loan Repayment program as a recruiting tool. Updated material should be provided to all medical and nursing schools.

Issue: Essential CHAP Training & Staffing Shortage

The shortage of available essential CHA/Ps available to 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 many cases, CHA/Ps are the only providers of care in their respective communities. When this care is not available, beneficiaries needing 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 CHA/P providers.

Recommendations:

- » Adequately fund CHAP training is an essential step in ensuring that communities have local healthcare providers.
- » IHS should plan accordingly and request the true need and ensure that Alaska programs are not adversely impacted if new training programs are established.
- » IHS must meaningfully include the Alaska Area in a national CHAP expansion and, per Congressional direction, hold the Alaska Area program harmless during this process.

Issue: Address Rural Health Professional Housing

Recruitment of health professionals is greatly impeded by the lack of housing. In many rural Alaska communities, there is no availability of staff housing. In many villages, multigenerational families live together in overcrowded homes because there are limited housing options available for community members and even less 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 often are 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 are high. In 2016, the Indian Health Service (IHS) reported a 12% overall health professional vacancy rate for the Alaska Service Area.⁷⁷ Recruitment of health professionals is also greatly impeded by the lack of housing in 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 made 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.

Recommendations:

- » IHS needs to work with the Administration and Congress on addressing the shortage of staff housing and appropriating much-needed funds separate from the IHS Health Care Facilities Construction Priority System.

⁷⁷ “Indian Health Service Briefing”. 2016, p. 9

- » Funding to maintain and replace the few existing houses in communities fortunate to have them has not been made available for the past 20-plus years. Not all clinics offer permanent housing for providers or even temporary housing for visiting specialists or locum staff.
- » Consider any amendments necessary to add rural health professional housing buildings to the eligibility list for 105L participation.

Issue: 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 AI/AN children. Funds are used for staff salaries and benefits, contracts to support dental services, dental lab services, training, supplies, and equipment. These funds are needed primarily to improve preventive and basic dental care services, as a large part of dental services is 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 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, and 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 for improving oral health. Supporting Dental Services and oral health is essential in protecting health.

Recommendation:

The Alaska Dental Health Aide Therapist training program must have training funds budgeted from the IHS to continue the work that is improving the quality of lives and improving health for AI/AN people.

Issue: Behavioral Health Program and Workforce Development

A more effective way to distribute behavioral health resources to Tribes is through self-governance contracts and compacts to ensure sufficient, recurring, and sustainable funding. Using existing funding allocation methodologies will allow Tribes to better plan for greatly needed services for their citizens, especially for Methamphetamine treatment and domestic violence services and prevention. This will also alleviate the burden on Tribes to use valuable staff time to apply for grant funding and

grant reporting and allow them to use their limited resources to treat behavioral health concerns instead.

Many communities face high rates of depression, substance abuse, domestic violence, and diabetes; these challenges have been exacerbated by the COVID-19 pandemic. The historical trauma associated with forced relocation, the removal of children sent to boarding schools, and the prohibition of our spoken language, religious ceremonies, and cultural traditions all compound the traditional social and economic factors associated with current negative health disparities.

Alaska Tribes have consistently listed behavioral health as a main priority. Necessity has required flexible thinking and drove the replication of the Alaska Tribal Health System's highly successful CHAP training model in creating an innovative Behavioral Health Aide (BHA) Model, which focuses on prevention, intervention, treatment, case management, and aftercare services in our rural communities. The trained and certified BHAs are an essential component of our care teams, providing local outreach and remote services for those who are affected by trauma, substance use, and mental illness. Traumatized individuals or those with substance use and/or mental health disorders often experience difficulty trusting others, including behavioral health providers, at the outset of their healing processes. Many BHA's grew up in the communities in the region they serve and are uniquely positioned to support rural communities, as they are familiar with the historical trauma and the unique challenges community members face.

Staff turnover, partially caused by the highly stressful nature of the job and remote locations with high costs of living, make recruitment and retention very challenging and therefore establishing trust with the vulnerable individuals needing care. Alaska's behavioral health programs statewide struggle with hiring Masters level qualified and licensed providers necessary to improve the quality, quantity, and consistency of the behavioral health workforce in Alaska. The BHA program helps address these challenges.

Alcohol and Substance Abuse has grave impacts that ripple across Tribal communities, causing upheaval and adverse experiences that begin or perpetuate a cycle of abuse, breaking the social fabric of our traditions and ties to one another. Stigmatization and lack of understanding of the disease of addiction make addressing the challenge even more difficult. The problems range from individual social and medical health loss to community distress, from unintentional injury to domestic violence to suicide and/or homicide.

Recommendations:

- » Culturally relevant, community-based psychological and behavioral health services are necessary to improve outreach, education, appropriate intervention, and treatment for depression, unresolved childhood trauma, and other risk factors contributing to suicide, violence, and other mental health disorders.
- » Increase the availability of alcohol treatment services and improve outpatient support for those returning to villages after in-patient/residential treatment.
- » We strongly advocate for increased funding to assist with the recruiting, retaining, and training of culturally-responsive Alaska Native behavioral health providers. This includes funding programs that support Alaska Native students studying within the field of psychology through initiatives such as Alaska Native Community Advancement in Psychology as well as those training to serve as certified BHAs.

Supporting the Continuum of Care**Issue: Travel, Medivac, and Lodging**

Alaska has a very remote large geography and very rugged terrain with extreme weather conditions, which present significant challenges to travel, not to mention the lack of broadband infrastructure, which is essential for telehealth capability. Travel issues have always been a concern for Alaska, but the rising costs and loss of air carriers associated with the COVID-19 pandemic have exacerbated these challenges.

Transportation is a basic and necessary step to have access to health care and address ongoing health conditions. Both primary health care and chronic disease care require clinician visits, medication access, and changes to treatment plans to receive the very best quality of care. However, without transportation, delays in clinical interventions can result, 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.⁷⁸ Rising travel costs are also putting non-emergency travel out of reach for many patients, and lodging costs during Alaska's summer tourist season have become prohibitive. Costs related to tourism have driven lodging rates to \$300-\$400 per night. Folks who come in for care from rural Alaska can end up homeless under such conditions. Once emergency medivacs are required, it can be difficult for providers to secure such services due to decreased medivac providers and exorbitant costs.

78 Appointment "no-shows" are an independent predictor of subsequent quality of care and resource utilization outcomes, *Journal of General Internal Medicine*, Published online 2015 Mar 17. doi: 10.1007/s11606-015-3252-3.

Tribal health providers feel the strain of inadequate transportation too. In the current healthcare environment where physician and nursing shortages are rampant, last-minute scheduling changes may result in unfilled timeslots, underutilization of valuable finite resources, and increased wait times for other patients. A secondary effect is lost third-party resources that help to cover expenses or to expand care for other patients.

One of the concerns that we have in Alaska is that the urban and rural locations often differ in transit options, cost of transportation, and availability of and distance to health care providers. Rural and isolated patients in Alaska Native villages face greater transportation barriers to healthcare access than their urban counterparts. Rural patients have greater problems with transportation and travel distance to health care providers, with a higher burden to travel when distance and time for travel are factored in. This affects medication use or can affect clinical outcomes.⁷⁹

Because of the importance of travel to receive health care, Alaska Tribes are requesting that the IHS begin to address the rising costs of travel and expand travel services or provide funding as part of its ongoing Health Equity work.

Recommendations:

- » Create a special initiative to address the rising costs of travel when patients seek care in Alaska and other high-cost frontier states. The Agency has created other special initiatives to address such issues as accreditation emergencies, quality oversight, recruitment and retention, and other special program needs.
- » Work with Tribes to explore innovative uses of funding, such as the Catastrophic Health Emergency Fund, to address increased emergency medivac costs.

Issue: Behavioral Health Funding

The new 5-year behavioral health grant funding cycle was initiated in 2022 makes it difficult to implement changes for which Alaska Tribes have spent years advocating, specifically to allow for these grant funds to be distributed through ISDEAA funding agreements. We remind the IHS that Congress added language in their FY 2019 Consolidated Appropriations Act Explanatory Statement, specifically encouraging the IHS to transfer these funds through ISDEAA mechanisms.⁸⁰

79 Strauss K, MacLean C, Troy A, Littenberg B. Driving distance as a barrier to glycemic control in diabetes. *Journal of General Internal Medicine*. 2006; 21(4):378-380. [PubMed: 16686817].

80 Chairman Frelinghuysen (NJ). "Explanatory Statement Submitted by Mr. Frelinghuysen, Chairman of the House Committee on Appropriations, Regarding the House Amendment to Senate Amendment on H.R. 1625." *Congressional Record* 164:50 Book II (March 22, 2018) p. H2629. (<https://www.congress.gov/crec/2018/03/22/CREC-2018-03-22-bk2.pdf>).

The Alaska Tribal behavioral health providers serve patients across the state, providing services for all ages, from infants to adults. Funding is very limited, especially with our high cost of providing services. IHS grants are very difficult for providers to apply for and operationalize because of the grant structures and requirements. For instance, the requirement for inter-organizational memoranda in these grants is challenging due to the amount of upfront effort required to put these agreements in place, which must occur before any award is announced. Many organizations are limiting their participation or choosing not to apply for the IHS grants because of the complexity and low levels of funding provided. The grants often offer around \$150,000 for any given program, and with our salary rates, this funding barely supports two positions when our programs need significantly more providers to meet the needs of the communities they serve. Once those funds are expended, there are no funds left over to assist individuals in need of treatment. These funding levels simply are not sufficient to provide adequate care.

Many of our providers rely on an IHS behavioral health grant to provide behavioral health services. Yet, this funding does not go far enough to meet the needs of their patients; most of the funding will go towards salaries, but it does not fund even half of the needed positions for most programs. Thus, to provide behavioral health care, providers must also utilize other funding sources, which reduces their ability to provide other care. Additionally, when new programs are started, there are no start-up funds, which makes beginning new programs very difficult.

The grant requirements do not make sense when compared to the level of funding provided. This is especially true for our smaller programs which simply cannot meet all the checkboxes in the grant applications. Our programs know what is best to serve our people. We should be provided the funds to do so without having to jump through so many burdensome hoops. IHS should instead utilize the self-governance model so we can tailor services to our people and our respective regions.

Behavioral health is foundational to the rest of healthcare. When our patients are unable to take care of themselves and suffer from poor mental health, it causes a multitude of other health issues, which are not currently tracked or factored into funding considerations. The very nature of how mental health impacts a person's well-being obscures the true cost of distributing these funds as grants as opposed to providing amounts for Tribes to shape their own programs. Supporting self-determination and self-governance is the key to ensuring our patients have the services they need when they need them most.

It is difficult to get behavioral health services in rural communities with this level of funding because these grants are highly competitive, forcing us to compete with Tribes in the Lower 48 when it is nearly impossible for small, rural Tribes to meet the requirements of these grants. Pitting Tribes against Tribes for these funds does not help to support the overall mission of IHS and developing services for rural communities. Alaska's behavioral health needs have greatly increased during the COVID-19 pandemic. Maintaining small competitive grants falls far short of addressing the need and ignores IHS's obligation to all Alaska Native and American Indian people to provide adequate and culturally-relevant care as close to home as possible.

Recommendations:

- » Increasing resources, in non-grants, for behavioral health to combat alcohol and substance abuse, including opioids, methamphetamines, and other addictions, are needed to break the cycle and reduce the disease and cost burden currently experienced by our Tribal communities.
- » Allow behavioral health grants to be distributed through ISDEAA mechanisms to support self-determination and self-governance in behavioral health care.

Issue: Telehealth & Tele-Behavioral Health

The COVID-19 pandemic has required a massive response from providers to retool and find new ways to deliver care to isolated patients across the country. This has been particularly true and challenging for Indian Country, which is both more rural and more isolated than other rural regions of the United States. This is never truer than in Alaska, where 80% of our communities are off the road system and still meet the federal definitions for "frontier." While the AHS has developed telehealth technologies that have allowed Alaska Tribes to work across vast distances, difficult geographies, and Arctic climate conditions, it does not mean that there are no areas in our system that need improvements to meet the new demands, given that Alaska's broadband systems and infrastructure are some of the least developed in the country.

IHS has preferred to invest in a system, Cisco, to provide telehealth services that do not work in Alaska's unique and underdeveloped broadband networks. The AHS has done extensive research to find platforms that can reliably perform in our unique conditions. It does not benefit our Tribal programs when decisions are made unilaterally at IHS headquarters on these matters. Telehealth is a critical component of care and is intricately paired with the CHA/P program. Telehealth increases local capacity to provide care with medical oversight. It reduces both the cost and stress of travel in medically underserved areas in a state that has one of the lowest rates of medical specialists in the United States.

Recommendations:

- » Increasing funding for tele-behavioral health capabilities like Video Conferencing (VTC) is essential to 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.
- » Increase funding to appropriately supply Tribal clinics with VTC equipment and the necessary Internet connectivity in order to sustain and expand service delivery and health care access. Many of our Alaskan villages are in remote areas off the road system, which severely compromises access to care. VTC offers promise, but some areas still require infrastructure development. In many villages, digital connectivity is non-existent, or they rely on a satellite-based Internet system that is slow and unreliable.

Issue: Long-Term Care and Eldercare

Alaska Native elders prefer to be in their own homes and communities throughout their lives. In the past, elders stayed at home with their families in multi-generational homes, but that is not always possible as their care needs exceed what their family and other supports can provide, and they require nursing or assisted living care. Alaska, as a whole, 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 a higher level 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/AIs reportedly have more disabilities than other ethnic groups.⁸¹ Higher rates of disability and functional limitations, along with the increasing numbers of elders, exacerbate the need for long-term care planning within the Alaska Tribal Health System.

Recommendations:

- » The authority provided in the reauthorization of the Indian Health Care Improvement Act (IHCIA), which allows IHS to offer and fund long-term care services, presents great promise for meeting the needs of our elders and those with disabilities. Alaska Native elders and the disabled must have access to the long-term care services and support necessary to remain healthy and safe while retaining as much independence as possible in their own communities.
- » Alaska Tribes urge the IHS to target funds to implement LTC services as authorized under the IHCIA.

- » There is also a need to support and coordinate the efforts of IHS and the Centers for Medicare & Medicaid Services to address reimbursement and certification/regulatory issues.

Issue: Purchased and Referred Care

The Purchased and Referred Care (PRC) Program is essential to assure our patients receive health care services not available at our IHS or Tribal facilities for specialty referral to access burn care and advanced neonatal care, etc. PRC funding levels only meet approximately half of the identified need for PRC services, and the denial of care under PRC due to a lack of funding is the most critical issue facing the Tribes concerning the PRC program. Many Alaska Tribal health programs still must rely on PRC funds because their programs do not have the resources or capacity to directly offer the needed or specialized medical care.

The majority of new facilities are for outpatient care; this has resulted in an increased need for referral to in-patient facilities with emergency rooms and higher acuity care services. While Medicaid Expansion has moved many facilities from being able to provide Priority One level of care to now providing Priority Three or Four levels, again, access is still highly restricted based on old PRC policies and a limited capacity to provide certain specialized services. Tribes believe that the ability to address the Priority Four level of care promises the greatest return with regard to health status and quality of life improvement.

Recommendations:

- » Tribes advocate for flexibility in the use of PRC funds based on actual patient needs. In order 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 Indian Health Care Improvement Act for long-term care, preventative, and other services are incorporated into the updated PRC manual. We fought long and hard for the IHCIA reauthorization, and these new authorities must be incorporated into all of the long-outdated IHS policy and program manuals and health delivery system reform.

⁸¹ <https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/LTSS-TA-Center/info/ai-an-age-and-disability>

ALBUQUERQUE AREA

Albuquerque Area Narrative

The Albuquerque Area Indian Health Service is made up of 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 federal service units represent the priorities of 27 distinctly different Tribal groups, including 20 Pueblos, three bands of the Navajo Nation, two Apache Tribes, and 2 Ute Tribes. In preparing their annual budget submissions, each of the service units conducted outreach and met with Tribal leaders within that service unit to discuss local priorities and concerns.

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, nephrology, gynecology, colposcopy, and podiatry. Additional services include pain management, medication-assisted therapy, optometry, and integrated behavioral health. Routine and emergent dental services are also provided at Zia Health and Dental Clinic. Due to the geographic location of the ASU, there has been a consistent increase in new patient enrollment and overall patient visits.

The Jicarilla Apache Nation increase recommendations are shown for increased funding distributed among several budgetary line items: H&C, Dental, Mental Health, Alcohol & Substance Abuse, PRC, Public Health Nursing, Health Education, and CHR. These recommendations are in support of the ongoing Staffing levels and Operations of the Jicarilla Service Unit and Jicarilla Apache Nation Tribal Programs to operate at the highest possible level to provide quality and compassionate health care to the constituents of the service area of Dulce, New Mexico.

It is the Mescalero Apache Tribe's position to use the same priorities from last year as the issues have not changed, and they want to remain consistent until the priorities are resolved or met.

The Santa Fe Service Unit (SFSU) Tribal Leaders and Tribal Representative called and met with the SFSU Governing Body members on November 18, 2022 to discuss and establish FY 2025 budget priorities that are aligned with the needs of the local tribal communities: Mr. Daniel Cox, CEO, Dr. Smoker, Clinical Director, Ms. Helen Ballantyne, Acting Chief Nurse Executive, and Ms. Helena Burbank, Chief Financial Officer. The Tribal Leaders/Tribal Representatives decided to build upon the budget consultations from the past years to arrive at an updated list of their top five funding priorities. After discussions, the participants recommended continuing our top priority as a consolidated increase in Hospital and Health Clinics as local community members are affected by post COVID-19 infections and would like the healthcare services to be broadly accessible and flexible for their health needs. The remaining budget increase priorities include Mental Health, Alcohol & Substance Abuse, Purchased/Referred Care, and Dental Health.

In order to be fully funded at the health centers serving the Southern Ute Indian Tribe and Ute Mountain Ute Indian Tribe, we respectfully request an increase for Alcohol and Substance Abuse, Hospitals and Clinics (H&C), Purchasing Referred Care, Mental Health, Dental Health, and Public Health Nursing to the IHS Budget for FY 2025. There continues to be a great need for comprehensive, culturally appropriate personal and public health services that are available and accessible to American Indian and Alaskan Native (AI/AN) people. In particular, mental health services, alcohol and substance abuse, dental, public health nursing, and geriatric care services are lacking, just to name a few. The Southern Ute Indian Tribe remains concerned about access to primary health care and specialty care for tribal members and all AI/AN. With proper funding, the ability to provide in-house, direct care to patients for medical specialists, diabetes care, and cancer screening, diagnosis, and care increases resulting in improvements to the Government Performance and Results Act (GPRA) measures. In addition, many AI/AN must travel great distances to receive specialty health care. The burden on the individual is great, and the continuity of care suffers. With increased funding, direct access to specialty services and high-quality health care increases, relieving the burden on the patients and the tribe. Moreover, with an increase in funding, the ability of the IHS to recruit highly qualified staff also rises, resulting in an innovative Indian Health System that promotes excellence and quality. With the huge increase in healthcare costs, and the ongoing health disparities in Indian Country, I think it is very vital for all of the budgets presented to be increased. The Native American population located on the Ute Mountain as well as those utilizing an IHS clinic, need more availability to health care

professionals. In order to attract more professionals to our Health Center, budgets need to be increased so we can provide a competitive wage. Also, with the health disparities increasing, we also need additional funding so we can either provide the correct professional in the IHS clinic or monies to send the patients to adequate healthcare facilities for proper treatment.

Alcohol and Substance Abuse

The Substance Abuse and Suicide Prevention Program (SASP) (MSPI) is a nationally coordinated program focused on providing much-needed substance abuse and suicide prevention and intervention resources for Indian Country. This initiative promotes the use and development of evidence-based and practice-based models that represent culturally appropriate prevention and treatment approaches to substance abuse and suicide prevention from a community-driven context. The Pueblo of Acoma Budget Formulation Workgroup recommendation is to permanently authorize the MSPI to make it part of recurring base funding and subject to annual congressional increases.

Additional funding for alcohol and substance abuse services is also necessary. Due to the lack of available resources, alcohol and substance abuse have further complicated primary healthcare facilities and overall healthcare costs. There is a greater demand for both inpatient and outpatient treatment. Additional funding would support culturally sensitive initiatives for education, prevention, and rehabilitation services and strengthen community wellness.

For the Jicarilla Apache Nation, alcohol misuse contributes to the increased number of crisis calls. Alcohol is a factor in crisis calls involving domestic violence, child abuse, and suicide calls. Alcohol-related incidences have increased during the COVID-19 pandemic. Resources have been limited because of the pandemic. Crisis Interventionists have been tasked with searching for alternative resources and handling each case appropriately. The Jicarilla Apache Nation advocates for more funding for substance abuse programs, specifically the manufactured chemicals being seen in the community: meth, heroin, and other pill types. Programs would assist addicts, their families, or another wing at the Jicarilla Behavioral Health Department specific for this particular focus.

The lack of mental health services in the Mescalero community is at an all-time high. Access is severely limited due to staffing shortages. Inadequate funding for alcohol and substance abuse services has shown a ripple effect on other funding sources. Alcohol and substance abuse causes an increase in the number of injury-related patient visits to our hospital as well as to the private sector and local emergency departments. A 20% increase in funding is necessary to allow opportunities for our members to participate in an in-patient treatment

program with treatment stays lasting 60-90 days. Although the Mescalero Tribe has a 90-day inpatient program through a 638 contract, the complexity of substance abuse disorders, including alcohol, methamphetamines, and opioid abuse individuals requiring that level are most often so severe that the patient demand requires more intense treatment services than what the program can provide. Many local facilities do not have immediate access to culturally relevant treatment programs, so individuals are required to seek off-reservation services at facilities located in areas that range from 100 to 200 miles away. Funds will also provide detoxification services for those individuals that require that level of care prior to admission to a long-term treatment facility. Mental health has also been impacted and directly related to COVID-19. Financial and family issues are overwhelming, with inadequate staffing to treat the level of mental health issues presented with rampant drug use in Indian Country. Integration of mental health services into everyday clinical practice is an absolute must. With limited staff and a limited ability to offer treatment, we are faced with serious levels of unmet needs. Additionally, we must focus to do more community outreach, health fairs, and focus time and energy on preventive services.

The SFSU Tribal Leaders/Tribal Representative recommends that 20 percent, or one-fifth of all funding increases, go to the "Alcohol and Substance Abuse" line item. For the past years, the tribal leaders/tribal representatives 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 and Tribal representatives recognize that 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 diagnoses. The increase in funding will be utilized to increase personnel and services for alcohol and substance abuse counseling.

Alcohol and Substance Abuse is the Taos/Picuris Service Unit's number one priority.

Inadequate funding for alcohol and substance abuse services has a ripple effect on other funding sources. Alcohol and substance abuse can cause an increase in the number of injury-related patient visits to our hospital as well as to the private sector emergency department. This puts an increased burden on Purchase Referred Care Services. We need an increase in funding to make available opportunities for members to participate in in-patient treatment programs with stays that last from 60 to 90 days. Many facilities do not have immediate access to culturally relevant treatment programs, so individuals are transported to facilities located in areas that range from 500 to 700 hundred roundtrip miles away. Funds will also be used to provide detoxification services for those individuals

that require that level of care prior to being admitted to the long-term treatment facility. Our recommended increase is to address the high patient percentage of alcohol-related and substance abuse-related encounters. The IHS providers treat patients for these types of diseases daily. Finally, many EMS programs spend many hours dealing with accident-related, domestic violence incidences, and trauma-related incidents that occur due to these diseases. Not only will this increase access to care, but this initiative will provide better customer services based on the community needs and make I.H.S a good investment in efforts to partner with the tribally operated Alcohol and Substance Abuse Program. The funding for Alcohol and Substance abuse treatment services should include direct service treatment, individual therapy services, group therapy services, and medication management options such as naltrexone and Suboxone therapy. Cirrhosis rates and accidental alcohol-related death rates remain high. Arrest rates are fairly high, and the number one arrest category for most Native American Reservations remains public intoxication/disorderly conduct. Staffing needs remain high, and collaboration is imperative to address these issues. Medication management options such as Naltrexone and Suboxone must be considered viable treatment options. There are currently very limited funds available for in-patient treatment. In previous years, there have been insufficient increases in the Alcohol and Substance Abuse Program. The positions specific to addressing substance abuse have remained vacant, limited, or nil at many facilities. Our communities suffer tremendously from alcohol-related illnesses such as depression, post-traumatic stress disorder, grief, alcoholism, bipolar disorder, suicide, etc. With the ongoing shortage and/or absence of credentialed and licensed staff (i.e. psychologists, psychiatrists, clinical staff, social workers, etc.), it is very difficult to determine a patient's level of care. In the absence of such services, patients are placed on waiting lists and eventually become frustrated from waiting for an appointment and not having their medical needs met. This leads to clients abusing alcohol or other substances to temporarily manage their own health needs. In addition, patients with severe alcoholism are left untreated and become a danger to themselves or the community at large. Therefore, Taos/Picuris Service Unit Tribes supports and highly recommends an increase in funding for the Behavior Health Program to address mental health and substance abuse disparities within our communities.

The Zuni-Ramah Service Unit tribes recommend an increase in funding levels for Substance Abuse as a priority, a disease that is prevalent throughout Indian Country with limited resources to combat the disease. Additional IHS funding will allow the federal facilities and tribal clinics/programs to continue efforts in developing effective programs to address the needs of those affected with alcoholism and substance abuse that is resulting in increased deaths, primarily in young age males/females, and suffering to families. Increased funding will



allow additional outreach programs, counseling services, and inpatient treatment programs locally that would be sustainable with adequate funding levels. The Zuni Pueblo Tribe has a vested interest in developing a culturally relevant inpatient treatment center focused on the treatment of the whole family to reverse the demise and sufferings of the individual affected by substance abuse as well as the suffering of families. The increased funding levels will allow the Zuni Recovery Program to continue its initiative to enhance the services being provided to those impacted by alcohol and substance abuse and continue efforts with its strategic goal. Thirty percent of annual emergency room visits at the service unit's hospital had an alcohol-related diagnosis, and it continues to be the top 5 leading primary diagnoses for hospitalization in 2021 and 2022.

Hospital & Clinics

The Pueblo of Acoma Budget Formulation Workgroup identifies H&C as a hot issue as well as a priority area. The recommendation represents the minimal infusion of resources that are critically necessary to bring the Acoma Canoncito Laguna (ACL) Facility health delivery system up to a safer standard of care. This hot issue is a priority area necessary to improve the delivery and quality of health care, reduce the high occurrence of health care disparities, and, most importantly, retain the services, i.e., emergency room and inpatient services that have been discontinued due to the decreased funding. However, it is important to note that additional funding for these services is critically important because current funding levels have not been adequate to meet the basic standard of care requirements. The Pueblo of Acoma Budget Formulation Workgroup recognizes that adequate funding for the H&C is the base funding for the ACL Facility and health programs that operate within the Pueblo of Acoma, predominantly in a rural setting. This is the core funding that makes available direct medical care services and is necessary as it supports medical care services, including emergency care, inpatient and outpatient care, medically necessary support services such as laboratory,

pharmacy, digital imaging, information technology, medical records, and other ancillary services. The workgroup further recognizes that despite the continued funding, critical operations have been discontinued such as the emergency room, inpatient care as well as other critical services. In addition, the H&C funds provide the support for the required range of services needed to target chronic health conditions affecting Tribal members, such as heart disease and diabetes treatment, rehabilitation from injuries, maternal, child health care, dental, and optometry services. The demands of direct care services are a continuous challenge in our ACL Facility, even more so with the substantial impacts of the loss of funding. We experience constant and increased demand for services due to the increased rates of chronic diseases that result in growing patient workloads in addition to emergency/urgent care due to the relentless spread of COVID-19 within the ACL service area. Adding rising medical inflation, difficulty in recruiting and retaining providers in rural healthcare settings, and the lack of adequate facilities and equipment, these resources are stretched. As a result, any underfunding of H&C equates to limited health care access, especially for patients that are not eligible for or who do not meet the medical criteria for referrals through PRC to the private sector, which shall be discussed in another section of this report. For many in Indian Country, there are no alternatives other than the direct care provided at an IHS or Tribal facility.

Maintaining adequate levels of funding under Hospitals and Clinics (H&C) is essential for providing optimal primary and continuity care services at IHS and tribally operated facilities within the Albuquerque Area. Expansion of H&C funds will allow facilities to meet the needs of the patient population, acquire supplies and equipment and employ necessary staff. Native Americans have historically had a higher prevalence of chronic disease, thereby heightening the need to provide comprehensive multidisciplinary care while also expanding on preventative education and initiatives.

The Mescalero Service Unit (MSU) believes the Hospitals and Clinics (H&C) Line item has been underfunded for many years. Funding of this line item will support current services, expansion of services, purchases of necessary supplies and equipment, and hiring of additional staff. This line item should be fully funded at the level it needs to be funded at. Traditionally, H&C funding is funded at a lower level making it difficult to provide appropriate levels of services in Indian Country. The lack of funding hinders staffing, such as physicians and specialty clinics. Services become limited based on the overall staffing of the facility.

Lastly, due to the remoteness of the MSU facility, the extension of the facility's urgent care hours to see patients is beneficial as the nearest Emergency Room is 25 miles away. This

extension of Urgent Care hours can be sustained with recurring funds with full ancillary services to meet our patient needs. Patient access to services beyond what can be provided as direct care at MSU is critical to ensure that medical conditions ranging from chronic and ongoing care, cancer treatment, in-home care, and catastrophic medical conditions are treated along with new illnesses such as the recent COVID-19 endemic. We must plan for the future to include funding for these services. No one expected the long-term effects COVID-19 has had, its impact beyond anyone expected. So many people are suffering from long COVID-related illnesses, and outcomes are logical to believe this will not end soon. Ongoing specialty care for chronic medical conditions can become very costly. It is crucial that there are funding increases in this line item to ensure tribal members have access to the provision of care outside of IHS via referrals to private sector facilities.

The Tribal Leaders/Tribal Representatives of the SFSU recommend that 20 percent, one-fifth of all budget increases, be directed toward hospitals and health clinics. Tribal Leaders/Tribal Representatives have expressed the underfunding of Indian Health Services, and the increase in funds will be used primarily to support staffing and services within the service unit, which in return will increase access and flexibility to quality health care services. The COVID-19 infection hit the Indian countries harder than most population, and the post COVID-19 infections are now affecting our communities which requires more access to health care. The increase in funds will allow our service unit to fully staff in most critical clinic department to address critical health care needs.

The Taos/Picuris Service Unit in conjunction with the Tribes, considers Hospitals and Clinics Line Item has been underfunded for many years. Funding of this line item will support current services, expansion of services, purchases of needed supplies, equipment and hire additional staff. In addition, support Patient Centered Medical Home (PCMH), access to quality Health Care, competitive salaries to hire physicians, dentists and other medical professionals in regards to recruitment and retention. Recruiting and more importantly, retaining core staff of primary care providers is essential to successfully achieve improved clinical outcomes, maintain a Patient Centered Medical Home status, and continuity of care. We respectfully request an increase to Hospitals and Clinics Budget Line Item in order to supplement other line item programs that may need additional funding. An increase would result to assist in meeting the Mission of the Agency along with the Goals and Priorities of the Indian Health Service Strategic Plan. With adequate level of funding, the ability to provide in-house direct care to patients for medical specialists, diabetes care, cancer screening, podiatry, geriatric care, etc., will result to meet and increase improvements to the Government Performance and Results Act (GPRA) bench marks. Therefore,

Taos/Picuris Service Unit Tribes supports and highly recommend an increase in funding for the Hospitals and Clinics Line Item Budget.

Both Zuni and Ramah Navajo Tribal leaderships continue to advocate ongoing support and priority for congressional budget increases to the Hospitals and Clinic recurring funding levels to keep up with the cost of delivering ambulatory, urgent/emergent, and inpatient healthcare services including labor and delivery services are maintained for Native Americans throughout Indian Country due to the continuous rise in inflation rates affecting purchasing power, as well as, the current environmental changes occurring resulting in pandemic crisis affecting the health/lives of the world resulting in high costs in delivering care. Continued increases in the budget will allow for additional healthcare providers and support staffing to increase the number of patients being served to truly work towards the mission of the Indian Health Services in elevating the health status of the Native American population by improving better patient outcomes through education, screening and preventative measures meeting the GPRA target goals.

The current public health pandemic for COVID, variants, influenza and RSV continue to negatively impact hospitals and clinics financially in keeping up with the demands in providing needed services not only staffing but other basic/critical medical supplies and equipment to be responsive to the needs of their patient populations. This particularly true with so many healthcare professionals, particularly, registered nurses opting either leave their profession by retiring or signing up with Travel Nurse agency to contract their services out which is 2-3 times extremely expensive to the healthcare facilities, but have no choice but purchase their critical manpower through contracting. Additional personnel in all healthcare fields including support staff continues to be in critical need to provide safe and quality medical care/treatment including surveillance. Similar to the national population, both the Zuni Tribe and Ramah Navajo are also dealing with the effects of the triple pandemic (COVID, Influenza and RSV) as part of the State of New Mexico that is rated as extremely high resulting in very sick patients in need of urgent/emergent care in this remote/isolated area.

Purchased/Referred Care

Purchased and Referred Care Services (PRC) are recommended to be a top funding priority for the Pueblo of Acoma. The ACL Facility serves in a rural area and provides limited primary care and community health services. PRC funds are critical to securing the care needed to treat emergent and specialized health issues like heart disease and cancer. Tribal members who cannot access PRC resources face enormous risk of personal

financial responsibility for care received outside of ACL Facility. The significant increase to ACL Facility PRC funding will allow more Tribal members to access private sector care before their healthcare condition becomes critical. Increases may also extend to the medical priority system reality beyond Priority I emergent care, improving and increasing the overall health of the Pueblo of Acoma population.

Increasing purchased/referred care funds for eligible patients within the Albuquerque Service Unit is essential to ensure access to services that are not available at IHS facilities such as, inpatient care, specialty care, cancer treatment, diagnostic imaging and dental care. Increased funds would support preventative care and screenings such as mammograms and colonoscopies.

At the Mescalero Service Unit, the facility has been able to move into Priority 4 at this time primarily due to Medicaid expansion in the State of New Mexico. This is one area that has made all the difference for IHS/MSU and has allowed us to maximize Third party revenue, however to ensure we continue to cover services at a priority 4 we are recommending a 20% increase. If current levels of funding are not sustained it will diminish the quality and level of services we can provide to the community. Further, with the upcoming Medicaid unwinding, states will resume annual Medicaid eligibility reviews after the Public Health Emergency (PHE) ends may have an impact on PRC funding.

The Tribal Leaders/Tribal Representatives of the SFSU recommends that 20%, one-fifth, of all funding increases go to Purchased/Referred Care. Beneficiaries in the SFSU 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 TL/TR 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.

The Zuni Pueblo and Ramah Navajo Tribes support and recommend continue priority to increase the level of Purchased Referred Care funding to ensure that eligible PRC IHS beneficiaries have access to medically necessary higher level or specialty healthcare services that are not otherwise available or provided by the Indian Health Service facilities or Tribal facilities to prevent harm, injury or loss of life of Native Americans.

Increased funding levels will insure access to medically necessary healthcare and services provided are paid to hospitals, specialty groups, emergency transport providers, durable medical equipment and other eligible entities who accepted and provided the needed service in good faith furthering the positive working relationships with the Indian Health Service facilities and tribal hospitals/clinics in the interest of our PRC eligible Native American population. The increased funding levels will assure that hospitals and clinics are able cover the healthcare cost in line with the current inflation rates. Without continued support to increase the annual funding levels, patient care will suffer due to limited funds available to refer patients for specialty care for both preventative and urgent/emergent specialty care that may result in harm, injury and death.

Mental Health

Zero Suicide Initiative (ZSI) became available in August 2017. The purpose of the ZSI funding was to improve the system of care for those at risk for suicide by implementing a comprehensive, culturally informed, multi setting approach to suicide prevention within Indian health systems including Tribal 638 Programs. The Pueblo of Acoma Budget Formulation Workgroup recommendation is to permanently authorize the Zero Suicide Initiative to make it part of recurring base funding and subject to annual congressional increases.

With the COVID-19 pandemic, mental health issues have been 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 also experiencing full or extensive waitlists for services and recruiting/retaining behavioral healthcare 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 healthcare.

For the Jicarilla Apache Nation Mental Health continues to be a priority for the Jicarilla community. Jicarilla Behavioral Health provides 24/7 Crisis Intervention for the community. The rural location contributes to the difficulties in finding appropriate resources for children, teens, adults and elderly during crisis situations. Increased funding is needed to appropriately train current staff to mediate and de-escalate those in crisis.

The Tribal Leaders/Tribal Representatives of the SFSU recommends that 20%, one-fifth, of all budget increases be directed towards Mental Health. For the past two years, our TL/TR has

emphasized that within our local tribal communities, the utmost need for mental health services has increased due to individuals having to cope with loss of family members and community members from the COVID-19 pandemic/surge. The post COVID-19 infection has also greatly affected the mental state of our community members which caused major health issues, stress and anxiety. Our community members would like to see the 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.

Mental Health (Behavioral Health Program) is Taos/Picuris Service Unit's number two budget priority. The Taos/Picuris Service Unit's (TPSU) priorities, as in any other American Indian/Alaska Natives', is the reduction of the health disparities of chronic diseases in our Tribal Nations. We are seeing more dual diagnosis of alcohol and substance abuse and mental health. The TPSU Tribes believes the root causes of these health disparities are due to traumas – historical and inter-generational, that continues to this day with all of the social illnesses causing adverse childhood experience (ACE) cycle. To quote, "Trauma has been garnering more and more attention over the past few years, with the rampant climb of Post-Traumatic Stress Disorder, and the understanding of what can cause it. Intergenerational trauma among American Indians is an area of study that has just started to generate attention from communities inside Indian country, academia and the medical profession." (Intergenerational Trauma: Understanding Natives' Inherited Pain. Mary Annette Pember). "According to researchers, high rates of addiction, suicide, mental illness, sexual violence and other ills among Native peoples might be, at least in part, influenced by historical trauma. The 1998 ACES study conducted by the Centers for Disease Control (CDC) and Kaiser Permanente showed that such adverse experiences contributes to mental and physical illness. AI/AN have been traumatized by historical genocide and colonial oppression. Mainstream media is full of stories about the dramatic improvements allowing science to see more clearly how trauma affects our bodies, minds and even our genes." (ibid) PTSD in AI/AN Population

- » AI/AN communities in general have higher risk of experiencing trauma than any other ethnic group.
- » Twice as likely as general population to develop PTSD.
- » Higher levels of PTSD reflect higher exposure to trauma.
- » Related problems: body pain, lung disorders, general health problems, substance abuse, pathological gambling.
- » Most frequently implicated trauma is military combat.
- » 2nd most common is interpersonal violence.

(IHS Trauma Informed Care & Historical Trauma Informed Care Webinar Series: Part I in 3 Part Series for Healthcare

Providers). To reduce our health disparities in our AI/ANs, ACE must be prevented, trauma must be prevented through PHN/CHR/CHAP intervention programs such as home visitation for our elders, children, and venerable adults using a trauma informed care delivery of healthcare. Our mental and medical health workers need continuous training on delivering trauma informed care to effectively reduce the health disparities in AI/AN populations. With adequate funding increase, the ability to provide Behavior Health Services will result in improvements Government Performance and Results Act (GPRA) Stats. The Taos/Picuris Service Unit Tribes supports and highly recommend an increase in funding for the Behavior Health Program (Mental Health) to address the health disparities in our AI/AN communities.

Both the Pueblo of Zuni and Ramah Navajo Tribes' healthcare priorities continues for increases to the overall behavioral health services funding levels to the ever-increasing concerns for limited behavioral health providers attempting to provide mental health services to their members suffering depression and other mental health issues that have led to suicidal ideation and often leading to completion, or other traumatic event for a population of 13,000+. Both tribes have and continue to endure loss of their tribal members, particularly the young due to depression similar to other tribal communities. Additional funding will allow for expansion of mental health services to include psychiatrists, psychologists, behavioral health counselors, case managers and other support staff to meet the needs of the population served, as well as, retaining the health professionals to remain. The current recurring federal funding levels in FY 2022 for the Mental Health Program continues to be inadequate for both the service unit federal hospital and the Ramah Navajo Tribe's PL 93-638 Pine Hill Health Clinic to permanently increase and hire additional behavioral health providers to address the mental health needs of the community. The inability to address the mental health needs only leads to negative outcomes of our indigenous peoples' overall physical health and mental well-being.

Dental Services

Oral health care access is one of the greatest health challenges the Pueblo of Acoma faces. The Pueblo of Acoma is struggling under the weight of devastating oral health disparities. The ACL Facility 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. Funds are used for staff salaries and benefits, contracts to support dental services, dental lab services, training, supplies, and equipment. These funds are needed primarily to improve preventive and basic dental care services within the Pueblo of Acoma.



Dental services throughout the Albuquerque Service Unit are limited by location and services provided. Many patients within the local urban area do not have dental insurance and often defer oral health as they do not have the means to travel to outlying facilities and/or the facilities have extensive waitlists or only provide emergency services. Maintaining oral hygiene is an important part of overall health. Inadequacies can have a significant impact on chronic disease management in adults and can contribute to impaired nutrition and general health in children and adolescents.

In Mescalero oral health is often neglected in the care of American Indians and Alaskan Native population. Although there has been improvement, AI/ANs still have poor dental health outcomes. Missing teeth, periodontitis, pain and dental caries contribute to the low SES of AI/AN. Poor dental health is not an isolated condition, it affects other medical conditions. Patients with diabetes and poor dental health have trouble maintaining a proper diet and correct glycemic control. Additional capacity to increase access, new programs at schools, integration of new technologies, and onsite abilities for surgery through increased funding to increase staffing levels of dentists, hygienists and dental assistants will open up needed appointment times for patients allowing patients to have biannual cleanings and same day.

The Tribal Leaders/Tribal Representatives of the SFSU recommends that 20%, or one-fifth, of all funding increases go to Dental Services. In the past years, the SFSU has successfully entered into agreements with regional private sector oral surgeons, endodontists, periodontists, and other dental specialists to provide higher level care that is primarily paid for out of PRC funds. The SFSU is expanding service, and access to provide preventive dental care by planning to staff a dental hygienist(s). The increase in funding will also be utilized for developing state of the dental services by replacing outdated equipment to comply with infection control and staffing/personnel. The TL/TR recommends increased financial support to dental programs within the Santa Fe Service Unit.

The Zuni Pueblo Tribe and Ramah Navajo Tribe supports and recommends priority to elevate the funding levels for the Dental line item budget to enable the dental programs to enhance/increase services with additional dentists, dental hygienists, dental assistants and support staff; purchase of needed dental supplies; purchase of new equipment and maintenance; ongoing training/education to increase the level of services provided that could potentially eliminate the need to refer patients to the provide sector that for many, creates a burden to travel for services that could potentially be provided locally. This is particularly true for the elder population and for those that may not have support for transportation or financial resources to travel long distances, possibly overnight. The Zuni-Ramah Service Unit's patient population has high rates of diabetes. Poor dental health is not an isolated condition, it affects other medical conditions when proper diet and glyce-mic controls are not maintained. In addition, elevating the funding levels will allow hospitals/clinics to see more patients with added dentists and support staff allowing positive impact on employee retention and lessening the time for patients to receive an appointment for basic oral hygiene and dental screening/treatment, and to be seen same day for unexpected/urgent care. At this time, Zuni Hospital's dental program is booked for appointments six months into June 2023 with a backlog for new exam appointments due to limited staffing. The limited staffing also impacts on ability to meet all of the dental GPRA targets and limits outreach education in the schools and community

Public Health Nursing

The Pueblo of Acoma is not equipped to respond to public health emergencies related to severe weather, infectious disease outbreaks, wildfires and active shooter events. Emergency funding distribution is generally contingent on density of population, negatively impacting smaller and geographically dispersed tribes. The Pueblo of Acoma Budget Formulation Workgroup is requesting funding to address detrimental consequences that could result from public health emergencies. Mutual aid agreements (MAAs) and other types of assistance agreements facilitate the rapid sharing of emergency aid and resources among governments and organizations at all levels.

The Pueblo of Acoma Health & Human Services seeks to obtain public health accreditation and requires technical assistance and resources to attain accreditation. Furthermore, the Pueblo of Acoma Budget Formulation Workgroup recommends dedicated public health funding to address the development of Public Health Infrastructure and implementation of applicable services that promote public health preparedness as opposed to the current reactionary approach to public health threats and emergencies. The Pueblo also requests an additional

budget line items and funding to better represent the broad public health needs among all AI/ AN, including full funding for tribal epidemiology centers.

The Taos/Picuris Service Unit's fourth budget priority is Public Health Nursing. The Taos/Picuris Service Unit Federal and Tribal Public Health Nurses play a critical role within tribal communities. The PHN is a vital member of the team in our PCMH model. They are a resource for AI/AN communities and are counted on to assist in our efforts to improve the health of our patient populations. They promote health and wellness, make home visits to elders, disabled and high-risk children and families. They assist with vaccination screening and administration and have an important role in providing health related education to patients and the community. There is a need for additional funding to support more PHN positions, especially when they are needed to cover expansive geographic areas. The TPSU PHN function 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. The request for increase is primarily based on an expansion of services and promotion of well-being, health promotion and health education. The Service Unit recognizes the needs for increased public health, prenatal care, immunizations and tracking and tracing activities especially in light of the COVID-19 pandemic starting in 2020 and beyond. In additional transportation needs for patients to and from vital appointments and referral services. The activities performed by the PHNs add to the longevity and quality of life for patients. An increase in the funding for PHNs would go a long way to close the health disparity gap. The Service Unit acknowledges a staffing shortage coupled with an increase demand of the services provided by the PHN program particularly due to the increase of the scope of work as it pertains to elderly care. The PHN programs assistance to patients and the community in promoting healthy lifestyles and disease prevention. As mentioned, the demand for services have increased and are integrally tied to access to care. The PHN Program is responsible for meeting majority of the GPRA measures, generally immunization and health screening. In addition, it is anticipated with better funding, this demand will continue to increase. Therefore, Taos/Picuris Service Unit Tribes supports and highly recommend an increase in funding for the Public Health Program to address the health disparities in our AI/AN communities.

Community Health Representatives

There is a critical need to protect and strengthen the Indian Health Service Community Health Representative (CHR) Program in FY24 and beyond. Today, CHRs play a critical role in the health care delivery system to link the patient to the Indian health care system and are intended to prevent avoidable hospital readmissions and emergency department visits through home visits to patients with chronic health conditions such as asthma, diabetes, and hypertension. CHRs have also played a critical role in COVID-19 response in the Pueblo via support with case investigation, contact tracing, PPE dissemination, health communication and education, and assistance with vaccination events. 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 education, translation and interpretation, patient navigation, transportation to medical appointments, and delivery of medical supplies and equipment within their tribal community. CHRs help to bridge the gap between American Indian and Alaska Native (AI/AN) individuals and health care resources through outreach by specially trained indigenous community members. CHRs are part of the direct provision of health services and are authorized in federal law within the Indian Health Care Improvement Act. Without these services and the people who provide them, patients will not receive the care or attention they need. The result will be reduced health outcomes and patient safety issues for the most vulnerable members of the Pueblo. The Pueblo of Acoma Budget Formulation Workgroup recommends an increase to the overall CHR budget to support and expand the CHR manpower in our Pueblo and the critical services they provide.

The Taos/Picuris Service Unit's fifth budget priority is the Community Health Representative (CHR) Program. We highly recommend an additional increase for the CHR program. This is a very important program for our communities and for IHS. Very often, the CHR is a first responder for many different types of issues identified in the home. They are in a position to provide vital information to tribal programs as well as the Taos/Picuris IHS Health Care Team.

The Community Health Representative (CHR) program is a bedrock program for Native American Communities. The CHRs provide a wide variety of services, from health education to families to home visits for elders to community health promotion activities. They are a valued link between the medical providers and the community often providing recommendations, solutions and services that otherwise wouldn't be available to community members. In many ways, the Indian Health Service perspective on the Community Health Representative's program in the best description on the following quote: "The Community Health Representative (CHR) Program is a unique concept for providing health care, health promotion, and

disease prevention services. CHRs have demonstrated how they assist and connect with the community and their work has become essential to the spectrum of Tribal community-oriented primary health care services. CHRs are great advocates in part because they come from the communities they serve and have tribal cultural competence. Their dedicated work has assisted many to meet their healthcare needs. The health promotion and disease prevention efforts that CHRs provide have also helped people from the community improve and maintain their health. By providing health education and reducing hospital readmissions, CHRs have contributed to lowering mortality rates. The demand for CHRs continues to grow." (<https://www.ihs.gov/chr/>). The CHR program faced elimination in the proposed President's FY 2019 budget. It was saved by congressional action but we need to ensure not only the permanency of the CHR program but also look at the shortage of CHRs in Tribal Community and how IHS might help alleviate this shortage.

Tribes should not have to worry about the elimination of this vital program and we need IHS to advocate for the effectiveness and importance of this program. Community Health Providers (CHR) is the primary contact person between IHS and the community. They provide services such as non-emergency transportation for community members wanting to access doctor appointments; conduct bedside care for home bound patients; are reliable resource persons between the provider and the patient in coordinating the health care; and outreach to promote prevention with many of the illnesses that affect our community. Limited budget affects how these services are provided. In order to provide not just patient care but transportation regarding purchasing of vehicles and maintenance along with staffing needs to be considered. Research has shown that home visits by a service provider improves health outcomes and is primary strategy in doing an effective prevention program. The CHR program covers the spectrum of the stages of life from prenatal to our Elders and they are the primary contact between the Services Units and patient homes. They have the ability to comprehensively assess their patient needs and develop a plan of care that can greatly improve their quality of life. For instance, the CHR program can develop patient centered medical homes (PCMH) to advocate and assist patients navigate their healthcare system. This can reduce no-shows and follow ups of patient care. In addition coordinated care can be developed so that patients can be assisted with other resources that can assist them in improving their quality of life. Increasing home visits can also address people who never access services and reinforce their connective to their community. Elders have stated that "no one visits them anymore" "Where have all my relatives gone?" In addition, Native communities have health disparities that are higher than the national averages and the root causes may be adverse childhood experiences.



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

By increasing TPSU’s Tribal CHR program budget whereby increasing their home visits to monitor the health of their communities through a coordinated health system will resolve a lot of our physical and mental health disparities that affect Native communities. Therefore, Taos/Picuris Service Unit Tribes supports and highly recommend an increase in funding for the Community Health Representative Line Item Budget.

Health Care Facility Construction

Health Care Facility Construction increases are highly recommended to evolve the planning phases for building replacements for the Jicarilla Apache Nation Head Start program and CHR buildings. These current buildings are not adequate and continue to be problematic with plumbing and structural design.

The Mescalero Service Unit recommends a 20% program increase for Health Care Facilities Construction (HCFC) line item. The MSU is obsolete and has long surpassed its useful life. As the existing health care facility ages, associated building equipment and components are also deteriorating to a point of failure and the decreasing availability of replacement parts on this antiquated equipment ultimately disrupts the already limited health care services. Overall, inconsistent funding levels for health care facilities hinders progress on the construction of a much-needed facility. The delay in implementing projects in a timely manner results in higher construction costs, often doubling the cost of a project over a 10-15-year period, which is generally the lifespan of a project from the

time a project is placed on the Priority List until it is fully constructed. These unreasonable timelines add to the growing health disparities and gaps in access to care. Without modern infrastructure, MSU has not been able to keep pace with available new and emerging health care technologies. MSU is in a remote and under developed area adding to the challenges we face. Increased funding for healthcare facility projects will provide greatly improved access to quality health care by improving access to services, performance, staff and customer satisfaction. Recruitment and retention efforts will increase with competitive abilities and will improve our service delivery and patient care. Fully funding this program will allow the facilities on the list to complete their existing projects and allow other projects such as MSU the opportunity to be placed on the priority list. Further, the Tribe has applied for Joint Venture options during their open season as an avenue to construct a new facility for our community. Sadly, we were not funded.

Jicarilla Apache Health & Fitness Center (JAHFC)

The Jicarilla Apache Health & Fitness Center (JAHFC) functions under two grants: the Special Diabetes Program for Indians (SDPI) and the 638 Community Health Representative (CHR) programs under which allow budgets for infrastructure. The JAHFC program houses 17 employees and a state-of-the-art fitness gym with array of fitness cardio and weights equipment. The current location is an old warehouse building that was built in the 1960’s. The building is in need of all new plumbing, electrical, heating/cooling along with many other issues. We don’t have adequate ventilation nor enough office and storage space to name a few. Our program provides transportation to the community to local and out of town medical appointments, home visits with our elders and those needing basic wound care and other basic medical needs, we provide in home exercise to those living with diabetes that are unable to come to the gym and serve over 80 gym clients a day in the gym. Our program also provides monthly food distributions to over 70 community members, as well as Personal Protective Equipment (PPE) as well as educational classes of any different health disparities. We are requesting the increase to aid us in starting the process of looking for state and other federal funding to build a new up to code facility. We will use this funding requested to hire an architect to start our project which is needed first when applying for such funding.

Jicarilla Child & Family Education Center (JC FEC)

Jicarilla Child and Family Education Center, is an early childhood facility that serves children ages 6 weeks to 5 years old. Building improvements to provide sufficient and well-maintained plumbing for program children enrolled in JC FEC. Proper

plumbing will offer safe sanitation to program building as well as prevent an imminent health hazard from corroded pipes. These services are essential for proper sanitation which include, sewage, water supply, and solid waste disposal which are essential services for American Indian communities.

EMS

EMS plays an essential role in rural Tribal communities and in this challenging environment, rural EMS provides excellent lifesaving care. EMS services within the ACL service area have been significantly impacted due to the closure of the ER at the ACL Facility therefore, additional increase in funds to assist with recruitment, retention, and direct care is required. EMS essentially is now providing direct care due to the negative impact of the closure of the ER. The Pueblo of Acoma currently operates an ambulance service however, the cost of operating the services has been extremely challenging due to the cost of operations i.e. staffing, training, equipment, and maintaining licensing. A natural movement toward regionalization of healthcare in rural areas is occurring. The appropriate treatment of time-critical conditions may necessitate additional transportation to regional centers that maintain trauma designation, stroke designation, and potentially cardiac designation, where true definitive care can be rendered. This additional transportation has had impacts within the Pueblo of Acoma and a major impact on EMS access. With the ACL Hospital and Emergency Department now closed, the closest major hospital is 50+ miles away. Because there is no other healthcare provider in the area, the EMS agency becomes the default healthcare provider. Patients who would typically go to the hospital now call EMS for care, treatment, or information. Many patients who are sick or injured require the higher level of care that only the hospital can provide. The duty now falls on the EMS agency to transport those patients to the next closest hospital, even if it is 50+ miles away. The long trek to the hospital now takes EMS personnel out of their normal service area for longer periods of time. Without enough trained personnel and/or additional vehicles, the access to EMS can be stressed beyond its limits. In some situations, the EMS agency closes operations because of that stress. This now places the burden of access to EMS on the next closest agency, which may be, again, several miles away. The transformation of rural healthcare delivery from volume to value/quality has significant repercussions not only for hospitals but also for patients. One of the major issues affecting EMS access in the rural areas such as the Pueblo of Acoma is the availability of workforce. Funding will allow for the expansion of EMS roles to include other levels of EMS providers. Community Healthcare Worker training, along with traditional levels of EMS certification may provide this community support while also providing for additional revenue to help support necessary services within rural Tribal communities such as the Pueblo of Acoma. Unfortunately,

access to care in rural Tribal communities is becoming more challenging, increasing the workload for rural EMS providers. These closures mean increased travel distance and time without additional resources. With an aging population within the Pueblo of Acoma the need for EMS will increase. Therefore, the recommendation for the increase will allow for an expansion of services. It has been very apparent by the budget amounts throughout the years that there has been a slow progression for increases. Historically, data confirmations over 26 years of a flat budget which is allocated at the same yearly percentage, these allocation of dollars does not keep up with inflation costs to sustain operations. The Pueblo of Acoma Budget Formulation Workgroup highly recommends the increase in the EMS budget to provide the quality and life-sustaining care that every AI/AN community deserves.

Jicarilla Apache Nations advocates for funding increases to allow for a more accessible EMS facility for the EMS program. This is a necessary line item as the Program Director and EMS Team have been flexible with facility-share, but for more accessibility, parking, inventory storage and patient care it would be an asset for the health and well-being of the community members or visitors. Also, importantly, an updated inventory: transport vehicles, state-of-the art training, and equipment to assist the Team in a rural, mountainous environment. Again, I am sure there are other more critical needs, and I would continue to prioritize the EMS Team.

Albuquerque Area Hot Issues

Hospitals & Health Clinics

The Pueblo of Acoma Budget Formulation Workgroup identifies H&C as a hot issue as well as a priority area. The recommendation represents the minimal infusion of resources which are critically necessary to bring the ACL Facility health delivery system up to a safer standard of care. This hot issue is a priority area necessary to improve the delivery and quality of health care, reduce the high occurrence of health care disparities and most importantly to retain the services i.e. emergency room and inpatient services that have been discontinued due to the decreased funding. However, it is important to note that additional funding for these services is critically important because current funding levels have not been adequate to meet basic standard of care requirements.

The Pueblo of Acoma Budget Formulation Workgroup recognizes that adequate funding for the H&C is the base funding for the ACL Facility and health programs that operate within

the Pueblo of Acoma, predominantly in a rural setting. This is the core funding that makes available direct medical care services and is necessary as it supports medical care services including emergency care, inpatient and outpatient care, medically necessary support services such as laboratory, pharmacy, digital imaging, information technology, medical records and other ancillary services. The workgroup further recognizes that despite the continued funding, critical operations have been discontinued such as the emergency room, inpatient care as well as other critical services.

In addition, the H&C funds provide the support for the required range of services needed to target chronic health conditions affecting Tribal members such as heart disease and diabetes, treatment and rehabilitation due to injuries, maternal, child health care, dental and optometry services.

The demands of direct care services are a continuous challenge in our ACL Facility even more so with the substantial impacts of the loss of funding. We experience constant and increased demand for services due to the increased rates of chronic diseases that result in growing patient workloads in addition to emergency/urgent care due to the relentless spread COVID-19 within the ACL service area. Adding rising medical inflation, difficulty in recruiting and retaining providers in rural health care settings, and the lack of adequate facilities and equipment, these resources are stretched. As a result, any underfunding of H&C equates to limited health care access, especially for patients that are not eligible for or who do not meet the medical criteria for referrals through PRC to the private sector that shall be discussed in another section of this report. For many in Indian Country, there are no alternatives other than the direct care provided at an IHS or Tribal facility.

EMS Maintenance and Repairs for Ambulances

Emergency Medical Services are an integral part of the comprehensive care provided by the Pueblo of Acoma Department of Public Safety. As with other rural and frontier EMS, IHS and Tribal EMS programs are in a constant state of development and evolution to meet the needs of the local service population and its communities. Given the steady increase within the Pueblo of Acoma population and the increased rates of morbidity and mortality associated with injury there is a corresponding need for continued development and increased resources for the operation of Tribal, Service Unit based EMS programs which are actively involved in patient care and injury prevention.

The Pueblo of Acoma has little or no dedicated funds for ambulance and equipment, purchase or replacement. The expansion of these services will assist with the maintenance and repairs

of existing equipment including ambulances. The Pueblo of Acoma Budget Formulation Workgroup further recommends an increase in FY 2024 for maintenance and repairs of ambulances line as this allocation has not received an increase to their base funding for years.

IHS Funding Transparency

The Pueblo of Acoma Budget Formulation Workgroup notices a lack of transparency by IHS at not only the area level but the service unit level as well therefore, a recommendation for a transparent and open budget process which allows for the fostering of trust and allows Tribal programs to plan and budget accordingly.

Special Diabetes Program for Indians

The Pueblo of Acoma Budget Formulation Workgroup recommends the permanent authorization of the Special Diabetes Program for Indians (SDPI). In recent years, the highly successful program has only been renewed in short 1-2-year increments. This has created instability in the program, long-term planning, and overall effectiveness.

SDPI has not received an increase since 2004, meaning that dollars are stretched even further when considering increased population growth and medical inflation. We strongly encourage an increase in funding for the SDPI program to at least match the inflationary and population growth increases. Additionally, because there is a return on investment for this program by the cost savings realized in prevention, we encourage this to be viewed as a cost saving measure, not necessarily an expenditure.

Additionally, late renewals and/or two-year renewals mean that SDPI programs have trouble in retaining and recruiting staff in rural Tribal communities such as the Pueblo of Acoma. The Pueblo of Acoma Budget Formulation Workgroup highly recommends a permanently authorize the Special Diabetes Program for Indians to make it part of recurring base funding and subject to annual congressional increases.

Domestic Violence Prevention Program

The DVPI promotes the development and implementation of evidence-based and practice-based models of domestic violence prevention that are also culturally competent. The DVPI also expands outreach and increases awareness by funding projects that provide victim advocacy, intervention, case coordination, policy development, community response teams, sexual assault examiner programs, and community and school education programs.

The Pueblo of Acoma Budget Formulation Workgroup recommendation is to permanently authorize the DVPI to make it part of recurring base funding and subject to annual congressional increases.

Health Promotion/Prevention

Historically, the funding that has been distributed by Indian Health Service is heavily based on user population or health disparities which creates a resource distribution imbalance geared toward larger tribes with higher disease rates. The Pueblo of Acoma is smaller in population therefore, the funds received for health promotion and prevention are not enough to conduct adequate interventions within the Pueblo.

Many leading causes of mortality among AI/ANs are preventable through early intervention, including prevention of obesity and encouragement of physical activity and overall wellness. It is important to ensure that the Pueblo of Acoma Health & Human Services Division can address health promotion activities in addition to addressing high priority illnesses. Low cost investments in prevention programs can have a tremendous impact within the community and prevent future expenditures for more costly chronic diseases such as diabetes and heart disease.

The Pueblo of Acoma Budget Formulation Workgroup recommends funding to increase health promotion, disease prevention programs, substance abuse prevention and data collection to include monitoring and efficacy of prevention activities. They also recommend expansion of programmatic funding to incorporate cultural and traditional practices. It has been shown that incorporation of traditional medicine and ceremonies greatly enhances health and well-being and resilience of American Indian people.

Equipment

The ACL Facility manages biomedical devices consisting of laboratory, medical imaging, patient monitoring, pharmacy, and other biomedical, diagnostic, and patient equipment with a high value. Increased support is necessary to replace outdated, inefficient and unsupported equipment with newer electronic health record-compatible equipment to enhance speed and accuracy of diagnosis and treatment. Accurate clinical diagnosis and effective therapeutic procedures depend in large part on healthcare providers using modern and effective medical equipment/systems to assure the best possible health outcomes.

Tribal Management Grants

Tribal Management Grants assists federally-recognized Tribes and Tribal organizations (T/TO) to develop and strengthen management ability in preparation to assume all or part of existing IHS programs, services, functions, and activities to further develop and improve their management capability. Tribal Management Grants (TMG) are competitive grants available to assist T/TO to establish goals and performance measures; assess current management capacity; analyze programs to determine if management is practicable; and develop infrastructure systems to manage or organize the programs, function, services and activities of the current health programs. The Pueblo of Acoma Budget Formulation Workgroup identifies Tribal Management as a hot issue and a critical component therefore recommends continued funding to support TMG grants.

TMGs consist of four types of awards designed to enhance and develop health management infrastructure. The project types include feasibility studies, planning and evaluation studies, and health management structure framework development. TMG's are necessary to assist Tribes and Tribal organizations assuming all or part of existing IHS PFSAs through Indian Self-Determination and Education Assistance Act agreements under Title I and Title V to develop, improve and implement management structures to improve their management capability. The Pueblo of Acoma continuously makes attempts to submit proposals for a TMG to enhance and develop the Pueblo's health management infrastructure.

Long Term Care/Elder Care

Pueblo elders prefer to be in their own home and communities throughout their lives. In the past, elders stayed at home with their families in multi-generational homes, but that is not always possible as their care needs exceed what their family and other supports can provide and they require nursing or assisted living care. Thusly, more Acoma elders 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.

People over the age of 65 are one of the most rapidly growing segments of the population in all Tribal communities. Increases in life expectancy can also lead to a higher prevalence of chronic disease and increased incidence of disability and functional limitations. Higher rates of disability and functional limitations along with the increasing numbers of elders exacerbate the need for long term care planning but local resources are limited.

More Tribal health organizations might be interested in assisted living including the Pueblo of Acoma if the IHS

provided some operating funding for individuals needing a lower level of care than nursing-level care. These services include residential care, such as nursing homes and assisted living facilities, home and community-based services, caregiver services, case management and respite care.

The authority provided in the reauthorization of the Indian Health Care Improvement Act (IHCA), 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. Additionally, the need for IHS to support and coordinate the efforts and partnerships with Centers for Medicare & Medicaid Services to address reimbursement and certification/regulatory issues is crucial.

Self-Governance

Tribal Self-Governance, known as Title V of the Indian Self-Determination Education and Assistance Act, authorizes Tribes and Tribal Consortia to assume programs, functions, services, or activities placing the accountability of service provision at the local Tribal governance level. The Self-Governance budget supports negotiations of Self-Governance compacts and funding agreements. This budget also supports oversight and coordination of IHS Agency lead Negotiators (ALN), technical assistance on Tribal consultation activities, analysis of new authorities in the IHCA, Self-Governance Planning and Negotiation Cooperative Agreements, and funding to support the activities of the Tribal Self-Governance Advisory Committee (TSGAC).

The Pueblo of Acoma Budget Formulation Workgroup recommends an increase to the overall budget to support and expand Self-Governance training and technical support for Tribes that wish to advance the administration of their health systems.

Health Professions

Similarly, to IHS system, the Pueblo of Acoma competes with the private sector in recruiting and maintaining health providers. However, there are few tools available to the IHS and Tribes that provide unique advantages in recruitment, principal among them - the IHS Scholarship and Loan Repayment Programs (LRP). Despite these unique opportunities, IHS is limited in its use of the programs due to significant underfunding and administrative policy. For example, in FY 2017, 788 health professionals - nurses, behavioral health providers, dentists, mid-level providers and pharmacists - who applied for the LRP were not funded. It is estimated that an additional \$39.4 million would be needed to fund the 788 unfunded health professional applicants.

Meanwhile, IHS is disallowing Tribes who contract and compact programs to receive LRP funds when their vacancy rates are less than IHS. To address the short- and long-term issues of staffing shortages the agency needs to deploy a workforce development pipeline approach that can aggressively assist in meeting the staffing need for health care professionals within rural Tribal communities such as the Pueblo of Acoma.

Facilities & Environmental Health Support

The Pueblo of Acoma Budget Formulation Workgroup recommends an increase to the Facilities and Environmental Health Support (FEHS) budget line item. The FEHS provides resources to staff and support its headquarters, regional, area, district, and service unit activities. These activities include Facilities Support, Environmental Support and Office of Environmental Health & Engineering (OEHE) Support. Facilities support include 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.

The IHS delivers a comprehensive, national and community-based and evidence-based Environmental Health program addressing children's environment, safe drinking water, Vector-borne and communicable disease, food safety, and healthy homes.

The Pueblo of Acoma Budget Formulation Workgroup recommends that not only technical assistance including training, but actual funding is filtered directly to Tribes and allowing for Tribes to identify their specific needs within each respective Tribal community.

Tribal Detention Health Care Resources

The U.S. Supreme Court has determined that correctional facilities are required to provide health care services to inmates in accordance with the Eighth Amendment of the Constitution, *Estelle, et. v. Gamble*, 429 U.S. 97 (1976), *Brown, et al. v. Plata*, 131S.Ct. 1910 (2011). Since 2009, the U.S. Department of Justice and Bureau of Indian Affairs have invested in modernizing jails throughout Indian Country, constructing new facilities that are designed to accommodate various number of inmate populations. Often these Tribal Detention facilities operate without licensed medical personnel to provide correctional health care services.

Neither the Bureau of Indian Affairs and IHS receive an appropriation for this purpose, therefore, incarcerated individuals must be transferred by law enforcement/detention officers to IHS and Tribal clinics for outpatient services. Tribes are generally unable to provide funds needed to support medical and behavioral health staff in correctional facilities.

The Pueblo of Acoma Budget Formulation Workgroup recommends that the U.S. Public Health Service establish agreements with Tribes and/ or the Bureau of Indian Affairs to allow medical staff under the U.S. Public Health Service Corp to be assigned to provide services at these correctional facilities. Furthermore, it is recommended that designation be expanded to include Tribal and BIA correctional/detention facility sites in addition to state and federal correctional facilities.

Additionally, the Social Security Act prohibits Medicaid participation for an inmate of a correctional institution. Currently, there is no “inmate exception” for IHS and Tribal health care facilities for outpatient services provided to Tribal member inmates and the costs for these services are ever increasing.

The Pueblo of Acoma Budget Formulation Workgroup recommends that IHS support and facilitate advocacy within Congress for the amendment of the Medicaid “Inmate exception” so that an “Indian exemption” authorizes Medicaid reimbursement for the outpatient services provided to any individual who is an inmate of a Tribal detention center.

Jicarilla Apache Nation - New Construction and Staff Housing

Additional Housing for professional staff has been a huge challenge. There are Staff that commute from Chama, NM, Pagosa Springs CO, or Farmington, NM which can be up to 80 miles one-way trip from the community of Dulce. Most applicants prefer to live in the community. To increase available resources for the community, professional staff housing is a dire need. Jicarilla Apache Tribal programs and Jicarilla Service Unit continue to struggle to recruit and retain staff, due to lack of housing. A new housing development can contribute to the successes of recruiting new hires for JAN Tribal programs and JSU staffing.

Jicarilla Behavioral Health has three separate buildings. To improve services for the Jicarilla community, it would be beneficial to have a one stop shop for all JBHD services. A new building would greatly improve service delivery and assist the community in locating all necessary JBHD services.



Zuni/Ramah Service Unit - Emergency Medical services

ISSUE: The Zuni Pueblo and Ramah Navajo Tribes’ federal funding levels to support their EMS programs are underfunded.

The lack of additional funds has resulted in the tribes’ inability or difficulty to insure 24 hours, 7 days per week basic and intermediate emergency medical services for their respective communities at times leaving the community and patients at risk when they are unable to evacuate more than one patient whether it be due to staffing issues or mechanical issues of their ambulances. This creates risk management issues for the EMS program and the hospital located in a remote area. The nearest emergency ambulance service located in Gallup are unable to provide backup service due to their responsibility in covering a larger area that only adds to the difficulties in finding other alternatives.

The minimal funding levels are inadequate to cover the cost of their EMTs and support staff, as well as, their upkeep of their ambulances and other operational costs that is negatively impacting on their desire to improve/enhance their services with additional EMT staffing and training efforts to include paramedics services. Both tribes’ EMS services are considered essential and critical services to both the hospital in the provision of patient care, as well as, the community who relies upon their EMS services to be responsive to their emergent medical needs in accessing medical care.

Both the Zuni Pueblo and Ramah Navajo Tribes recommend increased funding levels to the Hospital and Clinics (H&C) budget as a high priority that will allow for earmarking an acceptable portion of the H&C increases specifically for the Emergency Medical Service Programs in support of direct patient care.

BEMIDJI AREA

Bemidji Area Narrative

H&C +\$741M

The Bemidji Area recommends 8.11%, or \$741M above the FY 2024 current service & binding obligation, 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 their individual clinic functions to support the direct care needs unique to each tribal community. The increased H&C funding could provide the much needed boost for resources to AI/AN health programs, giving healthcare programs flexibility in finding effective treatments unique to their health delivery systems in reducing the health disparities of their community members to include traditional healing and long-term care.

Continued critical under funding of Bemidji Area Tribes has created an environment of uncertainty when it comes to planning, development, and implementation of tribal health programs. Most tribes are unable to compete with more populated high demand areas due to their geographical and historical territory of the Bemidji area.

With the above-mentioned attributes, there continues to be high rates of vacancies in the Area office and tribal settings especially since the COVID 19 outbreak. Recruitment and retention practices need to be more aggressive and competitive to bring in qualified health care medical professionals. It is necessary to mention the I.H.S loan repayment program is not keeping pace with current standards and require 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.

We are unable to keep up with inflation, whether it's salaries and fringe packages, medical inflation, population growth and the increased disease burden related to the pandemic. Increased reliance on grants and 3rd party billing has 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 importantly quality health care, and patient satisfaction.

Lack of mandatory funding has led to financial instability, interrupts necessary primary care and ancillary services needed for American Indians in the Bemidji Area. Tribes invest

large amounts of 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 our tribal populations. Moving the increased 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 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 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. 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.

Alcohol & Substance Abuse (ASA) +\$184.3M

The Bemidji Area recommends 5.76%, or \$184.3M above the FY 2024 current service & binding obligation, 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 +\$162.6M

The Bemidji Area recommends 4.96%, or \$162.6M above the FY 2024 current service & binding obligation funding 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. 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.

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

Purchased/Referred Care (PRC) +\$342.7M

The Bemidji Area recommends 4.79%, or \$342.7M, above the FY 2024 current service & binding obligation, to 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 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 were primarily PRC programs as part of the Great Plains Area when Bemidji was a Program Office. Approximately 2/3 of the Area Tribes are considered 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 this reality 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.

Health Care Facilities Construction +\$116.7M

The Bemidji Area recommends 6.73% or \$116.7M, above the FY 2024 current service & binding obligation, funding available to be applied to the Health Care Facilities Construction budget line item.

Many tribal healthcare facilities are dated 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. 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 healthcare or improved 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.

Electronic Health Record (EHR) Upgrade +\$14.5M

The Bemidji Area recommends 4.01%, or \$14.5M, above the FY 2024 current service & binding obligation, to 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 still many years from 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. 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's 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.

Urban Health +\$23M

The Bemidji Area recommends 2.75%, or \$23M, above the FY 2024 current service & binding obligation, to be 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 IHClA 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 and 105I leasing programs 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 Representative +\$22M

The Bemidji Area recommends 2.08% or \$22M, above the FY 2024 current service & binding obligation to be applied to the Community Health Representative 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 CHR's 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).

Maintenance and Improvement +\$37M

The Bemidji Area recommends 1.4%, or \$37M, above the FY 2024 current service & binding obligation to be applied to the Maintenance and Improvement (M&I) budget line item.

There is a substantial need for funding of health care facilities within the IHS, Tribal and Urban programs. This funding would eliminate the backlog of maintenance, repair and much need improvements to facilities, utility systems, non-clinical equipment, grounds, roads, parking lots and facility service equipment systems. These funds would also be used to organize these engineering related services include assessing the structure, utilities, and equipment, designing modifications, preparing engineering drawings and specifications for repairs and improvements, and troubleshooting major components or system failures. Along with these services needing funding would be the costs associated with real property.

Dental +\$21M

The Bemidji Area recommends 1.13%, or \$21M, above the FY 2024 current service & binding obligation to 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, and stroke) with compounded impacts from intergenerational, historical trauma contributing to disparate rates of tobacco product use and unhealthy diet. 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.

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.

<https://www.cdc.gov/mmwr/volumes/66/wr/mm6650a2.htm>

<https://dentistry.umn.edu/dental-therapy>

In Bemidji area, our funding priorities are...

1. Hospital & Clinics (H&C) +741M
2. Alcohol & Substance Abuse +184.3M
3. Mental Health (MH) +162.6M
4. Purchased/Referred Care +342.7M
5. Health Care Facilities Construction +116.7M
6. Electronic Health Record System +14.5M
7. Urban Health +23M
8. Community Health Reps (CHR's) +22M
9. Maintenance & Improvement +37M
10. Dental Service +21M

Bemidji Area Hot Issues

Summary Page

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 – to support financial stability and reduce interruptions in health care services.

Bemidji Area is Underfunded – despite serving the second highest number of tribes and among the top six in population served, Bemidji Area continues to be the lowest funded at 39% compared to the average of 49.46% other areas receive.

Secure and Support OMB Rate for Medicare Services – Current discussions of Medicare for all could pave the way for the elimination 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).

Advanced Recruitment and Retention Efforts – The I.H.S Loan Repayment program is not keeping pace with current standards and require significant increase in salary and fringe 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 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.

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 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.

Mandatory Funding & Advanced Appropriations **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.

BACKGROUND

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

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.

Critical Under Funding of Bemidji Area Tribes **ISSUE**

Critical Under Funding of Bemidji Area Tribes 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

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 related to the pandemic. The high rates of vacancies in the Area office and tribal settings especially since the COVID 19 outbreak.

RECOMMENDATION

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.

OMB Rate for Medicare Services **ISSUE**

Current discussions of Medicare for all could pave the way for the elimination of Medicaid programs that tribes in the Bemidji Area rely on as an additional resource for reimbursement when treating patients through Tribal health programs.

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 IHCA 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.

Recruitment and Retention **ISSUE**

The I.H.S 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 it 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.

EHR 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 still many years from 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 option to negotiate this.

Construction Funding **ISSUE**

Many tribal healthcare 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 healthcare 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 aren't 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 IHCA 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

Billings Area Narrative

1. ALCOHOL & SUBSTANCE ABUSE PROGRAMS

INTRODUCTION

Alcohol use and substance abuse is the most severe health and social problem facing the American Indian/Alaska Native (AI/AN) people today and the cost to the Indian people is great as measured in physical, mental, emotional, social and economic terms. The National Institute on Drug Abuse states, "...other costs include unemployment, poor educational outcome, domestic violence, child abuse, motor vehicle accidents and death. AI/AN are twice as likely to live in poverty and experience two and a half times the general rate of violent victimization as compared to the general population. AI/ANs are regarded as having a shorter life expectancy and a higher infant mortality rate than the general population."

Looking beyond the economics, it is the human cost that hits the heart of AI/AN people. Alcohol and substance abuse has detrimentally impacted native families including generations that span from our elders to our infants and everyone in between. AI/AN represent the largest population per capita in the Montana prison system. Many AI/AN children are in the foster care system as a direct result of their parents/guardians' use of alcohol and drugs. Native babies are born addicted to drugs or are developmentally impacted by alcohol. Additionally, native youth population start alcohol and drug usage at a very young age in contrast to other racial groups. These youth ultimately sacrifice their futures as a result.

DATA

Data used in this report comes from the Montana death certificates collected by the Montana Office of Vital Records and were limited to American Indian Montana residents. American Indian residents were identified as those who were classified as American Indian or Alaskan Native according to the race bridging procedure of the National Center for Health Statistics (NCHS).⁴ Deaths were tabulated by underlying cause using the International Classification of Diseases 10th Revision (ICD-10).⁵ Leading causes of death are classified according to the NCHS Instruction Manual Part 9 which includes the addition of COVID-19 (U07.1).⁶

In addition to the leading causes of death, alcohol-induced deaths, and deaths due to drug poisoning were assessed in this report. Alcohol-induced deaths included deaths with one of following ICD-10 codes as the underlying cause: E24.4,

Alcohol-induced pseudo-Cushing syndrome; F10, Mental and behavioral disorders due to alcohol use; G31.2, Degeneration of nervous system due to alcohol; G62.1, Alcoholic polyneuropathy; G72.1, Alcoholic myopathy; I42.6, Alcoholic cardiomyopathy; K29.2, Alcoholic gastritis; K70, Alcoholic liver disease; K85.2, Alcohol-induced acute pancreatitis; K86.0, Alcohol-induced chronic pancreatitis; R78.0, Finding of alcohol in blood; X45, Accidental poisoning by and exposure to alcohol; X65, Intentional self-poisoning by and exposure to alcohol; and Y15, Poisoning by and exposure to alcohol, undetermined intent. Drug poisoning deaths included deaths with one of the following ICD-10 codes as the underlying cause: X40-X44, unintentional poisoning; X60-X64, suicide; X85, homicide.

Deaths associated with substance use disorder or mental health crisis were also examined. The age-adjusted rate of alcohol-induced deaths was significantly higher in 2020 compared with 2015–2019. The mortality rate for drug poisoning and suicide, however, were similar in 2020 to 2015–2019. According to the latest Indian Health Service (IHS) Strategic Plan, the AI/AN populations also have disproportionately high rates of suicide, unintentional injuries, and drug overdose deaths.

The use of alcohol and/or drugs increased during the pandemic. All of our communities experienced so many deaths related to COVID-19 as well as other causes. Due to not having contact with loved ones in the hospital who passed away left some in shock, disbelief or guilt, with limited or no funeral attendance and lack of or restrictions of family support due to social distancing and isolation to name a few outcomes that interrupted the grief process. Licensed addictions counselors train to get to the root/cause of clients use and more often than not, an individual's use can be a result of unresolved and/or unidentified grief. The aftermath of the pandemic will undoubtedly inundate our Alcohol and Substance (ASA) programs. This pandemic affected the entire world, however, our total population only accounts for a small percentage of the total human population and this monumental event was devastating and traumatic. As a people, AI/AN have higher incidences of traumatic experiences historically, generationally and individually. The ASA programs all identify as trauma-informed facilities. The approach of trauma informed care in health care delivery has become the standard for all the ASA programs. The ASA programs will commit to continue to develop and implement trauma-informed care models and programs to meet the needs of the AI/AN people with compassion, kindness and care.

The Billings Area Tribal Alcohol & Substance Abuse (ASA) programs specialize in prevention, outreach, education, treatment and recovery efforts related to alcohol and substance abuse and aims to strengthen the overall health status of the AI/AN population. The ASA programs support the Indian Health Service mission to improve the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level. This narrative includes a list of budget priorities identified as areas, to receive increased funding as these priorities will support effective delivery of services. The Directors of the Billings Area Tribal Alcohol & Substance Abuse programs submitted the following list of priorities respective of their individual ASA programs beginning with the top priority:

BUDGET PRIORITIES

1. FACILITIES

The Billings Area ASA programs recommend an increase in Health Care Facility Construction. Many of the ASA programs 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 of the ASA programs encountered a situation in which a closet was repurposed as office space. The primary method of treatment is therapeutic group interaction. Every ASA 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 ASA programs 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 ASA 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 ASA Health Care Facility requires renovation and

expansion in order to meet the tribal communities' needs at the local level. It is the overall desire of the ASA Health Care Facilities to modernize their health care facilities and staff quarters to expand access to quality health care services.

2. CULTURAL CONSIDERATIONS

The second highest priority as expressed from the ASA programs 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.

3. TELEHEALTH SERVICES & EQUIPMENT

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.

4. 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 vehicles 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.

5. PEER RECOVERY SUPPORT

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 para-professionals 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.

6. DETOXIFICATION SERVICES

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.

7. PRIMARY RESIDENTIAL INPATIENT TREATMENT (LEVEL 3.5 AND/OR LEVEL 3.7)

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.

8. 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.

9. COUNSELOR RECRUITMENT & RETENTION/ TRAINING/CONTINUING EDUCATION & 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 health 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.

In the Billings Area, ASA programs strive to meet the three GPRA ASAP screening measures Tobacco, Alcohol Screening, and Brief Intervention and Referral to Treatment (SBIRT) for FY 2022. ASAP is authorized by the Indian Health Care Improvement

Act, 25 U.S.C. § 1621h. ASAP 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.

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2. MENTAL HEALTH

Mental Health is a high priority for the Billings Area for the FY2025 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.

Community Health Aide Program

The Community Health Aide Program (CHAP), with Medicaid authorization passed through the Montana Legislature in 2019, 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.

Reducing Suicides

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](https://www.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. We are conducting trainings on the reservations and with urban 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 Indian 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.*

3. HOSPITAL & 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; this is mostly due to stagnant budgets that do not increase with inflation and cost of living in rural areas. Third party reimbursement is highly needed to assist in fulfilling fiscal shortfalls and providing services that are not funded through the IHS or other Federal funding, including programs such as suicide prevention and oral health intervention.

Specialty services that were provided by our service units such as nephrology, pediatrics, obstetrics and gynecology and urology are no longer available at current funding levels. As a result, patients are forced to drive hundreds of miles in order to receive specialty care. With communities that have high unemployment rates, this makes accessing health care services



particularly difficult. Third party billing offered a pathway to providing these services, however, with the current cuts to Montana’s Medicaid Expansion, these programs may be in jeopardy of continuing or not able to be fully realized at all.

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 personnel for IHS facilities. An increase in medical providers would help decrease patient visits in our Urgent Care and reduce long waiting time for medical appointments. The IHS is modernizing its credentialing and privileging processes to facilitate the hiring of qualified practitioners. The credentialing process evaluates the qualifications and practice history of a provider such as training, residency, and licensing.

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.

H&C is linked to all GPRA measures. H&C is linked to the Indian Health Care Improvement Act, U.S. Code, Title 25, Chapter 18. The H&C supports the IHS Strategic Plan FY 2019-2023.

4. 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. 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's 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's 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.

5. 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 healthcare 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.

6. 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, even prior to the current pandemic. Shortages of staff being the core problem. Additionally, the pandemic revealed inadequacies in the ventilation systems in several dental clinics, and the need to improve them to increase patient and employees safety. 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.

Many, if not all of the service units are having difficulty recruiting and retaining qualified support staff. The support staff positions pay is often below entry level jobs in their communities. This is becoming a large factor decreasing patient's access to services as most clinics have unfilled assistant positions. Ideally clinics would have two assistants per provider, most clinics currently have one assistant per provider or less. Pay scale changes need to be looked at, as well as other financial incentives to try and get quality applicants for the current vacancies. These incentives also need to be explored so we can retain the current staff that we have.

Due to the high-risk potential for transmission of COVID-19 during dental procedures, appointment times have had to be lengthened, reducing the number of appointments that are available. The pandemic has increased the length of appointment times by requiring adequate time for screening of patients and adequate time for HVAC system to cleanse the air following the procedure. Some clinics have had to limit the number of operatories they are using because their ventilation systems were below the minimum air exchanges recommended. HVAC renovations can be quite costly but should be done to improve patient and employee safety when necessary. The reduction in available appointments has created a backlog of patients needing preventative care.

The recent increases in available funds for PRC have made a positive impact in many patients' lives. It has allowed dental clinics to help get some patients to outside providers to try and reduce some of the backlog of routine care. It has also allowed for patients some higher levels of service not previously available. The increase in PRC funding has been a real benefit to the patients we serve. This is funding that should be continued in the future to keep these services available.

With these limitations on available appointments, emergency care dental cases take priority over preventative care and education. Increasing funding for clinic ventilation improvements and for recruitment and retention for support staff is greatly needed. This would significantly increase patient's access to care. The increase in PRC funds in recent years has made a positive impact on some of the preventative and restorative services.

Prior to the pandemic, the Billings Area met all the 2020 GPRA measures for Dental: General Access, Sealants, and Topical Fluoride at 32.41%, 24%, and 44.35%. In one recent IHS study, some significant improvements were made in AI/AN adolescent's 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%). These are trends we would like to see continue and increasing funding for staffing, facilities and PRC in the Billings Area will help make this possible.

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.

7. 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.



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.

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8. SPECIAL DIABETES PROGRAM FOR INDIANS

To improve diabetes awareness, prevention, and treatment.

9. URBAN INDIAN HEALTH

COVID-19 has amplified health inequities in American Indian communities 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. 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.

Billings Area Hot Issues

Trauma to Resiliency

ISSUE

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.

BACKGROUND

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

ISSUE

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.

BACKGROUND

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.

Medicaid Expansion in Wyoming

ISSUE

Wyoming is among the minority of states where Medicaid has not been expanded and the State continues to refuse Federal funding that would allow it to expand coverage to about 20,000 low-income residents.

BACKGROUND

In 2017, Medicaid was the largest source of funding for medical and health services for people with low income by providing health insurance to 74 million low-income and disabled people. Medicaid is a jointly funded program by the State and the Federal governments and managed by the states. Each State has broad latitude to determine who is eligible for its implementation of the program. The Affordable Care Act (ACA) Medicaid expansion makes inexpensive health care coverage possible for millions of Americans. Under the ACA Medicaid eligibility guidelines, more people are eligible for Medicaid benefits. However, the additional coverage, often referred to as Obamacare, is only available in states that accepted the new rules and regulations. However, the possibility for states to add the additional coverage exists.

Under the ACA, states that expand Medicaid to cover more low-income people can count on the Federal government to pay 90 percent of the expanded program. The State covers the rest. However, according to an [April 2019 report](#) from the Health Insurance Resource Center (HRIC), failure to expand the program would mean Wyoming would forego \$1.3 billion in Federal funding over the next decade. Current data from the HRIC shows (BetterWyoming, 2019):

- » 57,970 – Number of people covered by Medicaid/ Children's Health Insurance Program (CHIP) in Wyoming as of July 2018
- » 27,000 – Number of additional people who would be covered if Wyoming accepted expansion
- » 6,000 – Number of people who have NO realistic access to health insurance without Medicaid expansion
- » \$1.3 billion – Money the State is leaving on the table over the next decade by not expanding Medicaid

According to the Bureau of Business and Economic Research at the University of Montana, expansion of Medicaid in the State of Montana brings in \$600 million a year into Montana economy that would not otherwise be there.

RECOMMENDATION

Support actions necessary to expand Medicaid in the State of Wyoming to increase health care for the AI/AN population.

Youth Regional Treatment Centers

ISSUE

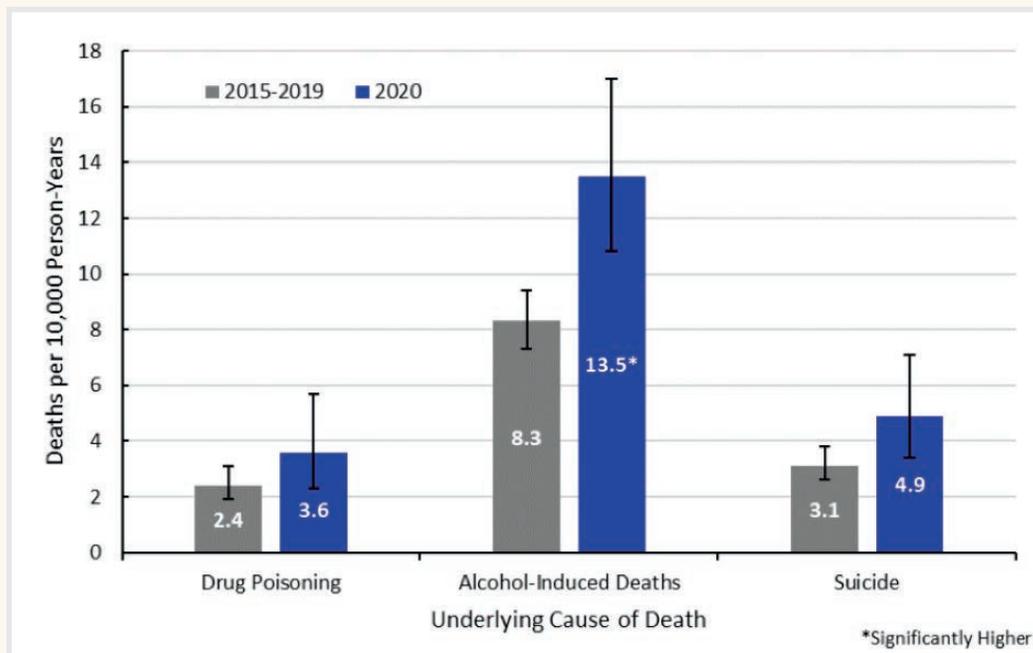
The Billings Area does not have a Youth Regional Treatment Center (YRTC) to serve the Montana and Wyoming Tribes.

BACKGROUND

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.



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.

REFERENCES:

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

California Area Narrative

The California Area is submitting a Budget Recommendation at the full funding FY 2025 Recommendation. The California Area Office and California Area Tribal Leaders support funding the California Area's Top 11 Budget Funding Priorities: Purchased/ Referred Care, Behavioral Health, Obesity/ Diabetes, Methamphetamines/Suicide/ Domestic Violence, Dental, Community Health Representative, Health Information Technology, Pharmacy, Indian Health Care Improvement Fund, Small Ambulatory, and Urban.

BUDGET INCREASES

1. *Purchased/Referred Care + \$283.0MM*

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 healthcare organizations rely heavily upon PRC funding. The vast 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 actually greater than the data suggests. In 2021, only 27 of the 45 health programs reported deferred and denied data.

2. *Behavioral Health + \$266.4MM*

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 2021 Government Performance and Results Act (GPRA) Data. Over 7,000 youth and just over 39,000 adult AI/AN patients were not screened for depression at Indian health programs in the California Area. Additionally, approximately 20,000 women were not screened for domestic violence and over 55,000 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.

3. *Obesity/Diabetes + \$216.4MM*

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 healthcare programs use these funds to offer education, self-management support through professional and community led education, direct clinical and specialty care for AI/AN patients battling diabetes and obesity. Behavioral health issues are also addressed which contribute to the obesity and diabetes rates of AI/ANs.

4. *Methamphetamines/Suicide/ Domestic Violence + \$199.8MM*

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 youth 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 2021 Government Performance and Results Act (GPRA) data, over 20,000 women at California tribal health programs were not screened for domestic violence. In 2021, 7 California health programs received IHS Domestic Violence Prevention Initiative funding and 14 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.

5. *Dental + \$166.5MM*

Dental decay rates of AI/AN children and adolescents are twice the national average and contribute to serious diseases. 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. California Tribal Leaders also recommend funding Dental Therapy and Dental Therapists. This classification would allow Native healthcare programs to serve more clients.

6. *Community Health Representative + \$149.8MM*

Across IHS, CHR Programs provide essential services for an under resourced, heavily chronic disease- burdened segment of the overall population. Just over \$ 2 million of the reported \$60 million for IHS CHR budget, is available for CA Area CHR

programs. Per data obtained through the IHS CHR Data Mart, California Area tribal and Urban Indian RPMS-using CHR programs in FY 2017 provided over 57,703 services with 76,413 client contacts. Over the course of this time period, the top CA Area Urban CHR program areas of activity (by visit) were socio economic-assistance (845) and diabetes (331); the top 5 categories of CA Area tribal program CHR activity were those associated with the following categories: Diabetes, Hypertension, Injury control, Administration and management, and Cardiovascular disease. Per a report generated through the IHS CHR Data Mart, between FY 2017 and FY 2019, the overall CA Area CHR services declined by 74,216 and the client contacts declined by 112, 030. During this same time period, the number of CA Area CHR reporting sites declined from upwards of 16 to 2, with no CA Urban reports available through the CHR Data Mart for FY 2019. 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 have not declined to the extent indicated, however that there is not a proper accounting of 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 healthcare professionals to extend services into the community setting, providing invaluable services that bridge coverage gaps by connecting patients with much needed healthcare 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.

7. Health Information Technology + \$133.2MM

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.

8. Pharmacy + \$116.5MM

The net prices for more than 1,200 prescription drugs rose on average 31.6% faster than inflation between July 2021 to July 2022. Specialty drugs (e.g. Rheumatoid Arthritis, HIV, Hepatitis C) have the highest inflation rate followed by brand name drugs. Tribal and Urban healthcare 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 are able to 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 healthcare 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 healthcare centers may still face difficult decisions on how to cover remaining drug costs as their revenue margins decrease substantially.

9. Indian Health Care Improvement Fund + \$99.9MM

Congress established an Indian Health Care Improvement Fund (IHCIF) in the Indian Health Care Improvement Act (IHCA) 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.

10. Small Ambulatory + \$16.6MM

The California Area strongly supports funding for new health care facilities under Sec. 141 of the permanent reauthorization of the Indian Health Care Improvement Act (IHCA) as well as Section 306, P.L. 94-437, of the IHCA which authorizes the IHS to award grants to Tribes and/or Tribal organizations for construction, expansion, or modernization of ambulatory health care facilities located apart from a hospital. California Tribal Leaders report that increased funding resources for Tribal healthcare ambulatory health care facilities would help meet modern health care delivery program needs for those facilities with insufficient capacity to deliver such services through the construction, operation and maintenance of facilities that meet building code requirements and health care accreditation standards. The FY 2017 Budget Request included \$10 million for the Small Ambulatory Grants (SAP) program of which \$5 million was approved. The FY 2018 Budget included an additional \$10 million for a total of \$15 million. California Tribal Leaders recommend increased funding for the SAP program.

11. Urban + \$16.6MM

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 healthcare 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 healthcare services. None are connected to a hospital and few are connected to specialty care services. There are ten urban Indian healthcare programs in California.

California Area Hot Issues

Drought Impacts on California Tribes

ISSUE

Severe drought conditions throughout 2021 and 2022 impacted California Tribes in numerous ways. Drought conditions have persisted into 2023, though recent rains have given some possibility for relief. IHS has provided direct assistance with drought issues and has created partnerships with other state and federal partners to maximize the resources available to Tribes.

BACKGROUND

As of January 3, 2023, 98% of the State of California was experiencing a drought, with 71% of the state at the highest levels – D2 (Severe Drought), D3 (Extreme Drought) or D4 (Exceptional Drought). The most obvious impact has been on Tribal drinking water systems. Starting in spring 2021, IHS began working closely with Tribal water systems across the state to monitor drought impacts. A monthly drought risk map has been prepared each month from June 2021 to present, with 15 Tribal water systems experiencing documented drought impacts at some point.

IHS has several avenues for providing assistance to Tribal water systems impacted by drought. Under the American Rescue Plan Act (ARPA), Sec 11001 (3), IHS at the national



level was provided with \$10M in funding for “expenses related to potable water delivery”. Three California Tribes received funding through this program (Kashia, Yurok and Hoopa Valley). California Area IHS also made \$100,000 available in 2021 for Tribes to meet any urgent drought-related needs. IHS Headquarters also has Emergency Funds available for immediate needs for emergencies (drought or otherwise) that cannot be met by the Area Office. Long-term solutions to improve the drought resilience in Tribal water and wastewater systems can be developed and funded through the IHS Sanitation Deficiency System (SDS). Finally, IHS has a team of Tribal Utility Consultants who have provided direct technical assistance to Tribes dealing with drought impacts.

California Area IHS has also partnered with state and federal partners, including the Governor’s Tribal Advisor, State Water Resources Control Board (Water Board), California Department of Water Resources (DWR), Environmental Protection Agency (EPA), to share information and direct Tribes to drought resources. In 2021 and 2022, several Tribes were able to work with DWR or the Water Board to get funding or technical assistance for their drought-related needs.

Additionally, extreme or exceptional levels of drought are also correlated to more numerous and more extreme wildfires, which in turn cause smoke inhalation hazards across large areas. One Tribal clinic was destroyed by wildfires in 2021, and smoke- and fire- related morbidity puts additional stress on Tribal health programs.

RECOMMENDATION

The Infrastructure Investment and Jobs Act (IIJA) is providing \$3.5 billion to IHS over a five-year period (\$700 million per year) to address water, wastewater and solid waste infrastructure needs in Indian country. This funding will be distributed through the Sanitation Deficiency System. EPA and other federal agencies are also anticipating funding increases as well to fund water and wastewater projects. Tribes are encouraged to work with local IHS staff to identify needs and develop



projects for funding, including developing new water sources, increasing the capacity of existing water sources, and building interconnections to other public water systems, all with a goal of improving resiliency.

Tribal water and wastewater utility organizations and Tribal health programs are encouraged to develop drought contingency plans, which could be linked to a larger Tribal emergency response plan. California Area IHS has developed a drought contingency plan template that Tribal water utilities may use as a basis for developing and approving their own plan. IHS will also continue to coordinate with the State's new requirements for counties and small water suppliers to build drought resiliency and planning (such as county drought task force, contingency plans, and facility resiliency improvements), and appropriate ways and roles for tribes to consider and implement.

Tribal health facilities are also encouraged to install or upgrade air filtration systems where necessary to prepare for smoky air conditions that occur during wildfires. Furthermore, Tribal water and wastewater utilities and health facilities are strongly encouraged to install backup power (generator) systems so that they can remain fully functional during extended power outages that often accompany wildfires conditions. IHS has provided funding for these emergency generators for Tribal health facilities since 2021. Thus far, eight generators have been funded through this program, though no fewer than 25 more generators are still needed.

Some Tribes have inquired if IHS has funding available to address impacts of natural disasters (wildfires, tornadoes, earthquakes, and drought) on healthcare facilities. Given the increased frequency and severity of such natural disasters due to climate change, additional reserve funds to address such emergency are recommended.

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 regional specialty care centers, mental health facilities or expansions of the youth regional treatment centers.

BACKGROUND

California Area IHS operates two federal health care facilities in the state – the Desert Sage and Sacred Oaks Youth Regional Treatment Centers. Tribal and Urban Indian 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, Tribal support for the concept of regional specialty care centers has been growing throughout 2022 and into 2023.

It is anticipated that the Health Care Facilities Construction (HCFC) priority list established in 1992 will be fully funded by FY 2030. 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 1992 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. There was also a feasibility study completed in 2013 for California Area regional surgical and specialty care centers, which is currently under revision based on growing Tribal interest in this option.

RECOMMENDATION

California Area IHS is beginning to plan for a new health care facilities master plan. California Area will develop a first draft statement of work for a master plan contract as a starting point. This draft will be distributed to all Tribal and urban health care programs for their input. Follow-up meetings may be scheduled as required to ensure all needs and concerns of Tribes and Tribal health programs are heard and included. This process will take place once IHS Division of Engineering Services has a contract established with a firm capable of conducting master planning, and once funding levels are established.

California Area is anticipating funding from IHS Headquarters for development of the master plans, with an initial recommendation of \$1.5 million per Area for master plans and

recurring for two full-time staff per Area to assist with planning activities. The Area is concerned that this funding will not be sufficient for a comprehensive master plan that would cover 38 Tribal health programs, 10 Urban Indian health programs, and two federal health care facilities. This concern about insufficient funding has been expressed on multiple occasions by California Area’s representative at Facilities Appropriation Advisory Board (FAAB) meetings.

The master plan will require consultation with all tribal and urban health programs in its execution. 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.

While the outcomes of a master planning process are not known, Tribal leaders have expressed interest in two regional specialty centers (one in Sacramento, one in Temecula). Other types of health care facilities for which interest has been expressed includes substance abuse treatment centers, behavioral health facilities, long term care for elders, and others.

Contract Support Costs (CSC) for the third-party-revenue-funded portions of the Tribe’s healthcare 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 healthcare programs, funded by Indian Health Services (“IHS”) in the amount IHS would have spent on a tribe’s health care. Because 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.

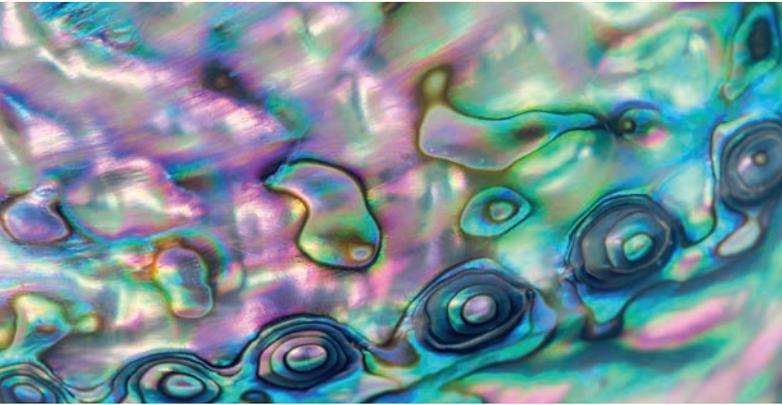
The issue is who pays the CSC for the additional money the Tribe recovers from outside insurers. The Tribe contends that

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 healthcare 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 healthcare 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 healthcare 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. Because the statutory language was ambiguous, the Indian canon applied, and the language must be construed in favor of the Tribe. The panel held that 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.



Mobile Crisis Stabilization Units

ISSUE

Funding is needed for Tribal Communities to augment available emergency services with specialized response teams trained to deescalate and support community members in acute psychiatric distress.

BACKGROUND

American Indian and Alaskan Natives experience behavioral health problems at higher rates than other races and ethnicities. Historical and intergenerational traumas, coupled with personal experiences of racial discrimination, set the stage for toxic stress. Over time, exposure to toxic stress can lead to the onset of behavioral health conditions or intensifying symptom expression. This exposure is believed to contribute to the high rates of suicide, substance abuse, and domestic violence experienced within AI/AN people.

Most calls for assistance with psychiatric emergencies begin with a call to 9-1-1. Law enforcement officials play a vital role as first responders to 9-1-1 calls. Many Tribal communities report having unreliable access to or strained relationships with county Sheriff departments. Most police departments do not offer the specialized training needed to stabilize psychiatric emergencies. Despite this, officers must use their judgment when determining to transport a person to a hospital or place of safety, acting as gatekeepers in the process.

Law enforcement officers who lack the proper training and skills to assist a person in psychiatric distress can exacerbate the patient's crisis. Patients report feeling traumatized and ashamed by the experience of being handcuffed and transported to a hospital in a police cruiser. Family members report secondary stress and may be reluctant to call for help on behalf of a loved one in the future if they believe it could make matters worse. If the patient perceives the interaction as a negative experience, they may be less likely to seek assistance in the future, leading to adverse health outcomes.

Many counties have incorporated Mobile Crisis Response Units to respond to psychiatric emergencies with a therapeutic approach. These Units use a team-based approach, pairing a Behavioral Health Expert with a trained Law enforcement officer. They travel together in specialized vans/RVs that offer a comfortable, private place to talk. The BH professional assesses and deescalates the patient, and they work together to find a solution based on the circumstances. The team assists the patient without using force or handcuffs. The patient can be transported to facilities with greater privacy and dignity.

RECOMMENDATION

The IHS/CAO, in cooperation with other IHS Offices, recommends funding for the following activities:

- » Create opportunities for Tribal communities and law enforcement offices to explore the feasibility of Mobile Crisis Response Teams.
- » Assess existing county resources and assist in building or enhancing relationships between the counties and Tribes so that Native communities can improve access and gain trust.
- » Develop cultural humility training for the MCRU teams.
- » Explore funding opportunities for program infrastructure if one does not exist.

GREAT PLAINS AREA

Great Plains Area Narrative

Executive Summary

Tribal leaders representing the Tribes/tribal organizations, and Urban Clinics of the Great Plains Area met on November 17, 2022, in Rapid City, South Dakota to develop the Indian Health Service Great Plains Area FY 2025 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, spread across the counties to include in the severely economically distressed service areas.

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 Healthcare 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 \$1,665,065 for FY 2025. 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. Mental Health	\$241,707
2. Alcohol & Substance Abuse	\$439,883
3. Maintenance & Improvement	\$100,000
4. Hospitals & Clinics	\$375,000
5. Purchase Referred Care	\$250,000
6. Sanitation Facilities Construction	\$158,000
7. Health Care Facilities Construction	\$100,475

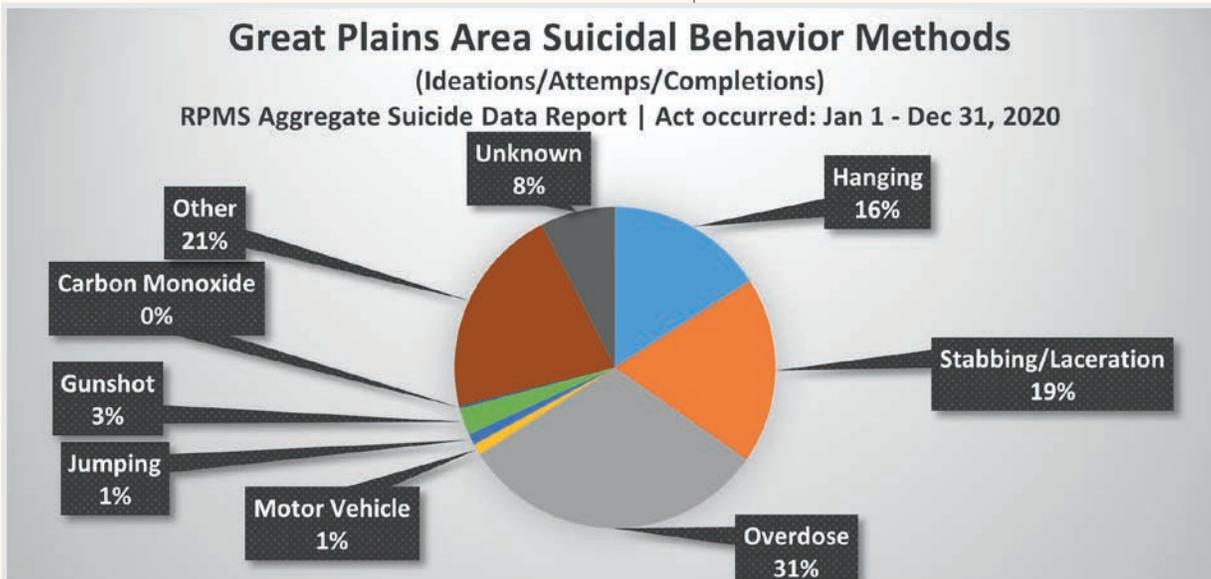
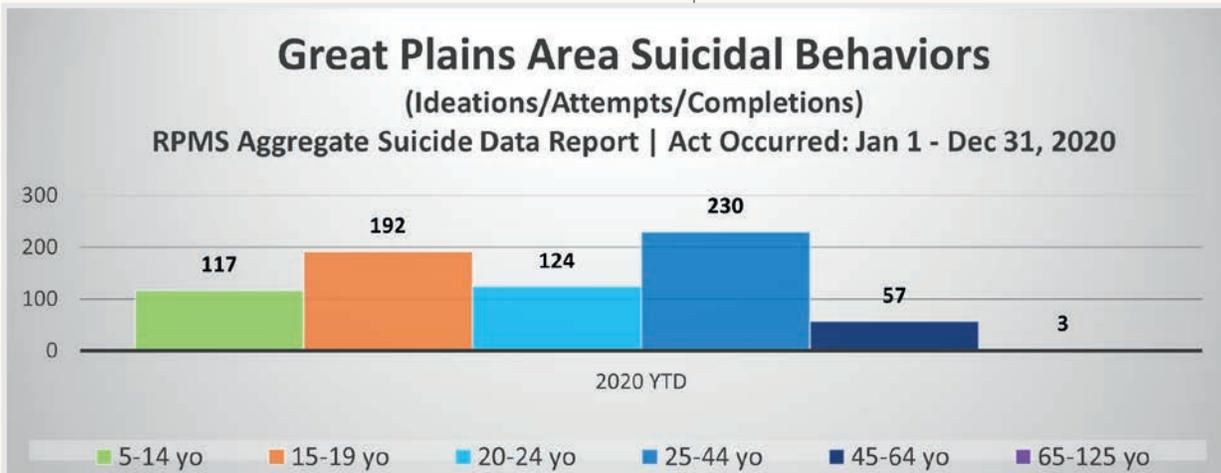
1. MENTAL HEALTH

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.



2. ALCOHOL & SUBSTANCE ABUSE

Great Plains Area has the one of the highest alcohol related deaths and the second highest rate of suicides in the country.

Most of the Alcohol and Substance Abuse programs in the Great Plains Area are contractual. The need for additional funding to assist Tribes in developing primary care facilities, after-care, and behavioral health models is greatly needed in order to fully utilize opportunities for Third party funding (Medicare, Medicaid, Private Insurance, VA) through the Affordable Care Act.

Alcohol abuse in Indian Country contributes to the high rate of violence and crimes on the reservations as well as alcohol related motor vehicle accidents. Motor vehicle accidents and liver disease are among the top alcohol induced deaths among

AI/AN. There is an overwhelming need for medical monitored detox center(s) in the Great Plains Area.

Drug abuse in Indian country contributes to the increase numbers of domestic violence, assaults/battery, burglary, child abuse/neglect, and weapons violations. The Great Plains Area has seen a drastic increase in the use of methamphetamines and prescription drugs that include non-medical use of pain relievers, sedatives, stimulants, and tranquilizers.

Overall, Great Plains Area AI/AN's were 3.5 times more likely to die of chronic liver disease and cirrhosis when compared to all AI/AN's in the United States. South Dakota reservation counties had the highest rate ratio of the four state regions, being over 4 times more likely to die from alcohol and substance abuse.

3. MAINTENANCE & IMPROVEMENT

Facility aging has increased costs and risks associated with maintenance and repairs. This trend is accelerating as maintenance and repair deficiencies could not be fully corrected because the maintenance and improvement budget was insufficient. The current reported backlog of essential maintenance, alteration, and repair (BEMAR) is \$767 million. There is concern that this number is under reported by facility managers due to the limited amount of funding available for such projects.

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 results in being many times greater than the cost the hospital would have incurred had it not deferred maintenance on that 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.

In alignment with industry practice, a sustainable IHS M&I program for maintenance, repair, and renovation of medical facilities is estimated at 6.4 percent of the current replacement value (CRV) of the eligible IHS building inventory. Within the IHS M&I system, about 1.2 percent is currently allocated to routine/non-routine maintenance thru the University of Oklahoma Formula (UOF) methodology, and 2.2 percent to deferred maintenance. This is equivalent to 20 percent of the BEMAR. Industry practice would allocate the remaining 3 percent to major renovations. Based on industry practice, for the IHS building inventory, the annual M&I need is \$536 million. The FY 2020 M&I funding appropriation was \$169 million or 32 percent of need. The 2021 total M&I need is \$3.1 billion. 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.

4. 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, inpatient care, routine

ambulatory care, and medical support services—such as laboratory, pharmacy, medical records, information technology, and other ancillary services. In addition, H&C funds provide the greatest flexibility to support community health initiatives targeting health conditions disproportionately affecting 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.

5. 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.

An increase to IHS PRC funds will allow more Tribal members to access private-sector care before the healthcare condition becomes an emergency, improving and increasing the overall health of the AI/NA population.

6. SANITATION FACILITIES CONSTRUCTION

The Indian Health Care Improvement Act (IHCA) requires the Indian Health Service (IHS) to identify the universe of sanitation facilities needs for existing American Indian and Alaska Native (AI/AN) homes by documenting deficiencies and proposing projects to address their needs. These projects prevent communicable diseases by providing new and existing homes with services such as water wells, onsite wastewater disposal systems, or connections to community water supply and wastewater disposal systems. These projects can also include provision of new or upgraded water supply or waste disposal systems. These outcomes support both the HHS and IHS Strategic Plans. (HHS Strategic Plan FY 2018 – 2022, Objective 2.2: “Prevent, treat, and control communicable diseases and chronic conditions” and IHS Strategic Plan FY 2019-2023, Objective 1.3: Increase access to quality health care services. Strategy 14, “Develop and coordinate environmental engineering, environmental health, and health facilities engineering services to provide effective and efficient public health services...”).

The four types of sanitation facilities projects funded through IHS are: (1) projects to serve existing housing; (2) projects to serve new or like-new housing, such as Indian homes being constructed or rehabilitated by the Bureau of Indian Affairs (BIA)-Home Improvement Program, Tribes, individual homeowners, or other nonprofit organizations; (3) special projects (studies, training or other needs related to sanitation facilities construction); and (4) emergency projects. Projects that serve new or like-new housing are funded based on a priority classification system.

Projects that provide sanitation facilities to existing homes are selected for funding in priority order each year from the Sanitation Deficiency System (SDS). The SDS is an inventory of the sanitation deficiencies of federally recognized AI/AN eligible homes and communities; the sanitation deficiencies include needed water, sewer, and solid waste facilities for existing AI/AN homes. Project selection is driven by objective evaluation criteria including health impact, existing deficiency level, adequacy of previous service, capital cost, local Tribal priority, operations and maintenance capacity of the receiving entity, availability of contributions from non-IHS sources, and other conditions that are locally determined. The SDS priority position of each unfunded project is reevaluated with the Tribes in each Area annually.

In 2020, the GPA DSFC completed 42 projects that provided sanitation facilities to an estimated 6,311 homes at cost of \$22.5M.

	A	B	C	D
	IHS Facilities Appropriation Line Item	FY 2020 Appropriation	Sustainable Program Annual Funding Need	2021 Total Health Facility Need
1	Maintenance & Improvement	\$169M	\$536M	\$3.1B
2	Health Care Facilities Construction	\$259.3M	\$750M	\$23.0B
3	Equipment	\$28.1M	\$125M	\$454M
	TOTAL	\$456.4M	\$1.411B	\$26.6B

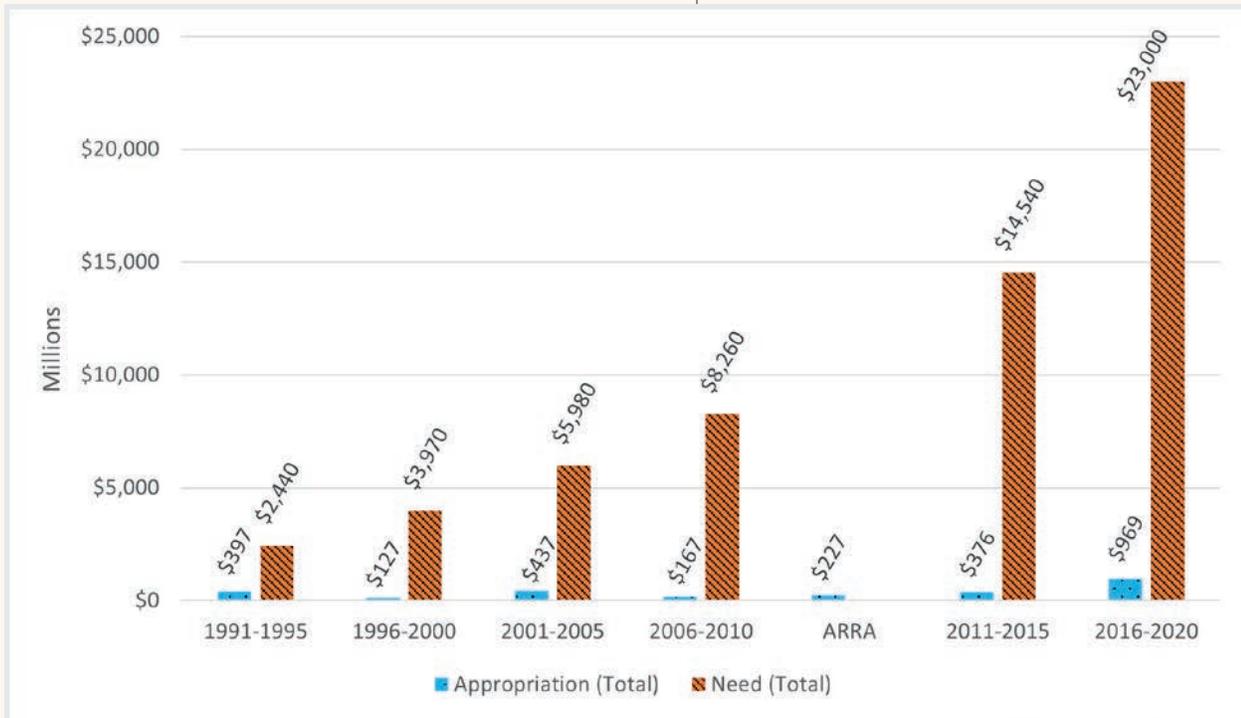
7. HEALTH CARE FACILITIES CONSTRUCTION

The Great Plains Area IHS facilities vary widely in age, capacity, design, and function. Some buildings were constructed decades ago before the modern era of medical practice, standards, and codes. Some of the oldest facilities continue to be used well past their expected useful life, are overcrowded, and do not have the same funding opportunities that newer facilities have. By contrast, newer IHS facilities are designed for state-of-the-art medical practice, such as patient/family center models of care, and are eligible for more funding opportunities. The newer facilities' internal configuration is updated, resulting in improved productivity and patient flow.

The IHS health care network has approximately 850 major health care buildings and over 1,000 supporting buildings and structures. Replacement and modernization in the IHS network has emphasized outpatient care. The outpatient space ratio to inpatient space is higher because IHS hospitals also provide outpatient services. Expanding and modernizing outpatient space parallels a similar trend in American medical practice. Although the IHS facilities network is sprinkled with modern replacements, especially ambulatory care facilities, the replacement rate is not meeting needs. The American Hospital Association recommends a useful life of 40 years for masonry and steel health care facilities (hospitals, Youth Regional Treatment Centers [YRTC] and health centers) and a useful life of 25 years for masonry, wood, and steel health care buildings (outpatient clinics and health stations). Over 220 major health care buildings in the Indian Health System currently report exceeding these standards. The IHS hospitals, which now average 39 years of age, are more than three times older than US not-for-profit hospitals in general (11.5 years of age).

The Great Plains Area IHS facilities need \$1,785 million that coincides with 2,050 thousand square feet.

Figure - Sum of Health Care Facilities' New Construction Appropriations during Each Report Period vs Total Need Remaining at end of Each Report Period (in \$ Millions)



Great Plains Area 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 healthcare 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 outsourced 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.

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.

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 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.

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.

NASHVILLE AREA

Nashville Area Narrative

Fully fund the Indian Health Service at \$54 billion

Nashville Area supports the National Workgroup recommendation distribution of \$52.4 billion. Nashville Area Tribal Nation's recommend distribution of the remaining \$1.6 billion to the following priorities:

1. Purchase Referred Care \$372,975 million
2. Hospitals and Clinics \$359,654 million
3. Mental Health \$333,013 million
4. Alcohol/Substance Abuse \$333,013 million
5. Dental Health \$133,205 million
6. Healthcare Facilities Construction \$133,205 million

1. *Purchased/Referred Care (PRC) +\$372,975M*

PRC funding is one of the key budget priority for the Nashville Area. IHS and the Tribes serve primarily small, rural populations and provide mainly primary care and community health services. Much of the secondary care, and nearly all of the tertiary care needed, must be purchased from non-IHS facilities. PRC funds are used to purchase essential health care services, including inpatient and outpatient care, routine emergency ambulatory care, transportation and medical support services, such as diagnostic imaging, physical therapy, laboratory, nutrition and pharmacy services. These funds are critical to securing the care needed to treat injuries, heart disease, digestive diseases, and cancer, which are among the leading causes of death for AI/ANs.

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.

IHS priorities are being evaluated to include changes in prioritization of preventative services, behavioral health services and rehabilitative services in an attempt to make the priorities more meaningful and applicable to clinical practice. Should these changes be implemented additional funding would be required to ensure increased access to care.

2. *Hospitals & Clinics +\$359,654M*

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.

3. *Mental Health +\$333,013M*

Mental Health, is 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. *Alcohol/Substance Abuse Program (ASAP) +\$333,013M*

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.

5. Dental Health +\$133,205M

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.

6. Healthcare Facilities Construction +\$133,205M

The Health Care Facilities Construction (HCFC) Appropriations are the primary source for new or replacement healthcare facilities. The number, location, layout, design, capacity and other physical features of healthcare facilities are essential for: Eliminating health disparities, Increasing access, Improving patient outcomes, Reducing O&M costs, Improving staff and operational efficiency, Increasing patient, visitor, and staff safety, Improving staff satisfaction, morale, recruitment and retention, Reducing medical errors and facility-acquired infection rates.

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

At the current rate of HCFC appropriations (~\$240 million/year), a new facility in 2019 would not be replaced for 400 to 450 years. To replace IHS facilities every 60 years (twice a 30 year design life), would need HCFC appropriations of ~\$700 million/annually.

Without a sufficient, consistent, and re-occurring HCFC appropriation, the entire IHS system is unsustainable.

Health Care Facilities Construction funding is needed in the Nashville Area. \$100 million has been requested under Obligated Agreements for previously approved health facility construction projects in accordance with the IHS Planned Construction Budget, referred to as the 5-Year Plan.

Standing Area Priority Recommendations 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, healthcare 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 2024 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. Nashville Area Tribes have continued to express previous grantees should be held harmless, and instead it appears as though the bulk of the impact is to be experienced solely by Nashville Area Tribal Nations.

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.

Funding Increases for Urban Indian Health Programs

The IHS Urban Indian Health Program supports contracts and grants to 34 urban health programs funded under Title V of the Indian Health Care Improvement Act. The Urban Indian Health Program line item is distributed through contracts and grants to the individual Urban Indian Health programs. The distribution is based upon the historical base funding of these programs. The funding level is estimated at 22% of the projected need for primary care services. Eighteen (18) additional cities have been identified as having an urban population large enough to support an Urban Indian Health Program. 2010 Census data shows that 71% of all American Indians and Alaska Natives live in urban centers.

It is important to bear in mind that urban Indian health programs are funded from a single IHS line item, and do not have access to funding appropriated to other areas of the IHS budget. Thus, any increase the Administration has proposed for the broader Indian Health Service budget will not benefit urban Indian health programs or the Native communities they serve. It is critical that Congress direct resources to the urban Indian health line item to provide health care services to urban Indian patients.

Nashville Area Hot Issues

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 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 telepsychiatry, 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 healthcare 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:

1. **Technology:** infrastructure updates, including software, wiring telemedicine carts, cameras, portable tablets and high-quality video conferencing systems.
2. **Staffing:** ongoing funding for Telehealth Coordinators and local, regional and national levels.
3. **Partnerships:** Securing various partnerships for increased, discounted broadband services, larger medical centers for specialty care services, etc.
4. **Connectivity:** Access to secure high speed internet/WiFi 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: Impacts of COVID on User Pop and Workload data BACKGROUND

Many locations closed in-person services due to COVID-19 concerns. This in turn decreased the number of face-to-face encounters for the year. Dental workload decreased the most, as many of the services provided are aerosol based and many clinics were only providing emergency dental services to help minimize the spread of COVID-19. Telemedicine services increased for medical and behavioral health encounters, but direct care services did decrease for the Area. Due to the availability of COVID-19 vaccines, services increased in FY 2021 and FY2022. However, for FY2022 ten (10) locations had decreases in user population from the already low FY 2021 numbers and eleven (11) locations are still below their 2019 user population calculations.

In FY2020, Direct Outpatient workload for the Nashville Area was at 523,518. In FY2021, we had 626,881 Encounters and in FY2022, we had 627,077 Direct Outpatient workload

encounters. In FY2020 Dental services were at 32,504 and in FY2021, the Area had 39,774 dental encounters, and in FY2022 we had 42,673. This is still lower than pre-pandemic totals for dental services. Direct Inpatient workload also increased from FY2020 to FY2021 from 788 to 879 and from FY2021 to FY2022 it increased to 937. User Population in FY2020 for the Area was 58,336, in FY2021 the user population number is 59,662 and in FY2022 the Area user population was 60,097. While the number of encounters and users of the health system did increase in FY2022, we are still not back to “normal” operations at health care centers as a direct result of the COVID-19 pandemic and necessary response measures.

RECOMMENDATION

Many IHS Funding Formulas utilize or rely on workload and user population data. As a result of COVID, Tribal Nations across the county experienced lower workload and user pop estimates. The Nashville Area recommends utilizing FY2019 data or a 3 year average excluding the FY2020 year as to not significantly reduce funding need for ITUs.

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 request that the IHS review once again the national funding formula to account for funding for Areas that have newly awarded grantees beyond 2023. This would also allow the time needed to gather critical data points that are needed in the national funding formula related to diabetes prevalence. Simultaneously, funding increases must also be directed to existing grantees, who have been forced to operate programs with declining purchasing power and increasing costs.

ISSUE: Modernizing Health Information Technology

BACKGROUND

Additional funding needed to modernize health information technology. The Indian health care delivery system is supported through a network of 594 healthcare 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 healthcare 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 hasn’t had the same advancements that some of the commercial off the shelf packages. IHS needs additional funding to determine the future of Health Information Technology for Indian

Country and needs to do so in consultation with Tribal Nations prior to formalizing drastic shifts. Continued and enhanced communication to Tribes, with 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 (IHCA) 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 healthcare. 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 IHCA 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 healthcare 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 healthcare 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's biggest competitors for retention of current healthcare 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

1. 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.
2. 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).
3. Implement 8-hour-leave category for Title 38 employees to match the VA.
4. 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.

NAVAJO AREA

Navajo Area Narrative

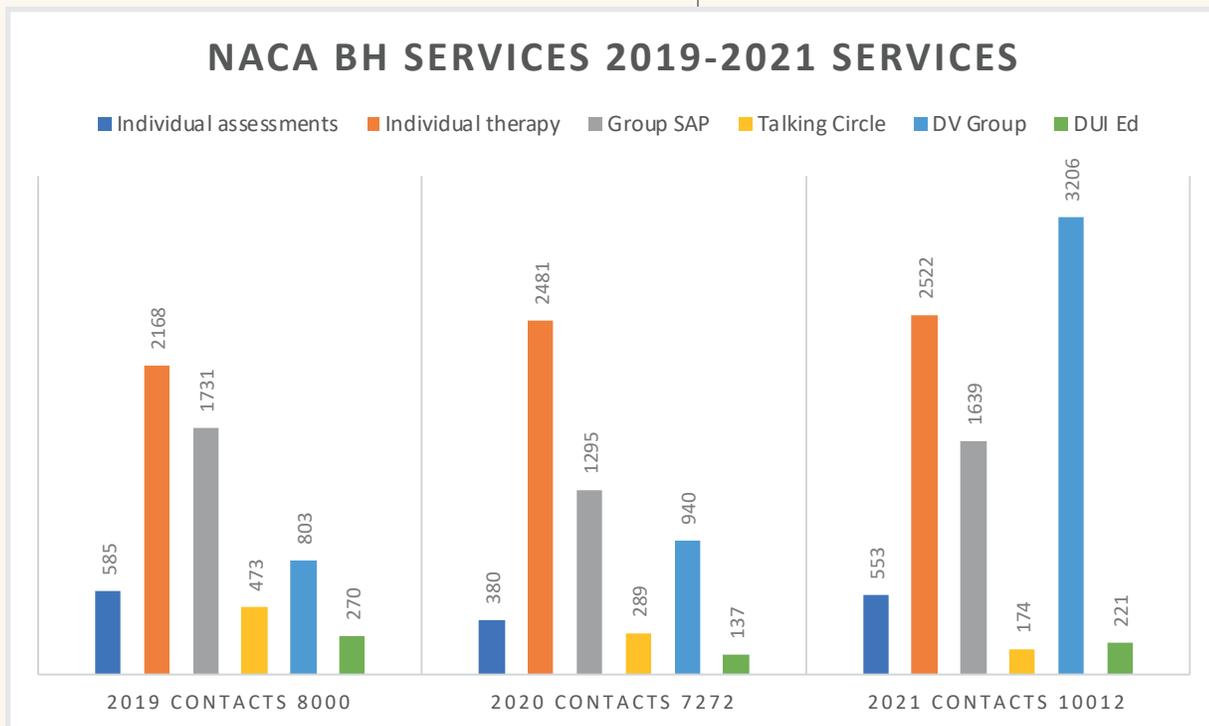
Mental Health

1. How the recommended budget increases should be allocated, i.e., why each growth is significant and how it will affect specific programs or initiatives. Include any effects of previous years' gains. Include any data that highlights the impact of last year's increases.

The Navajo Area requests a funding increase to the Mental Health central line account category. The Coronavirus (COVID-19) pandemic continues to significantly impact the need for additional Behavioral Health providers for primary care, outpatient mental health, and emergency departments. The COVID-19 pandemic continues to be a catalyst for onsets of new psychosis, increased depression, anxiety, and post-traumatic disorder. Suicide ideations, attempts, and completion rates have increased among American Indians/Alaska Natives (AI/AN). Social isolation and loneliness due to COVID-19 continue to have detrimental effects on individuals with Serious Mental

Illness (SMI). Emotional distress associated with the COVID-19 pandemic continues to impact the relapse of psychotic symptoms and re-hospitalization for acute psychiatric emergency care. Mental health services continue to function as a hybrid model to ensure accessibility. The limitations of information technology availability have significantly impacted accessibility to mental health services in urban, rural, and frontier areas, especially for individuals with no internet and transportation.

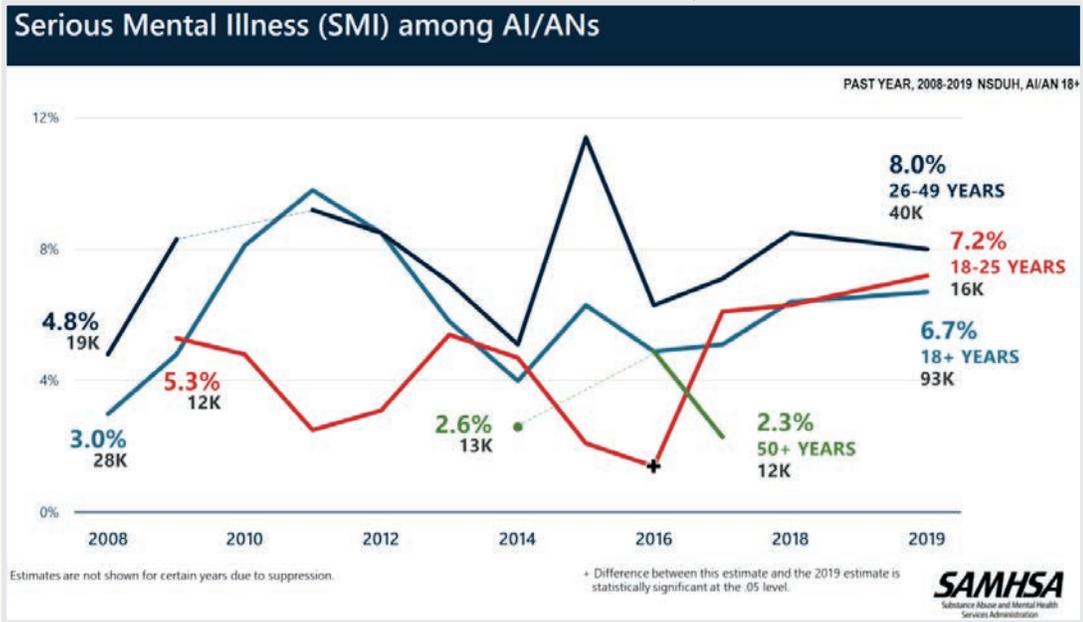
Acute psychiatric care facilities on the Navajo reservation are non-existent. Patients are transferred off the reservation to access critical psychiatric care. Transitional or step-down mental health services are much needed to support independent living for the chronically mentally ill. Limited specialized services are available to address postpartum depression, which is significantly higher among Indigenous populations. The high rates of suicidality among young adults and adolescents are critical areas that require advanced technical knowledge and skills in mental health interventions. The increase in domestic violence among AI/AN has impacted early childhood trauma, which triggers poor school performance, teen pregnancies, alcohol and drug use, and high school dropout rates.



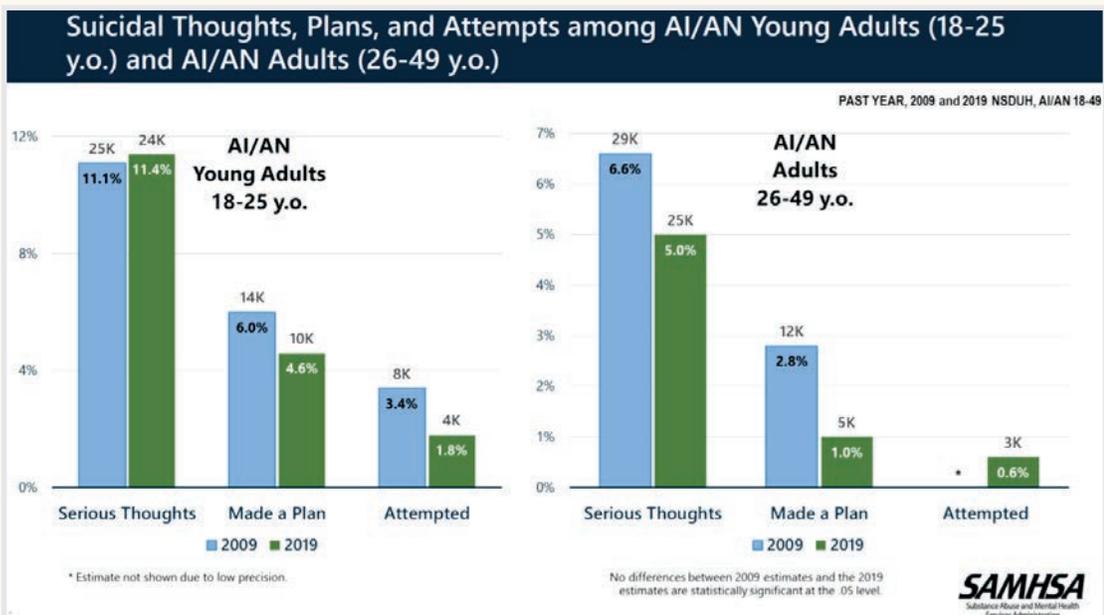
Data extracted from RPMS Daisy Barney, Clinical Applications Coordinator.
 Data set compiled Curtis Randolph Ph.D., LPC Director of Behavioral Health 1/14/2022
 Native Americans for Community Action, Inc. Urban Indian Organization (UIO), Flagstaff AZ

The data contained within this chart outline the growing need for behavioral health services in this urban population of AI/AN community members served. As one can see, the number of contacts pre-pandemic, 8000, rose to 10012 (21% increase) in two years, with numbers dropping in the middle and height of the pandemic by only 728 contacts (2019 to 2020). The most startling statistic in this chart is the increase in domestic violence contacts, from 803 (2019) to 3206 (2021), an almost

400% increase in domestic violence contacts. The reasons for domestic violence vary widely, but I would offer that increases in substance abuse and mental health concerns fueled by the pandemic and its inherent stressors were the cause for this alarming increase in domestic violence referrals and contacts. There is a dire need to increase funding across all mental health categories, including mental health and substance abuse services, to mitigate the increase in domestic violence referrals.



Suicide surveillance of high-risk patients is challenging due to inconsistent methodology in suicide reporting across Navajo communities.



There is a tremendous need to strengthen the Trauma-informed Care Approach in addressing the ongoing traumas related to early childhood exposure to family violence, sexual abuse, and substance use disorders. The Agency for Healthcare Research and Quality (AHRQ), 2016, “*Trauma-Inform Care*,” explains that “Trauma is a widespread, harmful and costly public health problem.” The AHRQ further explains the practice model, “Trauma-informed care and trauma-informed systems function according to at least four basic principles:

- 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) seek to Resist Re-traumatization actively.

These are often referred to as the “Four R’s.”

Inadequate funds lead to insufficient availability of behavioral health workers across the Navajo Nation and San Juan Southern Paiute lands, leading to access to mental health service problems. Continuous mental health care disruptions in care lead to poor patient health outcomes for chronic medical conditions. Specialized services to manage consistent and intensive treatment are needed to engage patients in mental health care and to improve health outcomes. The innovation of telemedicine for mental health services is an ongoing concern due to the remote and frontier demographic regions on the Navajo reservation.

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.

2. Link to Indian Health Care Improvement Act (IHCIA) provisions, where applicable.

25 USC § 1621 (h)-Mental Health Prevention and Treatment Services.

3. Link to GPRA performance targets and outcomes.

There are two GPRA measures relevant to the mental health line-item budget: 1) Depression Screening and other Mood Disorders for ages 12-17 years old. In 2021, Navajo Area did not meet the national target of 43.20%, and Navajo Area performance was 27.18%; 2) Depression Screening and other

Mood Disorders for ages 18 years and older. In 2021, the Navajo Area did not meet the national target of 49.40%, and the Navajo’s performance was 38.2%. In the prior year, 2020, the Navajo Area did not meet its two GPRA measures due to the Covid-19 pandemic onset. The pandemic caused the closure of some health services, including behavioral health care. Though the-behavioral health technology was activated, many patients could not access computers and phones and had no local internet connectivity. The pandemic exacerbated patient access to care issues, which impacted the achievement of GPRA measures.

4. Link requests to Indian Health Service Strategic Plan.

In the past, increased funding had allowed the Navajo Area to meet its GPRA performance targets for mental health screening for ages 12 and more significant, and this effort supports the IHS Strategic Plan 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 healthcare systems through solid partnerships and culturally responsive practices.

The Strategic Plan details how the IHS will achieve its mission through three strategic goals:

- 1) To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people;

Implementing the Primary Care Behavioral Health model will increase patient access to mental health care for screening, counseling, and intervention therapies/treatments. The COVID-19 pandemic has increased social isolation, emotional distress, and rapid change in activities of daily living skills. The impact of the COVID-19 pandemic on patients and the workforce has increased the need for additional mental health providers. The pandemic’s trauma has compounded the historical trauma experience for American Indians/Alaska Natives. Primary Care Behavioral Health will promote comprehensive, holistic health-care, decrease mental health stigma, and increase access and early intervention. Training and implementation of evidence-based screening and brief interventions for patients presenting with suicide symptoms in the emergency department will enhance access to the appropriate level of care. Suicide surveillance strategies will assist in the migration of suicide rates. Trauma-informed Care Approach will establish a user-friendly hospital environment that will enhance patient confidence and trust. Facilitating Trauma-focused comprehensive treatment interventions will enhance reintegration into the community environment and decrease re-hospitalization for patients with serious mental illness. The collaborative model supports the

Navajo philosophy of healing and well-being, where the whole person is treated within a network of relationships.

- 2) To promote excellence and quality through innovation of the Indian health system into an optimally performing organization; and

Significant innovative efforts have been made to integrate mental health screening and intervention with medical primary care services using the Primary Care Behavioral Health Model. The Model is a collaborative model that supports population-based care and a holistic approach to care. Primary Care and Mental Health, in collaboration with outpatient mental health services, will promote ongoing care for patients diagnosed with chronic mental illness to decrease the necessity of long-term care for the Indian reservation and community. Primary Care Mental Health facilitates the integration of medical and mental health care by including the patient's primary care provider. Primary Care Behavioral aligns with holistic healing, an integral element among Indigenous practices and beliefs. Evidence-based interventions will enhance mental health services through screening tools and mental health intervention models such as Cognitive-Behavioral Health Therapy. Evidence-based practices are established through scientific research to improve mental health outcomes. Comprehensive suicide surveillance will enhance community-based intervention and decrease the rate of acute psychiatric hospitalization located off the Indian reservations. Trauma-Informed Care Approach is used throughout Navajo Area to promote healing and recovery from the effects of trauma throughout one's life. Trauma-Informed Care is a necessity to enhance employee and patient satisfaction rates by addressing historical trauma and its impact on current life experiences within relationships, community, and society. Trauma-informed Care will provide a safe environment to engage in the emotional processing of the COVID-19 pandemic patients and employees, promoting and learning practical coping skills. Trauma-informed Care is essential for Indigenous populations to heal and establish safe environments at home, in the community, and in society. Trauma-informed Care will decrease the stigma associated with mental health. Robust development of tele-behavioral health technology and practice throughout the Navajo Area will significantly improve access to care. The increased use of telemedicine has increased dramatically since the COVID-19 pandemic. The challenge of access to services for patients included unreliable transportation, long-distance traveling to mental health outpatient clinics, and social-economic limitations. Patients with Internet access can mediate these barriers by accessing services through tele-health. Tele-behavioral health is also relied upon for ongoing education and training for professional staff to maintain current competencies for mental health practices. However, the limited capabilities of internet services have created additional

challenges, such as slow internet speed, narrow network towers, abilities, and accessibility to specific applications.

- 3) To strengthen IHS program management and operations.

To strengthen the Navajo Area's behavioral health program and operation, the following approaches to care, Primary Care Behavioral Health and Trauma-Informed Care, and reliable information technology to support the best practice models must be fully realized and integrated to achieve excellence with population behavioral health. In addition, staff must be trained in these best practices to achieve the desired outcomes and to ensure technical support for efficient behavioral health practices. The advent of the COVID-19 pandemic has forced healthcare providers to capitalize on digital technology to reach patients. A 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.

REFERENCE

Agency for Healthcare Research and Quality (AHRQ). (2016). *Trauma-Informed Care*. Retrieved on 01/7/2021 from Website: [Trauma-Informed Care | Agency for Healthcare Research and Quality \(ahrq.gov\)](https://www.ahrq.gov/trauma-informed-care/)

Health Facilities Construction

1. **How the recommended budget increases should be allocated, i.e., why each increase is important and how it will affect certain programs or initiatives. Include any effects of previous years increases. Include any data that highlights effects of previous years increases.**

The Navajo Area is requesting for an increase in funding for the Health Facilities Construction Program major line item account to support, nationally, the Indian Health Service's (IHS) 10 new Inpatient, Outpatient and Small Ambulatory facilities, Staff Quarters Program, Green Infrastructure, Demonstration Projects and the Joint Venture Construction Program planned for construction. Currently five of the facilities on the current five year plan are currently funded for construction. Three of the facilities are currently fully funded for construction.

The Navajo Nation requests the U.S. Congress to continue to support health care facility construction projects, including infrastructure development and the design of Navajo Area's next major project, the Gallup Indian Medical Center replacement facility, Gallup, New Mexico.

Further, Congress is urged to consider appropriation of funding in the estimated amount of \$942 million for the Navajo health

facilities that remain on the IHS Construction Priority List. The planning and construction of projects on the List will elevate the quality of care, 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. Congress is also asked to acknowledge other facility needs and to be cognizant of future Navajo health care facilities, which require expansion, renovation and/or replacement.

The most current IHS Annual Facilities Planning document (Five -Year Plan) lists 10 national projects, including three Navajo health facility projects. The final Program Justification Documents (PJD) and Interim PJDs for the three Navajo projects were approved by the IHS and are listed as follows with estimated funding needs:

PROJECT	ESTIMATED COSTS*	FUNDING NEEDED	ADDED COSTS*
Pueblo Pintado Health Center	\$171,400,000	0	
Bodaway-Gap Health Center	\$ 238,700,000	\$117,500,000	
Gallup Indian Medical Center	\$ 850,500,000	\$824,500,000	\$1 million

*These figures could change based on approved final Project Justification Documents & current construction costs.

The Navajo Area currently has three health facilities (1 inpatient hospital and 2 outpatient clinics) on the national IHS Health Facility Construction Priority List, with a total combined cost estimate of \$1,260,600,000.00 billion. The existing facilities are obsolete with an average age of 50 years and have long surpassed their useful lives. The facilities are grossly undersized for the identified user populations, which has created crowded conditions among staff, patients, and visitors. In many cases, existing services are relocated outside the main health facility. Often to modular office units to provide additional space for medical primary health care and specialty services. Such displacement of medical services creates difficulties for staff and patients and increases wait times, resulting in numerous inefficiencies within the health care system which delays care.

Previous increases in Health Facilities Construction have allowed for the completion of the planning documents for the Pueblo Pintado Health Center and the Bodaway/Gap Health Center which has allowed these projects to move forward to design and construction. Pueblo Pintado Health Center has completed the design of the health facility, with a construction contract projected to be awarded September 2023. The staff quarters design-build contract is projected to be



awarded September 2023. The Bodaway/Gap Health Center has completed planning and a Title V Construction Project Agreement (TVCPA) was awarded to the Tuba City Regional Health Care Corporation on August 18, 2022 for the design. The new Gallup Indian Medical Center is currently completing the planning phase and design projected to start in early FY2024.

As the existing health facilities age, associated building equipment and infrastructure also deteriorate to a point of failure. The decreased availability of replacement parts for aged equipment and infrastructure ultimately disrupt the already limited medical services. For example, piping systems that provide potable water for health services, frequently experience failures, requiring the systems to be shut down for extended periods of time. This often results in discontinuation of patient care until the appropriate repairs are made. The rural and isolated conditions associated with the Navajo Area health facilities complicates the repair of failed systems and extends the time required to make needed repairs. The constant system failures deplete designated maintenance and improvement funds and requires the use of third party collections or other funding sources that would otherwise be used for direct patient care. In terms of medical and laboratory equipment, the Navajo Area makes every attempt to keep pace with changed and modernized technologies; however, due to limited equipment funds, the Navajo Area health facilities will typically use equipment well beyond their expected useful life. The construction of new health facilities alleviates many of the problems associated with failing building systems and equipment, while simultaneously modernizing medical, laboratory and information equipment technologies.

2. Link to Indian Health Care Improvement Act (IHCA) provisions, where applicable.

The budget request is aligned with the provisions of the Indian Health Care Improvement Act (IHCA) (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, resulting in improved lives and health of American Indians/Alaska Natives. In line with the IHICA is the IHS Health Care Priority System that identifies Health Facilities Construction projects for priority inpatient, outpatient, staff quarters development, Joint Venture, and Youth Regional Treatment Centers. Increased funding eliminates deficiencies in health status and health resources, eliminates backlogs in the provision of health care services, and meets the health care needs of people in an efficient and equitable manner.

3. Link to GPRA performance targets and outcomes.

Increased funding for health facilities construction and renovation eliminates incidences of and types of complications resulting from diabetes and other chronic diseases; and capitalizes on community health promotion and disease prevention programs. A dedicated health facility is an organized array of medical services located in an area, and this existing structure with core services and staffing resources permit the identification and implementation of health care measures for monitoring health outcomes, hence monitoring of population health. Where health facilities exist, there is a determined implementation of the mandated GPRA performance targets and better outcomes.

The health facilities in Navajo meet regulatory requirements for safe and quality care as they are the Joint Commission (JC) accredited or Centers for Medicare and Medicaid Services (CMS) certified.

4. Link requests to Indian Health Service 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:

- 1) 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 recruiting and retention of essential staff, ensuring access to needed care and training resources, and maintaining clinical proficiency of professional staff. A new state of the art hospitals, ambulatory care facilities, and new housing can help attract and retain the professional staff needed for our facilities.

- 2) To promote excellence and quality through innovation of the Indian health system into an optimally performing organization; and

Assuring that IHS hospitals and clinics are accredited is a high priority for IHS. Meeting Medicare standards also allows IHS facilities to be reimbursed for all eligible Medicare and Medicaid services. The IHS is working to strengthen organizational capacity to improve our ability 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, and 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 may be heightened at facilities located in rural, remote locations.

In the construction of new hospitals and ambulatory facilities at additional locations can help to address these issues and ensure access to care.

- 3) To strengthen IHS program management and operations.

The Indian Health Care will strengthen the IHS program management and operations by building modern hospitals and ambulatory facilities. Many of the IHS and Tribal health care facilities are operating at or beyond their capacity, and their designs may not be efficient in the context of modern health Care delivery. 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.

Water & Sanitation

1. Discuss how the recommended budget increases should be allocated, i.e., including any effects of previous year's increases and/or include data that highlights those effects.

The Navajo Nation has more than 2,600 existing homes lacking funding for adequate water and sewer facilities. The total Navajo Nation water and sewer economically feasible unmet need is nearly \$75 million. 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. Decreased disease rates reduce medical costs. Therefore, increased funding to address this severe Navajo Nation backlog in sanitation facilities is

requested. The additional resources will reduce the backlog and will also address the need for sanitation facilities for eligible new homes being purchased and constructed annually.

The provision of sanitation facilities is an extension of primary health care delivery. The availability of essential sanitation facilities can be a major factor in breaking the chain of water-borne communicable disease episodes, but by no means is their value limited to disease intervention. Safe drinking water supplies and adequate waste disposal facilities are essential preconditions for most health promotion and disease prevention efforts. Efforts by other public health workers are much more effective when safe water and adequate wastewater disposal systems are in place.

Patients admitted to the hospital have longer lengths of stay when there is a lack of sanitation facilities at the home. For example, an elderly patient recovering from a broken hip will not be discharged when they should 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.

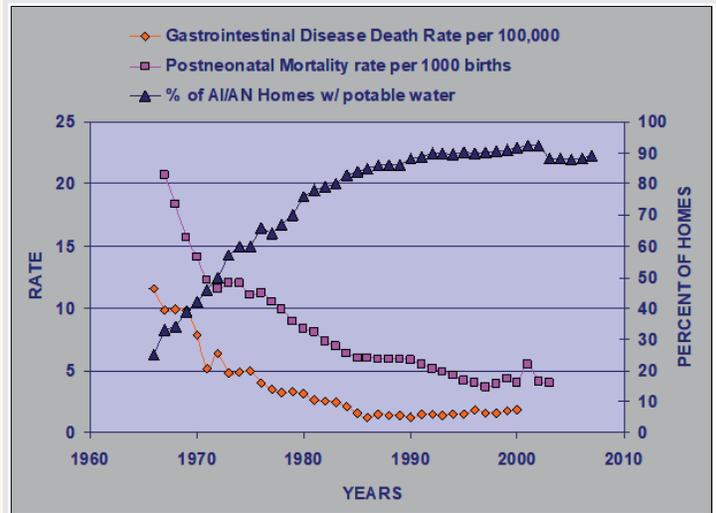
A recent cost benefit analysis indicated that for every dollar IHS spends on sanitation facilities to serve eligible existing homes, at least a twentyfold return in health benefits is achieved. The IHS Sanitation Facilities Construction Program has been the primary provider of these services since 1960.

2. The linkage to IHCIA provision, where applicable.

Provision of safe water and sanitary waste disposal facilities is referenced in 25 U.S.C. § 1632.

3. The linkage 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 existing homes and new and like new homes for Navajo Area is 10,081 homes. Increased water and sewer (P.L. 86-121) funding will allow IHS to provide facilities to more homes thus improving the quality and access to health care as described below.



Graph 1

While 1% of the U.S. general population lacks access to safe water, 9% 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, the current sanitation appropriations are not reducing the backlog. In addition to providing safe sanitation facilities to existing homes, the IHS also provides sanitation facilities to new homes.

4. The linkage to the IHS Strategic Plan.

The goal for providing public health services critical to improve the health of the Navajo Nation is part of IHS' Strategic Plan which includes environmental health 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, reducing project durations. In Calendar Year 2022, Navajo Area's project duration was 4.99 years, which exceeded the national goal of less than 4.0 years.

Hospitals and Health Clinics Prevention Programs (CHR, PHN, & Health Education)

5. Discuss how the recommended budget increases should be allocated, i.e., including any effects of previous year's increases and/or include data that highlights those effects.

Sustained and increased federal investments in Public Health and Disease Prevention are important cost-effective measures



in population health to achieve equity of care, alongside diagnostic and therapeutic care. According to the Navajo Nation Epidemiology Center, 2019, the “Five Year American Community Survey” shows the population of the Navajo Nation is projected to increase in the coming years. The Navajo population on the Navajo Nation reservation has increased by 3% and the Navajo population throughout the United States has increased by 6.6% between 2010 and 2015.⁸² To ensure the Navajo Nation and Navajo Area IHS leaders are prepared to meet the growing demand for preventive and public healthcare needs and their cultural proficiencies, it is essential to increase funding and align and integrate preventive healthcare services with primary, secondary and tertiary medical care services (diagnostic and therapeutic). Intentional efforts and resources must be dedicated to bridge health promotion, disease prevention, and public health with the medical care delivery system to bring about a holistic approach to care and treatment for individuals, families, communities, and tribal nations. Doing so strengthens the overall health performance of the population and decreases health disparities.

The Navajo Area recommends increases to the Community Health Representative (CHR), Public Health Nursing (PHN), and Health Education (HE) Programs’ budget line items to fully provide quality health care, health promotion, disease prevention, and health education services to the Navajo Nation. These patient care services are provided by the Navajo Nation under a P.L. 93-638 contract to improve patient health and care, decrease morbidity and mortality, and reduce health disparities. Increased funding will allow expanded training and practical experiences in health promotion, disease prevention, and public health best practices. Increased funding will support and address disease prevention and public health efforts that address infectious disease, public health emergency preparedness, public health priorities, and individual, family,

and community well-being and safety. Each dollar invested in public health increases the potential for future cost savings in healthcare, given that only \$9.1 million (30%) of the Navajo Department of Health P.L. 93-638 Master Health Contract goes toward treating preventable chronic conditions and public health measures. The Navajo Nation health disparities may be reversed when primary prevention, public health, and health education efforts are fully resourced.

The CHR Program administers health services in remote and desolate areas throughout the Navajo Nation. A CHR is a front-line bi-cultural public health worker who is a trusted member of a care team and is culturally competent in their understanding of the local communities and patients. The program acts as a liaison/advocate for Navajo patients, families, and communities in upholding Navajo holistic healing practices, traditional philosophy of well-being and sickness, value of kinship network system in healing, and appropriate approaches to integrating western medicine with cultural beliefs to bring about healing and well-being. A Community Health Worker (CHW) plays a critical role in the health care delivery system by linking the patient to their local Indian health care system to prevent avoidable hospital readmissions and emergency department visits through home visits to manage and educate the family and patient to his/her chronic health condition.

The Navajo Nation’s Public Health Nursing Program, Kayenta, Arizona strives to give excellent public health nursing care in the following settings: homes, worksites, educational institutions, and community settings like chapter houses, senior citizen centers, and other congregated sites. The Public Health Nursing Program covers a rural geographic area involving 110 Navajo communities across three States. Public Health Nurses are Registered Nurses who educate on diseases/illnesses and management of such, promotion of health and well-being, prevention of diseases, and identification, surveillance and mitigation of contagious disease outbreaks. They are the front-line health care workers who give nursing services, care and treatments in homes and communities, and connect patients with community resources. They assist health care teams with community assessment and planning to prevent, mitigate and combat public health crises and emergencies. Improved funding will increase the number of Public Health Nurses in the Navajo communities to carry out community protection work and emergency readiness work.

The Navajo Nation Health Education Program serves 110 Navajo communities across three states of the Navajo Area geographic region under a Public Law 93-638 contract. Since July 1981, the Health Educators have been the primary vanguards in Navajo communities to respond to public health epidemics and Covid-19 pandemic through health education and practices to prevent and mitigate infection transmission

82 Navajo Nation Epidemiology Center, 2019. Five Year American Community Survey.

and promote physical, psychological and environmental health to prevent diseases. They are the tribal communities' subject matter experts on health promotion and disease prevention to avert premature deaths and disabilities. Increase funding will expand the Health Educators' knowledge and skills through training involving best practices and increase the number of Health Educators in each Navajo communities to protect communities from diseases. Educators are force by digital consumerism to integrate digital communication tools, accessibility, and management of content into their health education platforms and these digital media requirements are costly to the program.

6. The linkage to the Indian Health Care Improvement Act (IHCIA) provisions, where applicable. 25 U.S.C. § 1601. Chapter 18-Indian Health Care.

The FY 2023 budget request is aligned with the provisions of the IHCIA as follow:

- » SUBCHAPTER II-HEALTH SERVICES
 - ▶ 1616f. Tribal culture and history.
 - ▶ 1616p. Health professional chronic shortage demonstration programs.
 - ▶ 1621c. Diabetes prevention, treatment, and control.
 - ▶ 1621b. Health promotion and disease prevention services.
 - ▶ 1621d. Other authority for provision of services.
 - ▶ 1621h. Mental health prevention and treatment services.
 - ▶ 1621k. Coverage of screening mammography.
 - ▶ 1621m. Epidemiology centers.
 - ▶ 1621n. Comprehensive school health education programs.
 - ▶ 1621q. Prevention, control, and elimination of communicable and infectious diseases

7. Link GPRA performance targets and outcomes.

The accomplishments of the Prevention Programs (CHR, PHN, & Health Education) are supported by the IHS GPRA Performance measures outcomes. The Prevention Programs provide public and community health and education outreach in tribal congregated settings such as schools, senior citizens, work-place, chapter houses, etc., in addition to in-home visits, hence the Programs are vital to population health management and outcomes outside a medical facility setting. Example, a significant portion of immunizations are given outside hospitals and clinics environments, usually in communities and in homes, and supported with patient/community education efforts.

Below are the GPRA performance measures results for FY2022. 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%.

8. Link requests to Indian Health Service Strategic Plan.

Prevention Programs (CHR, PHN, & Health Education) contribute to the IHS Strategic Plan by ensuring accessibility to culturally appropriate personal and public health services, accessibility to quality health care services and preventive care services, and strengthening the local Indian health

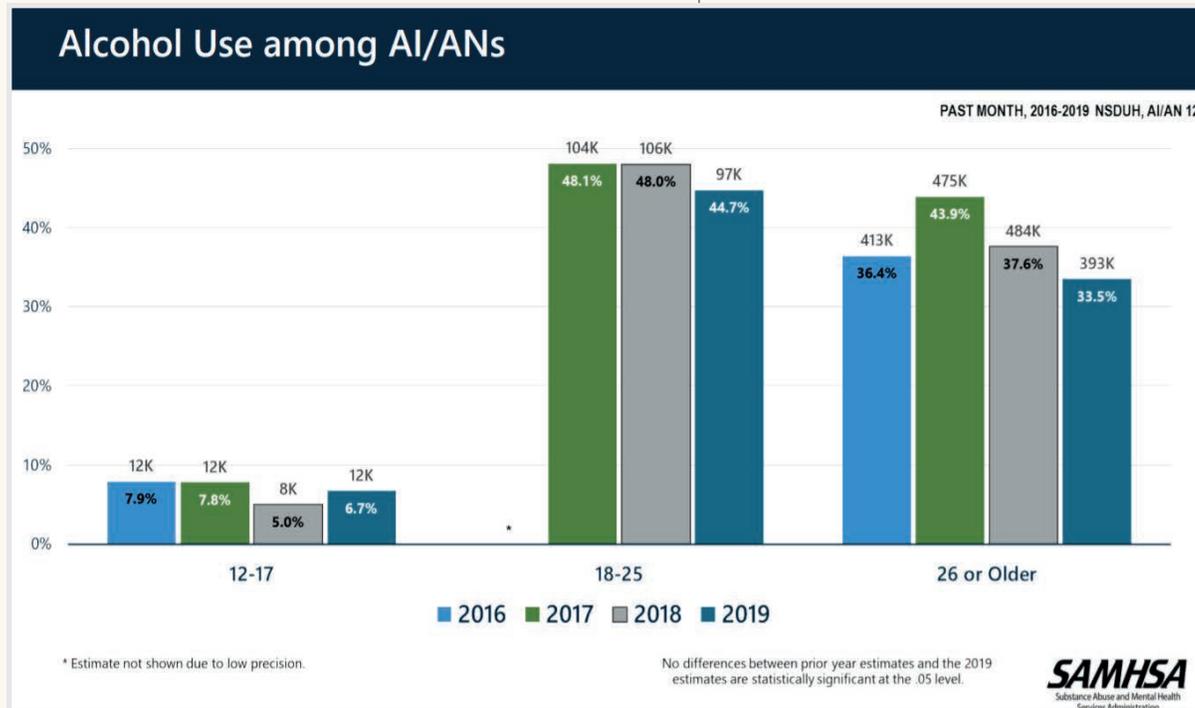
care delivery system’s management and operations to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level.

Alcohol and Substance Abuse

1. How the recommended budget increases should be allocated, i.e., why each growth is essential and how it will affect specific programs or initiatives. Include any effects of previous years’ increases. Include any data that highlights the impact of last year’s gains.

The Navajo Area requests a funding increase to the Alcohol and Substance Abuse major line-item budget category. Alcohol use disorder is a critical public health concern on the Navajo Nation and San Juan Southern Paiute reservation. According to the Substance Abuse Mental Health Services Administration (SAMHSA) (2020) 2019 National Survey on Drugs Use and Health, 10.2% of American Indians/Alaska Natives (AI/AN) have a substance use disorder, and 3.8% of >18-year-old had both substance abuse and mental illness. The alcohol and drug use statistics among AI/AN denote a higher rate than other ethnic groups in the United States, as shown in Figure 1.

Figure 1: Alcohol Use among AI/ANs:



The impact of the Covid-19 pandemic reflects the multifaceted struggles of the Navajo and San Juan Southern Paiute. Arrazola et al. (2020) indicated that AI/AN experience a greater incidence of Covid-19 than among non-Hispanic Whites and reported: “cumulative incidence laboratory-confirmed Covid-19 cases among AI/AN persons was 3.5 times that among White persons.” The previously reported Tribal Consultation Issue Paper indicated the disparities in social, behavioral, and mental health/co-occurring disorders that continue to affect the Navajo population.

The complexities of Covid-19 have strained the Navajo Nation and the San Juan Southern Paiute systems of care with Indian Health Services, 638 Contracted Health Care Corporations

hospitals and clinics, and the Navajo Nation Department of Health programs by creating a greater need to address substance use, mental health, and co-occurring disorder issues with a culturally responsive and spiritual-based approach to address the diverse needs of the population. The Navajo Division of Behavioral and Mental Health Services DBMHS is tasked and committed to developing more residential, detoxification, and transitional housing facilities in Navajo to address substance use, mental health, and co-occurring issues. Due to the increase of clients served, recommendations included for the DBMHS are to seek collaboration with all resources to address the behavioral health, mental health, and co-occurring issues with a holistic, cultural approach; continuing to explore avenues for current and future funding, and to sustain

recruitment and retention of personnel and program initiatives to decrease the socioeconomic effects of Covid-19 on all our communities.

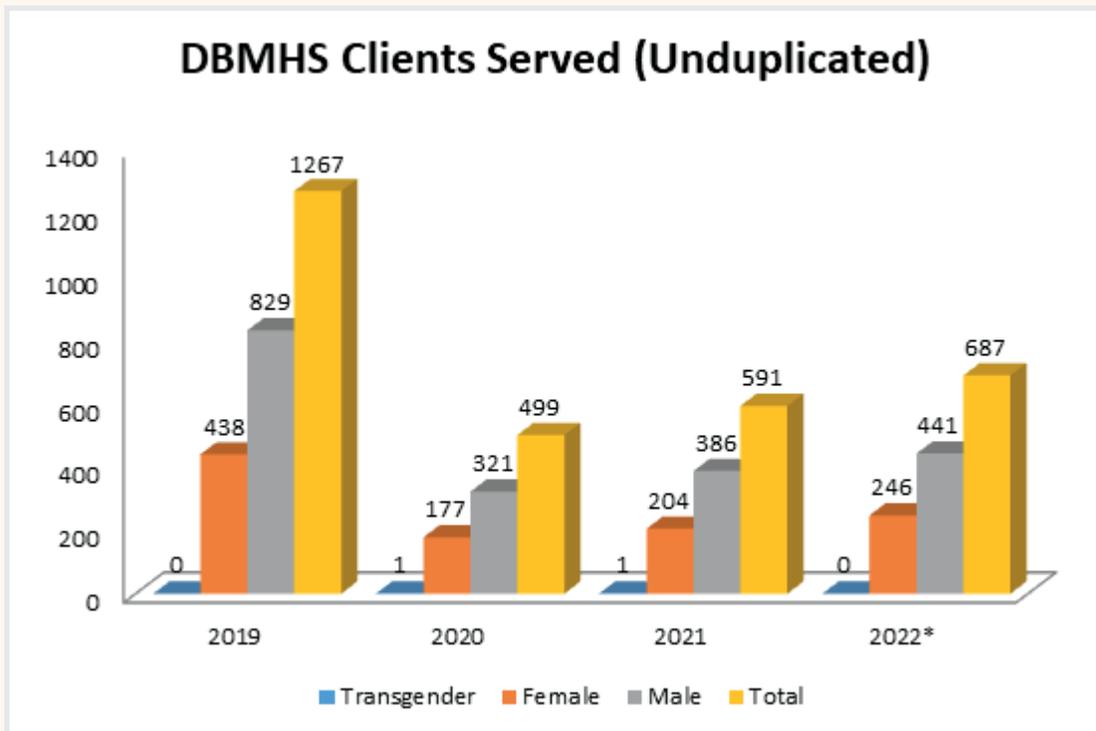
DBMHS has seen a rise in substance use referrals and enrollments from 2021 to 2022 for persons seeking outpatient and residential substance use disorder treatment services, as shown in Table 1.

Table 1: DBMHS Referrals, Enrollments.

Navajo Division of Behavioral and Mental Health Services (1/1/21-12/31/21)					
	Referrals	Active Start	Enrollments	Discharges	Active End
2021	890	614	618	946	286
2022	957	286	644	561	369

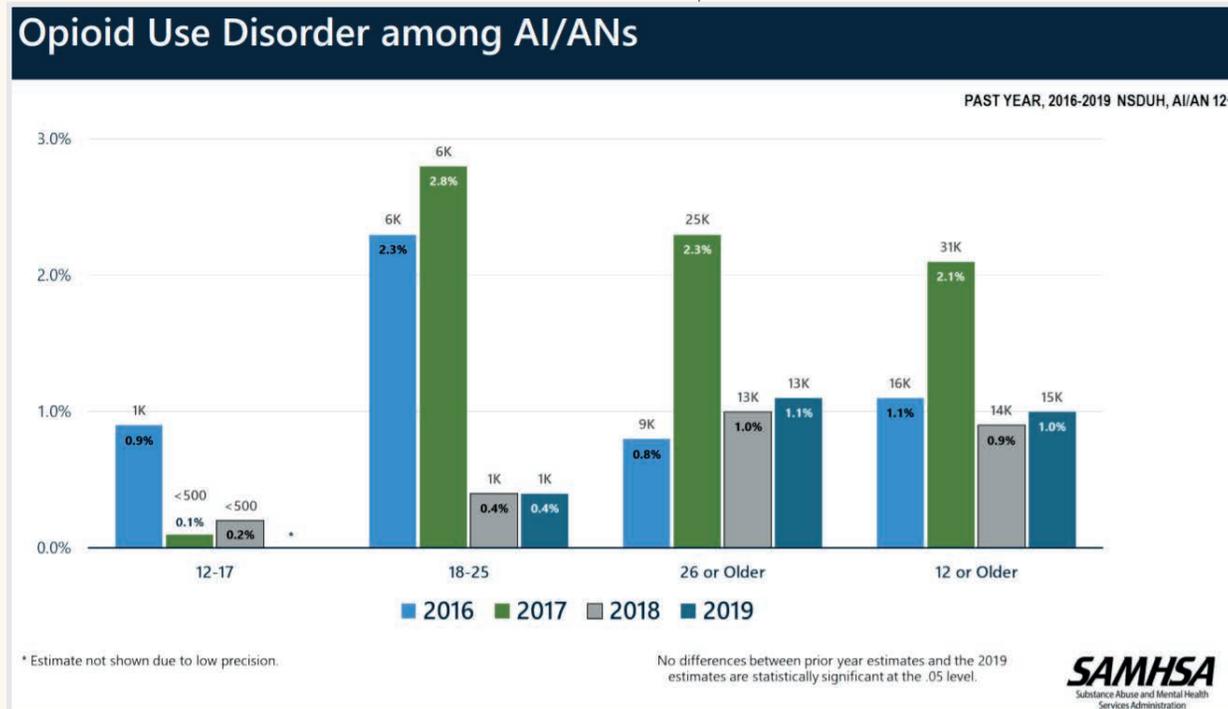
The services provided by DBMHS during the COVID-19 pandemic significantly declined due to the implementation of public health safety measures to prevent the spread of the virus in the Navajo Nation. The Public Health Emergency orders mandated a decrease in face-to-face contact and group gatherings. Therefore, services were minimized and completed in an individualized and group setting conducive to the Public Health Emergency orders. Access to substance abuse services was also achieved through the internet applications such as Zoom and Webex. As shown in Figure 1, in 2019, 1267 individuals were serviced, whereas, in 2021 and 2022, the number of individuals served declined to 591 and 687, respectively. The barriers to access significantly impacted the services; however, the expected increase is projected to substantially increase in substance use disorders, including illicit drug use.

Figure 2: Unduplicated count of services provided through DBMHS.



Opioid abuse intervention is needed on the Navajo and the San Juan Southern Paiute reservations. SAMHSA (2020) reports indicate that AI/ANs have the highest opioid use disorder rates, including past month use at more than three times the rate of any other ethnic group, as shown in Figure 2.

Figure 3: Opioid Use Disorders AI/ANs



Limited substance abuse education and outpatient and inpatient residential services are significant barriers to access to services. Relapse and new onset of substance use have created a substantial influx of emergency use related to alcohol, Methamphetamine, and opioid use and toxicity. The high cost of care for emergency utilization impacts the availability of resources for non-alcohol-related emergency medical conditions. No residential treatment facilities are available to meet the needs of methamphetamine and opioid addiction. All inpatient facilities for substance use disorders are located off the reservations. Step-down and transitional care is not available for substance use disorder patients. Treatment services to address comorbidity are limited due to limited qualified providers specialized in providing services for co-occurring disorders. Tele-psychiatry and behavioral health services are limited because of the frontier and rural areas and minimal access to broadband internet services. Additional support is needed to establish a secure internet and robust Information Technology infrastructure to deliver quality patient care services. Recruitment of qualified substance abuse providers is a barrier to providing quality performance-based care. Recruitment challenges include the inability to offer competitive salaries and a lack of housing.

2. Link to Indian Health Care Improvement Act (IHCA) provisions, where applicable.

25 USC § 1655 (a) Behavioral health prevention and treatment services.

3. 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 2021, Navajo Area did meet the Universal Alcohol Screening target of 39.00%, with Navajo Area’s performance at 39.24%. In 2021, Navajo Area did not meet the SBIRT target of 14.30%, with Navajo Area’s version at 9.03%. In 2020, Navajo Area did not meet the Alcohol Screening target of 42.40%, with Navajo Area’s performance at 41.96%, and Navajo Area did meet its SBIRT target of 15.22% while the national target was 12.20%. During the COVID-19 pandemic in 2020 and 2022, completing the GPRA targets became a challenge due to the closures of health clinics.

4. Link requests to Indian Health Service Strategic Plan.

In the past, increased funding allowed the Navajo Area to meet the Universal Alcohol Screening targets. The effort supports the IHS Strategic Plan 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 healthcare systems through solid partnerships and culturally responsive practices.

The Strategic Plan details how the IHS will achieve its mission through three strategic goals:

- 1) 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 IHS and Navajo Area to meet GPRA targets for Universal Alcohol Screening and, more significantly, use relevant culturally appropriate approaches to screening and care/treatment. The Navajo philosophy of healing and well-being was incorporated into counseling, intervention therapies, and treatments, thereby treating the whole person within a network of relationships. In addition, evidence-based alcohol screening tools were utilized to ensure an appropriate level of intervention and individualized treatment plans. Screening, Brief Intervention, and Referral for Therapy (SBIRT) were implemented in primary care clinics and the emergency departments to improve access to care. The Navajo Area uses the Primary Care Behavioral Health model and Trauma-informed Care Approach. Both have significantly contributed to personal and culturally oriented care. The unitization of telehealth services increased dramatically during the COVID-19 pandemic to ensure patient access to care.

- 2) To promote excellence and quality through innovation of the Indian health system into an optimally performing organization

Significant efforts have been made to integrate mental health and intervention with medical primary care services to support innovation. A collaborative model, the Primary Care Behavioral Health Model, supports the integration above of care activities and the Model also supports population-based care and a holistic approach to care. The Model facilitates early intervention and referral to treatment services. Trauma-Informed Care is being used throughout Navajo Area to promote healing and recovery from the effects of trauma throughout one's life. Cultural sensitivity to historical trauma and the impacts of trauma related to the COVID-19 pandemic require ongoing training for incoming and long-term employees. Robust development of tele-behavioral health technology and practice through the Navajo Area will significantly improve access to

care. The remote and frontier geographical location and the extensive land base of the Navajo reservation are challenges for patients to establish consistent patient care at outpatient behavioral health clinics. Unreliable transportation is a barrier to health care services. Therefore, the use of telemedicine is another option for ongoing patient access. However, digital technology needs to be improved across the reservation to optimize telemedicine practice.

- 3) To strengthen IHS program management and operations.

To strengthen the Navajo Area's behavioral health program and operation, the following approaches to care, Primary Care Behavioral Health and Trauma-Informed Care, and the use of reliable information technology to support the above-mentioned best practice models must be fully realized and integrated to achieve excellence with population-based behavioral health outcomes; In addition, staff must be trained in utilizing these best practices to achieve the desired results and to ensure technical support for efficient behavioral health care practices. A 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. The availability of the latest information technology assures the recruitment and retention of staff and facilitates virtual training to enhance staff development and support best practices.

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Information Technology Infrastructure

1. How the recommended budget increases should be allocated, i.e., why each increase is important and how it will affect certain programs or initiatives. Include any effects of previous years increases. Include any data that highlights effects of previous years increases.

The Navajo Area is requesting an increase in funding for Information Technology (IT) Infrastructure and its components (network equipment, computers, servers, and software programs requirements). The funding to support the IT Program is located under the Hospitals & Health Clinics (H&C) major line item budget account. There is not a separate designated line item account for IT, hence when there are competing needs and priorities, the advancement, and often the sustainability, of an IT program becomes secondary until a failure or immediate threat occurs. The previous H&C funds increases that were specifically earmarked for IT modernization and maintenance have been used accordingly and successfully. The advancement of medicine and patient care procedures and treatment require the interfacing of medical equipment and electronic health records with the latest information technology and network systems which are critical to the operations of hospitals and ambulatory field clinics in the delivery of safe patient care. The current funding appropriations for the H&C line item account does not meet the needs and should be increased with funds earmarked specifically for the continual advancement and maintenance of IT and IT security.

In 2022, the Navajo Area is working to update the IT needs assessment and its 5-year IT plan. The plan reflects IT needs/priorities and associated annual costs to keep current with changing technology and medicine. An IT modernization effort is an intentional investment to keep pace with the latest health care technology by terminating, stabilizing, upgrading and replacing equipment and systems. The modernization plan has a strong focus on IT Security compliance and a 4-year life cycle replacements of IT equipment, periodic upgrades of software programs and 2 to 3 years replacements or upgrades of network systems to keep abreast of advancing security requirements 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 has expanded and continues to improve the use of tele-medicine/health and tele-behavioral health technologies to prevent disruption of patient care services, with a significant focus on the high risk and elderly populations. The use of these digital technologies support prevention and mitigation of Covid-19 virus exposure. With the

growth of tele-medicine, the healthcare facilities' bandwidth capacities, transmission speeds and accessibility to information require annual quality and risk evaluations and associated costs for upgrades and replacements. In a digital environment, bandwidth and internet are considered crucial.

Telemedicine is here to stay and bandwidth and internet speed and availability are indispensable for medical providers and their patients. The current funding for IT is not sufficient to cover upgrades and enhancements to meet the needs of the Navajo Area healthcare facilities. The Navajo Area's IT Modernization Plan's investments target the next 3 years in core healthcare infrastructure development and maintenance: Patient Care Medical Home (PCMH) model, cloud computing, and Wide Local Area Network (WLAN), wireless voice and radio services. The 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 of care for real time and almost real-time medical information accessibility to care for and manage the patient. As the digital environment evolves, the hybrid and cloud services will progress to a comprehensive delivery of computing services over the internet – and health care information computing will be part of this advancement and healthcare facilities will need to be prepared to use this platform as part of their daily business practices. Telemedicine practice will double in the next two years, becoming a mainstay of a provider's clinical practice.

With the advent of COVID-19 pandemic and possible future pandemics and endemics, healthcare facilities will need to be well organized and prepared to maximize their WLAN, wireless voice, and radio services with their local partners such as counties, states, tribes, federal and others, i.e., first responders, emergency disaster teams, schools, police, other medical facilities, etc. Delivery of electronic health information to the point of care and across networks of partners is highly dependent on a reliable IT infrastructure.

Information Technology Disaster Recovery Plan (ITDRP) and Continuing of Operations Planning (COOP) is a fundamentally sound process for any IT Infrastructure and Navajo Area IT needs to bring this to the forefront of these budgetary items. In the last 4 months Gallup suffered 8 outages in the last 4 years and in recent months NAO just experienced an outage that proved problematic for our IT infrastructure. In recent weeks Navajo Area HC's suffered outages that lasted numerous business days thereby having a significant impact on direct patient care. Getting IT Services back up immediately is paramount to our IT investment as delays in power and network

services have proven to be costly and have impacted direct patient care as providers have spent long hours in workarounds just to get services in their respective sites operational. NAV IT is charged to deliver a sound ITDRP and COOP that will work in conjunction with OIT to assist at the SU and HC across Navajo Area.

The Navajo Area’s IT infrastructure needs, annually for Fiscal Years, 2024, 2025, 2026, 2027, and 2028.

Summary of Spending	FY2019 Planned Total Costs	FY2020 Planned Total Costs	FY2021 Planned Total Cost	FY2022 Planned Total Cost	FY2023 Planned Total Cost
FTE & Contract Costs Total	\$9,402,585.00	\$9,547,057.00	\$8,416,966.00	\$8,574,017.00	\$8,717,498.00
Hardware Replacement Total	\$12,935,005.00	\$12,734,158.00	\$7,647,922.00	\$8,389,974.00	\$8,850,814.00
Software Total	\$3,413,894.11	\$1,948,354.04	\$2,036,666.04	\$2,107,772.04	\$2,211,416.04
Planned Project Total	\$10,114,496.00	\$6,962,381.00	\$3,965,059.00	\$5,106,822.00	\$5,062,980.00
Planned Cloud Projects Total	\$210,000.00	\$0.00	\$8,500.00	\$0.00	\$470,000.00
Total Area IT Spending	\$36,075,980.11	\$31,191,950.04	\$22,075,113.04	\$24,178,585.04	\$25,312,708.04

2. Link to Indian Health Care Improvement Act (IHCA) provisions, where applicable.

- » SUBCHAPTER I-INDIAN HEALTH PROFESSIONAL PERSONNEL
 - ▶ 1616b Recruitment activities.
 - ▶ 1616c Tribal recruitment and retention program
 - ▶ Tribal health program administration.
- » SUBCHAPTER II-HEALTH SERVICES
 - ▶ 1621c. Diabetes prevention, treatment, and control.
 - ▶ 1621d. Other authority for provision of services.
 - ▶ 1621h. Mental health prevention and treatment services.
 - ▶ 1621k. Coverage of screening mammography.
 - ▶ 1621m. Epidemiology centers.
 - ▶ 1621n. Comprehensive school health education programs.
 - ▶ 1621q. Prevention, control, and elimination of communicable and infectious diseases.
- » SUBCHAPTER III-HEALTH FACILITIES
 - ▶ 1638c. Contracts for personal services in Indian Health Service facilities.
 - ▶ 1638e. Other funding, equipment, and supplies for facilities.
- » SUBCHAPTER V-ORGANIZATIONAL IMPROVEMENTS
 - ▶ 1662. Automated management information system.

3. Link to GPRA performance targets and outcomes.

The data entry, collection, and profiling of GPRA data is entirely dependent on a modern IT and its electronic health records system.

4. Link requests to Indian Health Service Strategic Plan.

The IT budget priority is in line with the modernization of the 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:

- 1) 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.

- 2) To promote excellence and quality through innovation of the Indian health system into an optimally performing organization; and

Obsolete and outdated IT systems will be replaced with current technologies that support organizational excellence and quality and fosters innovation.

- 3) To strengthen IHS program management and operations.

To strengthen IHS programs management and operations, a healthcare facility's IT infrastructure and equipment must be advanced and reliable or trustworthy to handle the volume and complexity of a digital work environment and protects patient privacy and confidentiality of health records. The technology is seamlessly integrated with appropriate medical and non-clinical equipment, health devices, work computers, and digital platforms. The technology is 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.

To develop a sound IT DRP in conjunction with a viable dependable business continuity plan where IHS Navajo Area initiatives, priorities, and recovery time objectives for information technology are developed and enhanced according a viable business impact analysis with the firm goal in restoration of hardware, applications and data in time to meet the needs of the Navajo Area IHS recovery processes.

Maintenance & Improvement

- 1. How the recommended budget increases should be allocated, i.e., why each increase is important and how it will affect certain programs or initiatives. Include any effects of previous years increases. Include any data that highlights effects of previous years increases.**

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 to support the operation of health care facilities to accomplish its ultimate goal of the delivery of health care. Previous M&I funds increases were used for maintenance, repair, and improvement of physical plant (buildings), utility systems (exterior and interior), clinical equipment (medical and often non-medical, grounds, roads, parking lots, and building service equipment systems that provide the physical environment for patient care. Organizing these engineering related services include assessing the structure, utilities, and equipment, designing modifications, preparing engineering drawings and specifications for repairs

and improvements, and troubleshooting major components or system failures. The funds are also responsible for the realty, and facilities environmental programs that support patient care activities.

Furthermore, the IHS maintains government owned/leased buildings whether operated by the Indian Health Service (IHS) or Tribal health programs pursuant to contract or compact arrangements executed under the provisions of the Indian Self Determination and Education Assistance Act (P.L. 93-638). The IHS also provides funding to tribally owned/leased buildings containing health programs pursuant to contract or compact arrangements executed under the provision of the Indian Self Determination and Education Act (P.L. 93-638).

Increased M&I funds will be used to enhance the M&I Program objectives as follow: providing routine maintenance for facilities, achieving compliance with buildings and grounds accreditation standards of The Joint Commission (TJC) or 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 functional health care facilities that meet building/life safety codes, conform to laws and regulations and satisfy accreditation standards. The M&I appropriation has historically been underfunded. The amount of funding historically provided was adequate to fund at the level of sustainment. Sustainment is activities conducted to keep the buildings in their current condition. This is only to keep the building in their current condition with no replacement or upgrades of building infrastructure. In FY2022 the IHS received \$169.664 million M&I funding, which is beyond the amount required for sustainment. The M&I funds are Routine M&I (UOF) \$87.8M, Environmental/Demolition Projects \$3.5M and Backlog of Essential Maintenance, Alteration, and Repair (BEMAR) \$78.364M. The Navajo Area requests these levels be maintained, as it is needed to address the Backlog of Essential Maintenance, Alternation, and Repair (BEMAR). There is an IHS required report on the current backlog, which now totals approximately \$1,226,717,744.00.

The Navajo Area currently has a BEMAR need of \$255,569,527.00. Included in this need is \$60,043,740.00 of mechanical BEMAR. The current HVAC systems in our health facilities are old and need of replacement. A majority of the HVAC units were installed when each facility was originally built. The Navajo Area healthcare facilities age range from 7 years to 61 years. The oldest facility being our largest facility, the Gallup Indian Medical Center (GIMC).

The COVID-19 pandemic brought to the forefront the problems with the antiquated undersized equipment. Data shows that improving indoor ventilation can reduce the risk of virus transmission. These systems could not be modified or expanded to meet the American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) requirements for air changes. The increased funding will help reduce the mechanical BEMAR of \$60,043,740.00.

The increased in M&I funds will incrementally improve the IHS capability to meet sustainment and repair/replace/improve existing infrastructure and building equipment for each health facility. Though we are above M&I sustainment levels our plant replacement value is increasing more than two times our M&I funding level. This increase will help IHS and Tribal facilities to maintain, improve the condition index, and meet accreditation requirements of these facilities.

2. Link to Indian Health Care Improvement Act (IHCA) provisions.

CHAPTER 18 – INDIAN HEALTH CARE GENERAL PROVISIONS SEC.

» § 1602. Declaration of national Indian health policy

SUBCHAPTER II – HEALTH SERVICES

» § 1621. Indian Health Care Improvement Fund

(a) Use of funds

(j) Maintenance and Improvement

» § 1638a. Tribal management of federally owned quarters

» § 1638f. Indian country modular component facilities demonstration program

» § 1638g. Mobile health stations demonstration program

SUBCHAPTER IV – HEALTH SERVICES FOR URBAN INDIANS

» § 1656. Other contract and grant requirements

» § 1659. Facilities renovation.

» § 1660g. Use of Federal Government facilities and sources of supply

SUBCHAPTER V – ORGANIZATIONAL IMPROVEMENTS

» § 1661. Establishment of the Indian Health Service as an agency of the Public Health Service

SUBCHAPTER VI - MISCELLANEOUS

» § 1674. Leases with Indian tribes

» § 1680a. Contract health facilities

» § 1680h. Demonstration projects for tribal management of health care services

3. Link to GPRA performance targets and outcomes.



The increase of Maintenance & Improvement dollars will allow the IHS to keep all existing health care facilities operational and meeting Accreditation standards. Given there are few opportunities to replace healthcare facilities, maintaining current facilities is imperative. This will allow the IHS, Tribes and Tribal Organizations to continue to provide health care and to increase and improve the health care of the Native American and Alaska Native People. This will allow the IHS to continue to provide health care and meet the GPRA performance targets and outcomes.

4. Link requests to Indian Health Service Strategic Plan.

The Strategic Plan details how the IHS will achieve its mission through three strategic goals:

- 1) 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. A place where buildings, utility systems, medical equipment, etc. are not constantly breaking down due to aging and lack of parts to make repairs. Funding increase for the Maintenance & Improvement Program will support the operation of health care facilities, i.e., maintenance, repair, and improvement of physical plant (buildings), utility systems (exterior and interior), clinical equipment (medical and often non-medical, grounds, roads and parking lots, and building service equipment systems.

- 2) To promote excellence and quality through innovation of the Indian health system into an optimally performing organization; and



To promote excellence and quality through innovation requires daily safe and optimal functioning buildings, utility systems, grounds, roads, and parking lots, and clinical equipment. The Navajo Area's highest priority is assuring that hospitals and clinics are accredited. Accreditation is a display of quality and safe patient care which involves buildings, utilities, medical equipment, and other physical and structural conditions of hospitals and ambulatory clinics. Increased funding of the Maintenance & Improvement Program will not only permit compliance with accreditation standards, but also move towards decreasing the Backlog of Essential Maintenance, Alternation, and Repair (BEMAR) projects. Decreasing the BEMAR projects backlog allows organized M&I projects planning to prevent and mitigate risks involving healthcare buildings, utility systems, clinical equipment, etc. over frequent reactive responses to break downs of buildings, utility systems, clinical equipment, etc. These break downs repeatedly disrupt and interfere with health care delivery creating frustration and stress of staff and patients. For people to be innovative, they need a safe place to work.

3) To strengthen IHS program management and operations.

To strengthen IHS program management and operations increased funding for the Maintenance & Improvement Program is critical as many of Navajo Area's hospitals and freestanding ambulatory facilities are aged/aging. Many of the existing facilities and building systems are obsolete with an average age of 48 years and have long surpassed their useful lives. The age of building systems make preventative maintenance more intense, increased routine maintenance, and repairs more frequent. Many clinical equipment are aged beyond their useful lives and continue to be used for patient care due to no other alternatives. As the existing health facilities age, associated building equipment and infrastructure also deteriorate to a point of failure. The decreased availability of replacement parts for aged equipment and infrastructure ultimately disrupt the already limited medical service and funds. The constant system failures deplete designated maintenance and improvement funds and requires the use of third

party collections funds that would otherwise be used for direct patient care. The strength of a healthcare system requires reliable buildings, mechanical infrastructure, clinical equipment and so forth, free from breakdowns, disruptions and risks to patient care and staff, and threat to accreditation compliance. The strength of an organization involves retaining and recruiting of staff into a safe environment.

Hospitals and Health Clinics

1. How the recommended budget increases should be allocated, i.e., why each increase is important and how it will affect certain programs or initiatives. Include any effects of previous years increases. Include any data that highlights effects of previous years increases.

The Navajo Area requests funding increase to the Hospitals and Health Clinics (H&C) Program major line item account as the 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 targets health conditions disproportionately affecting members of the Navajo Nation and San Juan Southern Paiute Tribe such as diabetes, maternal and child health, and communicable diseases including influenza, human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS), hepatitis, and Covid-19. The federally-operated healthcare facilities in the five Navajo Area Service Units serve 67.8 percent of the Area User Population while the tribally-operated healthcare facilities serve 32 percent of the Area User Population. Resources under the H&C budget category are distributed to and supports all healthcare delivery stakeholders in the Navajo Area, including PL 93-638 Indian self-determination contracts and tribal self-governance compacts.

Increased funding for the H&C budget category will support increasing population growth and increasing life expectancy where elders with chronic health conditions will drive 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 the continued efforts to modernize health Information Technology systems and infrastructure across the Navajo Area. A modern Information Technology will allow full integration of tele-medicine into routine clinical practice. Increased

funding will support a robust public health infrastructure of effective response, recovery, and prevention for ongoing COVID-19 pandemic crises and other unforeseeable emerging challenges from infectious disease outbreaks, disasters from climate changes, and environmental hazards from industrial contaminates, etc. Increased funding will develop a centralized epidemiology program which provides uniformity in health data management and reporting, optimize data sharing, and use data analytics for public health, reducing health risks and population-based health planning. The H&C budget category is a catch all budget for hospital and ambulatory health care operations, hence a default to budget when other funds are unavailable to support health care operations.

Past funding increases allowed a proactive response to the COVID-19 pandemic by redirecting existing resources to infection control/surveillance and contact tracing, support patient isolation and quarantine, purchase and maintain adequate supply level of Personal Protective Equipment, medical supplies and medicines, and upgrade and expand several computer and telecommunication technologies to support tele-medicine by ensuring a smooth flow of information and images between providers (internal and external), and support staff telework. Past funding increases established COVID-19 testing sites and vaccinations sites. Past funding increases allowed the standing up of the Area's and Service Units' Emergency Management Operation Centers. Past funding increases permitted funds to pay for overtime and hiring of temporary staff (federal and contractors) to fulfill federal permanent hires staff shortages. Past funding allowed the Navajo Area to meet a significant number of the GPRA performance targets and outcomes, however this changed with the onset of COVID-19 where less performance targets were met in 2021 and 2022. The Navajo Area's healthcare delivery system changed focus from chronic health care management and preventive medicine to crises or emergency health management while responding to COVID-19 pandemic. Past funding allowed the implementation and designation of Primary Care Medical Home Model (PCMH) across the Area, along with Trauma-informed Care Approach to behavioral health care. Past funding allowed continue accreditation and certification by The Joint Commission and Centers for Medicaid & Medicare, respectively. State certifications for Levels III and IV trauma center designations for three hospitals were also supported by past funding increases.

2. Link to Indian Health Care Improvement Act (IHCA) provisions.

- » SUBCHAPTER I-INDIAN HEALTH PROFESSIONAL PERSONNEL
 - ▶ 1616b Recruitment activities.
 - ▶ 1616c Tribal recruitment and retention program
 - ▶ Tribal health program administration.

- » SUBCHAPTER II-HEALTH SERVICES
 - ▶ 1621c. Diabetes prevention, treatment, and control.
 - ▶ 1621d. Other authority for provision of services.
 - ▶ 1621h. Mental health prevention and treatment services.
 - ▶ 1621k. Coverage of screening mammography.
 - ▶ 1621m. Epidemiology centers.
 - ▶ 1621n. Comprehensive school health education programs.
 - ▶ 1621q. Prevention, control, and elimination of communicable and infectious diseases.
- » SUBCHAPTER III-HEALTH FACILITIES
 - ▶ 1638c. Contracts for personal services in Indian Health Service facilities.
 - ▶ 1638e. Other funding, equipment, and supplies for facilities.
- » SUBCHAPTER III A-ACCESS TO HEALTH SERVICES
 - ▶ 1647b. Access to Federal insurances.
- » SUBCHAPTER V-ORGANIZATIONAL IMPROVEMENTS
 - ▶ 1662. Automated management information system.
- » SUBCHAPTER VI-MISCELLANEOUS
 - ▶ 1677. Nuclear resources development health hazards.
 - ▶ 1680d. Infant and maternal mortality: fetal alcohol syndrome.
 - ▶ 1680q. Prescription drug monitoring.

3. Link to GPRA performance targets and outcomes.

During FY2022, Navajo Area made improvements to meet targets in several GPRA performance measures compared to FY2021. As pandemic efforts declined, the Navajo Area opened majority of patient services and continued to address GPRA performance measures.

Below are the GPRA performance measures results for FY2022. 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 glycemc 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%.

4. The Link requests to Indian Health Service 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:

- 1) To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people;

The H&C funds ensure comprehensive, culturally appropriate personal and public health services are available and accessible to patients across the Navajo Area. The 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 and improve positive health outcomes. One of the factors that drives positive health outcomes is a commitment to increasing access to care for the population. Continual H&C funds facilitate health services availability and the Navajo Area strives to ensure services are relevant and effective to allow patients, families, and communities to gain access to care. The Area has implemented the Primary Care Medical Home model, Primary Care Behavioral Health model, and Trauma-informed Care Approach to support integration of physical and mental health care and combining these models with the Navajo philosophy of healing, well-being, and health, hence developing a culturally appropriate holistic approach to healing and well-being.

- 2) To promote excellence and quality through innovation of the Indian health system into an optimally performing organization; and

The Navajo Area's highest priority is sustaining hospital accreditation and certification by The Joint Commission and Centers for Medicare & Medicaid, respectively. Accreditation is a mark of excellence and quality. The Navajo Area is facing numerous complex challenges including funds shortfalls, competing, nationally, for professional health care workers, aging facilities, and COVID-19 pandemic, and incredibly, the Area continues to be innovative in maintaining hospital accreditation/certification, sustaining State certifications for Levels III and IV trauma center designations, implementing best practices models of Primary Care Medical Home, Primary Care Behavioral Health and Trauma-informed Care Approach, keeping aging facilities repaired for patient care services, and an effective immediate and far reaching response to COVID-19 pandemic. The people who manage the Area's healthcare delivery system and those who deliver health care are to be commended for their dedication and innovative spirit in excelling health care in Navajo.

- 3) To strengthen IHS program management and operations.

Increased H&C funds will continue to strengthen the Navajo Area's healthcare delivery system. The strength of a healthcare system requires reliable recurring funds that keep current with advancing information technologies, biomedical equipment technologies, building codes, competitive salaries and benefits, and a robust population health data collection and

management system. The strength of an organization involves retaining and recruiting of talented staff into a safe environment and who have access to the latest technologies and clinical practices and processes available in the healthcare industry.

Urban Indian Health Facilities

1. How the recommended budget increases should be allocated, i.e., why each increase is important and how it will affect certain programs or initiatives. Include any effects of previous years increases. Include any data that highlights effects of previous years increases.

The Native Americans for Community Action, Inc. (NACA), located in Flagstaff, AZ, is one of 41 Urban Indian Health Programs (UIHP) serving the Urban Indian population. Urban Indians refer to American Indian/Alaska Native (AI/AN) individuals who are not living on a reservation, either permanently or temporarily, often because of the federal government's forced relocation policy or lack of economic opportunity. According to the 1990 U.S. Census, 62% of all AI/ANs reside off-reservation. The 1994 Census identified 1.3 million or 58% residing in urban areas. NACA was established as a 501C (3) nonprofit organization in 1971. NACA provides services to approximately 6,000 AI/ANs. These services include Primary Health Care, Behavioral Health, Health Promotion, Suicide Prevention, Alcohol/Substance Abuse Prevention, Workforce Investment, and others. Social services offered include rent, utility, funeral assistance, etc. NACA also has an economic development program called the Overlook program where Native American artists sell their arts and crafts to tourists through an agreement with the U.S. Forest Service (USFS) and as a result produces revenues for both NACA and the artisans.

Currently, NACA leases space for their programs in a central shopping center plaza comprised of 16 suites. Any facility improvements are financed by NACA including all of the recent Covid-19 renovations that needed to be completed.

Infrastructure is a problem not only faced by NACA but other UIHPs as well. Many UIHPs are housed in outdated facilities, do not own the facilities, and encounter liability issues. If NACA could utilize the IHS funding it receives for Leasehold Improvements, then it could better manage its limited resources and capital on other necessary items. NACA's financial position could improve if leasehold capital projects could be completed using IHS funding, this in turn would allow the organization to build its financial reserves for a possible property ownership in the future. This is a benefit not only to NACA but just ownership in general.

Currently, there is no UIHP line item for leasehold improvements. The current structure does not allow for growth and improvements, unless the facility is JCAHO accredited, which is difficult to do when there is an older facility out of compliance. For the 70 percent of the AI/ANs who reside in an urban setting, this is not advantageous or economical. Many of the IHS service areas have identified facility construction as one of the top funding issues, from Alaska's "Small Ambulatory Grants Program (SAP) to Nashville Area's recommendations for increased funding for both Maintenance and Improvements and construction funding to support critical maintenance and construction needs.

Approximately 5% of the U.S. annual health expenditures are investments in health care facility construction. In 2018, that \$158-billion-dollar investment in health care facility constructions equaled \$574 per capita, compared with IHS health care facility (non-Urban Centers) construction appropriation of \$77 million, equally \$35 per AI capita. The nation invests over 10 times the amount per capita that it appropriates to IHS facility construction. Equipment replacement is another infrastructure expense for NACA. NACA must balance the needs for available capital for leasehold improvements and necessary medical equipment.

2. Link to IHCIA provisions, where applicable.

In regard to the IHCIA provisions, IHCIA does not contain provisions for facility construction funding for UIHPs. Per Title 25 U.S.C, Chapter 18, Subchapter IV. Sec 1659; Facilities Renovation; "The Secretary may make funds available to grant recipients for minor renovations to facilities, or construction or expansion of facilities in meeting or maintaining the JCAHO for Accreditation standards." The ability to make leasehold improvements will enhance and ensure maintenance of accreditation and greatly improve the chances of attaining accreditation for those UIHPs seeking accreditation. One of NACA's goals is to obtain AAAHC accreditation. One of the obstacles has been ensuring the facility meets accreditation standards. For example, in 2019, NACA finally was able to modify its entrance/exit to the health center to become ADA compliant. UIHPs with multiple locations also incur additional basic operating costs, electrical, HVAC and other expenses associated with administering multiple locations. Having leasehold improvement funding will ensure that UIHP facilities meet accreditation standards as well as utilize operating funds much more efficiently.

Access to and continuity of health care and other critical services for AI/ANs will be improved by having adequately sized and equipped facilities. Some of the UIHPs have outgrown their space and lack the resources to expand to meet demand for services, while some have facilities in need of major renovations and repair. For other UIHPs, gentrification has displaced

Urban Indian communities to other neighborhoods leading to transportation challenges for AI patients. To meet patient care goals, many UIHP's have largely self-financed the necessary relocation, modernization and facility expansion costs.

The IHCA, as amended in 2010, specifically states the policy of the Federal government is "to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy". The 2010 United States Census reported that 78% of the 5.2 million American Indians and Alaska Natives reside in urban areas. Historically however, less than 1% of the funding provided by the Federal government for health care services for AI/AN goes to funding for services at UIHP facilities.

The Urban Indian population experiences greater rates of substance abuse, chronic disease, infant mortality, and suicide as compared to all ethnicities from the same Metropolitan Statistical Areas (MSAs). UIHPs have an important role in the safety net and attract a disproportionate share of those without any other resources. In the IHS Office of Urban Indian Health Programs (UIHPs) Strategic Plan for 2019-2023, the number one goal is "To support currently IHS-funded UIHPs in their efforts to address the key challenges they identified for improving and expanding their capacity to provide access to quality, culturally competent health services for urban Indians." This goal is in line with the IHCA provisions as set forth in the amended version.

In regard to the IHS priorities, investment in the necessary resources and infrastructure to sustain urban programs is one of the most essential priorities. Investing in leasehold improvements and capital improvement programs will positively impact the recruitment and retention of a dedicated workforce and allow for improved patient care and quality measures as well as foster local partnerships through contractual arrangements for health care delivery. The proposed funding allocations will have a tremendous impact on the ability of Urban Indian Health Programs to enhance and surpass current levels of healthcare by increasing appropriations required to meet the health care and other needs of the AI/AN population residing in urban areas. Services that are only available at IHS tertiary facilities need to be reallocated to where the majority of the patient population resides. Moving diagnostic and screening services closer to the urban centers will allow more AI/ANs to take advantage of preventative services and care that is otherwise difficult to obtain.

3. Link to GPRA performance targets and outcomes.

The allowance for Urban Indian Health Programs to utilize their IHS funding for leasehold improvements, facility renovations, and capital improvements will have a significant impact towards elevating and reaching GPRA measures.

With improvements in clinical operational design and facility investment and expansion, barriers for urban AI patients can be addressed and the investment in the future of UIHPs will contribute to achieving the IHS mission of raising the physical, mental, social and spiritual health of American Indians and Alaska Natives to the highest degree.

4. Link requests to Indian Health Service Strategic Plan.

Investment in the necessary resources to strengthen the infrastructure of Urban Indian health programs through facility renovation, expansion, and overall capital improvements will benefit the individuals served by UIHPs through the recruitment and retention of a dedicated workforce, improved patient care and quality of care, and strengthening of local partnerships through contracted arrangements for health care delivery.

The proposed funding allocations for UIHPs in the FY 2025 budget will have a tremendous impact on the ability of UIHPs to enhance and surpass current levels of healthcare by allowing funding required to take care of 70% of the AI/AN population in urban areas.

Hospitals and Health Clinics - Public Health Infrastructure

1. How the recommended budget increases should be allocated, i.e., why each increase is important and how it will affect certain programs or initiatives. Include any effects of previous years increases. Include any data that highlights effects of previous years' increases.

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, including building and sustaining essential Public Health Infrastructure. There is not a separate Public Health and Preventive Health Services budget, hence these functions are supported by the H&C budget category. Hospital and Clinic funds allow for more flexibility to address public health services at every level of patient care and most importantly Tribal epidemiology centers. The priority of the Navajo Area is to strengthen public health programs, community partnerships and planning, health promotion, and epidemiology. This will support development and implementation of an effective surveillance, response, recovery, and prevention for ongoing and emerging health challenges – including infectious disease outbreaks, chronic illnesses like diabetes, heart disease, cancer, injuries, violence, mental health, behavioral health and environmental issues like access to safe water and uranium exposure.

The ongoing COVID-19 pandemic continues to address the importance for coordinated, data-driven programs, systems and responses to public health crises, as well as the effectiveness of working together with communities and across a healthcare delivery system. During the pandemic, staff members were pulled from ongoing clinical and public health activities to focus on crisis response, leading to delays in patient care. Adequate staffing to address a pandemic will require investments in training and a robust public health emergency response within and outside health facilities.

During the pandemic, public health was addressed by federal health facilities, Tribal health facilities, Tribal programs, and the Urban health program. The overall workforce capacity of the public health system includes limited professionals that has traditionally evolved from public health service through Indian Health Service such as public health nurses, community health representatives, and preventive health programs; however, this is now outdated and requires us to strengthen the existing system by including expanded public health positions. An enhanced public health system will address the following:

- » Surveillance (reporting, data collection, monitoring, tracking, data repository) – monitoring and tracking health outcomes requires an information technology platform that is capable of data sharing, data exchange, data security, and data storage across partners. The health facilities and the Navajo Epidemiology Center must build the capacity to share and report data to address real-time health gaps and needs. For example, suicide surveillance is an ongoing challenge over a decade ago, without the staffing and structure it will remain a challenge in saving lives.
- » Public health research – research has traditionally been conducted within health facilities and through university's; however, evaluation of program outcomes must be expanded to strengthen the public health system as many of the collaborations were not aligned before. Allocation of additional funds will provide opportunities for innovative approaches in using strategies from the COVID pandemic. The response to the pandemic showed us that through collaborations and problem solving together can result in improved decision-making and health outcomes.
- » Tribal capacity building, including public health accreditation – public health infrastructure is not entirely defined in Indian Country. As a result of COVID, there is a new focus on public health infrastructure by the Biden Administration. In the Navajo Area, health facilities and tribal government understand the need to encourage tribal sovereignty and a strong collaboration to address care coordination and outreach to address public health issues in the community. With this in mind, the Indian Health Service can provide better support in improving the public health skills and needs to become accredited as a health department.

- » Community assessments and surveys to identify health issues – Tribal epidemiology centers have not experienced an increase in funding for several years until the pandemic, ongoing needs to conduct community assessments and surveys are valuable in determining public health program activities. Funding for staffing and information technology to assist in collecting, analyzing, and reporting assessment or survey results is still needed beyond current funding levels.

During the pandemic, public health professionals worked together to create cluster investigation processes, community safety guidelines, resources for families (e.g., food boxes and isolation kits) to allow the family to stay home and recover. Public health professionals continue to respond and pivot 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 and having the funding to bring in more professionals to respond, train, and prepare for future pandemics and prevention initiatives are essential for the public health infrastructure in the Navajo Area.

Public health and prevention programs serving Indigenous communities have historically been significantly underfunded. During the Pandemic many of the successes and work accomplished were due to COVID funds allowing for the hiring of temporary staff. Proactive, recurring support for Public Health Infrastructure, rather than one-time, crisis-based funding, is essential to sustain systems to protect families and communities.

Balanced, effective Public Health Infrastructure for American Indians/Alaska Natives (AI/AN) communities includes the elements of observation (surveillance, data collection, and community listening); planning (data analysis, meaning-making, and dialogue with communities and partners); action (direct preventive and public health services to support families and communities); and keeping track (epidemiology and reporting).

Flexible, respectful partnerships between local communities, Tribal programs, Nongovernmental organizations, and Indian Health Service during the COVID-19 pandemic resulted in high levels of vaccination, direct support to thousands of families to successfully complete isolation/quarantine and limit spread, mitigate risks at the individual, family, community, and nation levels, and promote transparent systems for epidemiologic data collection and sharing. Similar partnerships over the years have contributed to improvements in behaviors and conditions related to risk and protective factors for diabetes and other chronic diseases.

Sustained investment in expanded Public Health Infrastructure serving Tribal communities should be balanced, support partnerships, and build the skills and competencies of all staff and partners.

2. Link to Indian Health Care Improvement Act (IHCIA) provisions, where applicable.

- » SUBCHAPTER I-INDIAN HEALTH PROFESSIONAL PERSONNEL
 - ▶ 1616b Recruitment activities.
 - ▶ 1616c Tribal recruitment and retention program.
 - ▶ 1616n. Tribal health program administration.
- » SUBCHAPTER II-HEALTH SERVICES
 - ▶ 1621b. Health promotion and disease prevention services.
 - ▶ 1621c. Diabetes prevention, treatment, and control.
 - ▶ 1621d. Other authority for provision of services.
 - ▶ 1621h. Mental health prevention and treatment services.
 - ▶ 1621k. Coverage of screening mammography.
 - ▶ 1621m. Epidemiology centers.
 - ▶ 1621n. Comprehensive school health education programs.
 - ▶ 1621q. Prevention, control, and elimination of communicable and infectious diseases.
- » SUBCHAPTER III-HEALTH FACILITIES
 - ▶ 1638c. Contracts for personal services in Indian Health Service facilities.
 - ▶ 1638e. Other funding, equipment, and supplies for facilities.
- » SUBCHAPTER III A-ACCESS TO HEALTH SERVICES
 - ▶ 1647b. Access to Federal insurances.
- » SUBCHAPTER V-ORGANIZATIONAL IMPROVEMENTS
 - ▶ 1662. Automated management information system.
- » SUBCHAPTER VI-MISCELLANEOUS
 - ▶ 1677. Nuclear resources development health hazards.
 - ▶ 1680d. Infant and maternal mortality: fetal alcohol syndrome.
 - ▶ 1680q. Prescription drug monitoring.

3. Link to GPRA performance targets and outcomes.

Since 2020, the COVID-19 restrictions have negatively affected our GPRA measures. Despite our small yet strong Public Health Teams focusing on preventing Covid-19 spread, several health services were closed, which negatively impacted our GPRA measures. Therefore, the Pre-COVID GPRA measures are recommended to be the comparison data versus the current Government Performance Results Act (GPRA) measures to provide an overall depiction of the GPRA measures pre-pandemic.

The COVID-19 pandemic highlighted the impact of the lack of Public Health Resources to deal with routine services and

COVID. The additional staff hired with COVID funds focused on COVID-19 patient care, testing, prevention, vaccine drives, and treatment of COVID-19. The Navajo Area was profoundly affected by COVID-19; therefore, all resources and preventive services focused on slowing the spread of COVID-19 and treating our community.

The Navajo Area has consistently strived to improve AI/AN health care outcomes using medical treatments, preventive care, and public health outreach. Increasing H&C funds allows the Navajo Area to meet and enhance its annual Government Performance GPRA performance measures, enable teams to screen more effectively, and implement strategies that will improve population health. Building capacity and Public Health Infrastructure across the Navajo Nation will allow innovative, focused interventions, increase early detection for cancer screenings, and enable our teams to focus on the community's public health needs.

We plan to utilize Public Health Aides to support our health centers and clinics in the future. The 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 prevention.

During the pandemic, the Navajo Area worked diligently with the Navajo Nation, the 638's, and Urban programs to slow the spread of COVID-19. This Public Health team on the Navajo Nation will continue to increase GPRA measures, combat any infectious disease, and be ready to respond to any Public Health crisis, mainly when a Public Health team is adequately supported and funded.

Below are the GPRA performance measure results for FY2022.

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%.

4. Link requests to Indian Health Service Strategic Plan.

Increasing H&C funding to support the 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. 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:

- 1) To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people;



The 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 and improve positive health outcomes. One of the factors that drives positive health outcomes is a commitment to increasing access to care for the population served. Continual H&C funds facilitate Public Health and Preventive Health Services availability and the Navajo Area strives to ensure services are relevant and effective to allow patients, families, and communities to gain access to care.

- 2) To promote excellence and quality through innovation of the Indian health system into an optimally performing organization; and

The 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. The H&C funds would help us hire and sustain qualified candidates to extend disease surveillance projects, implement more preventative programs, and increase our GPRA screenings.

- 3) To strengthen IHS program management and operations.

The H&C funds permit strengthening IHS program management and operations by employing and retaining qualified individuals who are subject matter experts in their professions. This expertise grows and strengthens leadership, management and operations which benefit AI/AN patients and communities, leading to dynamic relationships between healthcare providers/workers and patients, families and communities. The strength of health programs and operations stem from individuals and teams who make up the organization, their passion for excellence, compassion for serving underserved populations, and dedication to advancing Indian health care.

Navajo Area Hot Issues

Advanced Appropriations

ISSUE

The Consolidated Appropriations Act, 2023 is one step towards advance appropriations for Indian Health Service for the first time.⁸³ Forward funding is necessary to avoid disruption of health services and towards a more stable funding allocation. While IHS now can access FY2023 and FY2024 funds this is not a permanent solution. Indian Health Service (IHS) will continue to experience challenges with funding in annual appropriations acts designated for a fiscal year unless otherwise specified. Health facilities across Navajo experience access to care issues stemming from financial management, recruitment and retention, and administrative burden during government shutdowns impacting patient care for elders and those with chronic health conditions.⁸⁴

BACKGROUND

The Navajo Area is not opposed to streamlining funding appropriations in order to make it more efficient in the delivery of needed health care services. However, the Navajo Area strongly opposes any actions that adversely impact the already inadequate level of funding attempting to meet the health care needs of both the Navajo and Southern San Juan Paiute Tribes.

Usually, an appropriations act makes budget authority available beginning on October 1 of the fiscal year (FY) for which the appropriations act is passed (“budget year”). However, there are several types of appropriations that don’t follow this pattern, e.g., forward funding, advance funding, and advanced appropriations.⁸⁵ Advanced appropriation is one type of alternate period of funding that is made available one fiscal year or more beyond the fiscal year for which the appropriation act is passed. The Consolidated Appropriations Act, 2023 in this case is limited to two fiscal years.

The federal trust responsibility of the federal government must be at forefront as the COVID pandemic showed vast disparities in COVID mortality and prevalence compared to other racial and minority groups. The unmet needs by the federal government to adequately fund Indian Health Service annually left health facilities unprepared while the virus took many lives such as elders across Navajo and tribal communities. We believe that Congress treats other agencies in a manner no

different than what is being asked of IHS and providing that the trust relationship is not breached or compromised.

RECOMMENDATIONS

Navajo Area recommends additional funding appropriations, including increases, should be spread over four (4) years and only after meaningful consultation with tribal governments. Consistent and timely annual funding for Indian Health Service to not disrupt necessary health services seamlessly is critical as the Indian healthcare delivery system and the country is recovering from the COVID pandemic. Delayed care is seen across Tribal communities and the impact is still unknown, for that reason, stable funding for Indian Health Services is critical to improving health outcomes and moving towards the next normal for COVID.

Additionally, Congress to provide oversight and direction to IHS to modify its health care cost projections so that it could provide better predictability for IHS funding in future years. IHS and tribal governments have analytic tools for measuring demand for healthcare, treatment capacity, and fixed and variable costs associated with delivering rural healthcare. Continue to allocate separate funding for a cost study on actual needs of Indian Health Service.

COVID-19

ISSUE

The response to the ongoing COVID-19 global pandemic that began in early 2020 has not ceased. The Navajo Area continues to combat COVID-19 with no additional funding since Coronavirus Aid, Relief, and Economic Security (CARES) Act (2020), Consolidated Appropriations Act (2021), and recently the American Rescue Plan Act of 2021. While additional funding is needed to maintain access to testing and updated vaccines this has not been met in 2022. Additionally, coverage for health services and supplies related to COVID will impact the patients most in need across the Navajo Nation. The flexibilities for health facilities and insurance plans will diminish at the end of a public health emergency thus adding additional healthcare costs to the Indian healthcare system that is historically inadequately funded.

BACKGROUND

The Navajo Area was the epicenter, alongside New York City, in the first 2020 surge where shelter-in-place and lockdowns orders were the only means to keeping the transmission of COVID-19 down. Since 2020, COVID variants have mutated and mitigation strategies have evolved as we continue to learn about this virus that may not go away soon. For that reason, we will continue to address the gaps in ensuring the Indian healthcare delivery system is prepared and able to respond during any potential surges.

83 [H.R.2617 - 117th Congress \(2021-2022\): Consolidated Appropriations Act, 2023 | Congress.gov | Library of Congress](https://www.congress.gov/bills/117/2617/versions/1/summary/house/all)

84 IHS. Indian Health Service Considerations Related to Providing Advance Appropriation Authority. (2018) Access at <https://www.gao.gov/products/gao-18-652>

85 Congressional Research Service. Advance Appropriations, Forward Funding and Advance Funding: Concepts, Practice, and Budget Process Considerations. (2019) Access at <https://sgp.fas.org/crs/misc/R43482.pdf>

The public health workforce became a priority during the pandemic as the virus impacted the places we live, play, and learn. The field of public health has existed in the general US population for decades. The public health landscape is unique on Navajo and Indian Country; some Tribal nations were prepared, but many were not during this pandemic. On Navajo, the public health workforce is a shared responsibility across federal and tribal healthcare facilities including the Navajo Nation. Pre-pandemic there were few public health professionals identified in the Navajo Health System. We now know that medical informatics, biostatisticians, contact tracers and epidemiologists are valuable positions in a public health emergency. These positions are scarce in the Indian health delivery system because we have heavily depended on the Tribal Epidemiology Centers that are not sufficiently funded.

The mental health workforce has plummeted during this pandemic due to staffing shortages. Staffing for behavioral and mental health services remain a challenge as the need for these services increased during the pandemic. Investing in staffing and assessing different staffing models may help improve access to services. Suicide surveillance of suicide attempts, ideations, and completions are also well known to Indian Country but has not been fully funded to ensure proper communication, reporting, information technology and staff capacity are met across Tribal communities. While the 988 crisis line has been implemented in the United States, collaboration needs to occur among stakeholders and Tribal communities to connect individuals with appropriate tribal resources and partners.

Medical staffing vacancies on the Navajo Nation and Indian Country was a pre-pandemic need and remains a critical issue in adequately providing patient care to patients. Specialty providers such as Pulmonologists were limited, due to this limitation it's been a common practice to transfer patients to neighboring towns and metropolitan areas in all three states both pre-pandemic and now. The US Public Health Service Commission Corps is critical to the Indian health care delivery system, but it wasn't sufficient. During this pandemic, the Navajo health system survived the surges because of volunteer organizations and federal deployments of medical staffing from Department of Health and Human Services and other federal agencies. We were never adequately prepared to respond or to continue to fight the pandemic with these unmet needs.

RECOMMENDATION

- » Fully fund Tribal Epidemiology Centers
- » Support Tribal Epidemiology Centers accessing data directly through electronic health records
- » Provide IT infrastructure to keep data secure for the EPI Centers

- » Address building a public health infrastructure at all levels of the Indian healthcare delivery system. One way to establish this is to develop a common language and strengthen the definition of public health in Indian Country and to develop a discipline within the Indian healthcare delivery system.
- » Change medical staffing models in government and learn from past to meet short-term and long-term needs of this pandemic.
- » Incentivize health facilities and reimburse at higher rates for marginalized communities such as Tribal communities in this pandemic and future public health emergencies.
- » Additional funding will support ongoing management of COVID and other viruses and is critical to enhance the infrastructure and response to future public health emergencies.

Services for Unsheltered Relatives and Veterans

ISSUE

Unsheltered relatives – patients who do not have access to stable housing – make up a small but significant portion of the people served by IHS and Tribal Health programs. This group faces multiple barriers to care, and often accesses care only through Emergency Departments when their health issues become a crisis. Innovative “street medicine” outreach programs can provide primary and preventive care, access to and coordination of support programs, as well as health promotion and education for these relatives. These programs have demonstrated effectiveness in improving health, preventing hospitalizations, and reducing high-cost emergency care. IHS and Tribal Health programs have an opportunity to improve the health of this high-risk group by providing direct care services where the people are, and by working collaboratively with other community social and behavioral support programs and services.

Some of these unsheltered relatives are Veterans. It is well known that American Indians and Alaska Natives have the highest rate of service in the armed forces of any group in the United States. After they complete their service, many Native Veterans face challenges in accessing health services. There are existing intergovernmental agreements between the Veterans Administration, the Indian Health Service, and Tribal Health Programs, but the potential of these agreements has not been fully realized. The health status of Native Veterans could be improved by including them in the outreach approaches to care and coordination of services for unsheltered relatives, as well as bringing VA services closer to where they live. Bringing VA specialty care services to IHS and Tribal Health facilities – rather than sending Native veterans for care at VA facilities



far from their home, and bringing mobile VA clinics to remote communities - can improve access to care. Specific recommendations made by Tribal Leaders in consultation sessions with the VA should be implemented.

BACKGROUND

As a group, patients experiencing homelessness have poorer health status and face more barriers to healthcare services than any group in the U.S. today. Health systems based on hospitals and clinics do not reach this group, who often delay care until a crisis exists, using expensive, short-term, emergency department care. “*We treat and street these patients*”, said Asha Atwell, DO, former Emergency Department Director at Northern Navajo Medical Center in Shiprock, NM, “and they often return to the ED with their next crisis.”

A review of the frequent users of the Emergency Room at Gallup Indian Medical Center showed high levels of homelessness, substance abuse, mental health disorders, and traumatic brain injury. This minority of patients consume a disproportionate amount of healthcare, especially in the ED and contribute to unnecessary healthcare utilization, rising healthcare costs, staff burnout.

Nationally, 1.2% of people self-identify as American Indian and Alaska Native (AI/AN). In shelters, 4% of all homeless people and 4.8% of all homeless families self-identify as American Indian and Alaska Native. “Point in Time” counts – which attempt to take a snapshot of homelessness on a given day, have shown AI/AN people face rates of homelessness that are 6 times the rate for White individuals.

Outreach programs implemented across the country targeting individual needs have been shown to decrease hospital admissions, ED visits and hospital cost. “Street Medicine” programs, that bring primary and preventive services to people experiencing homelessness, wherever they are, have been one model of care with positive outcomes studied in several urban centers.

During the COVID pandemic, outreach to these groups was recognized as an important part of reducing the risks for entire

communities. Northern Navajo Medical Center’s Community Health team brought testing, vaccination, support, education and isolation services to unsheltered relatives living under bridges, in abandoned buildings, and on the street – and was welcomed by these patients.

This outreach effort grew into the *Sih Hasin* (Hope for the Future) Street Medicine clinic, which now brings primary care, preventive services, minor surgery, and behavioral health support to hundreds of patients experiencing homelessness in Shiprock and nearby border towns. Other IHS, Tribal, and Urban Native programs are studying and planning similar direct service outreach programs.

Key elements of these programs are staffing – with providers, nurses, behavioral health, and social services professionals, linkages with local partners, organizations, and programs, tie-ins with pharmacy and laboratory services, as well as local transportation and shelter services.

There is a need to support and expand outreach efforts to meet the physical, mental, emotional, and spiritual health needs of this underserved and often ignored group.

Some of our unsheltered relatives are veterans of service in the US Armed Forces. Native Veterans, in general, face many barriers to obtaining the care and services that they are entitled to as a result of their service. In October 2022, the Indian Health Service and the Department of Veterans Affairs (VA) renewed a partnership, begun in 2003, to improve services to Native Veterans. Connecting American Indian and Alaska Native Veterans to the benefits they have earned through their service is a top priority for the Department of Veterans Affairs.

To improve access to health care services for Indian Country’s Veterans, the VA Veterans Health Administration (VHA) and the Indian Health Service (IHS) work together under a memorandum of understanding (MOU) to leverage resources and share knowledge toward the common goal of enhancing care for AI/AN Veterans. Under this agreement, The VA is to provide needed resources for costs under the Agreement and to provide access to and application for benefits, evaluation of medical needs, referrals, and other arrangements, and provide counseling to Navajo Veterans, gather and validate data regarding Navajo veterans’ health and social needs, and facilitate Navajo Veterans’ full utilization of all existing health benefits and resources.

Important accomplishments based on this agreement to date have included:

- » Reimbursement agreements have been established between the VA and 116 Tribal Health Programs and one IHS site. Many other sites, including Navajo Nation and Navajo IHS sites

- » VA's *Video Connect* program has expanded access to mental health care services for some rural AI/AN Veterans who receive care from IHS and THP facilities.
- » VA's mail-order pharmacy delivers prescriptions directly to some Native Veterans as expanded access to mental health care services for rural AI/AN Veterans

Currently, the more than 7,395 Navajo Veterans who live on the Navajo Nation face barriers in accessing the care they are entitled to because VA clinics and hospitals are hundreds of miles away, and the processes for accessing care are often complex. Many of these Navajo Veterans choose to obtain care closer to home, but the IHS facilities that serve them do not include the full scope of specialty services available at VA hospitals and clinics. The VA also offers greater access to personal medical supplies and equipment – such as hearing aids, glasses, and prosthetics – than many IHS sites.

During the pandemic, critical care services throughout many regions have been full, limiting ability of IHS and Tribal health facilities to obtain care for critically ill patients. The VA system includes another pool of critical care resources that could be made available for AI/AN patients.

Navajo patients referred for sub-specialty care – such as cardiology or endocrinology – often face not only distant travel, but also long waits to see providers at University and private health systems, when referred through the IHS Purchased and Referred Care program (PRC). Including VA provides as an option could reduce wait times for appointments.

RECOMMENDATION

It is recommended to increase funding to address the unmet healthcare needs of Navajo and other American Indian/ Alaska Native patients experiencing homelessness:

- » Provide funding to support provider, nursing, behavioral health, and social service staff to implement street-level outreach programs to reach unsheltered relatives where they are
- » Support collaboration and coordination between all elements of the care system working with homeless individuals – care providers, counselors, social workers, emergency departments, police departments, fire and EMS services, shelter and feeding programs and others.
- » Support transportation options to improve access to care and shelter for homeless patients
- » Improve support for and access to detoxification and treatment programs for substance use disorders for this population
- » Support innovative outreach service delivery systems, including mobile vans and clinics

- » Support Case Management staff to work with both Emergency Departments and Homeless Outreach clinics to coordinate the complex care issues faced by this group.

It is also recommended to increase funding and support to realize the full potential of the IHS/VA Interagency Agreements to improve services for Native Veterans:

- » Streamline the procedures for using monies appropriated for Veterans by Congress
- » Reevaluate and request a waiver on existing federal laws and policies that present a barrier to veterans and homelessness, e.g. co-pays, pharmacy reimbursement rates.
- » Improve access and allocate revenue sharing and other federal funds directly to the Navajo Nation to be used to satisfy Navajo priorities specific to Veterans and Homelessness.
- » Reaffirm and re-evaluate Interagency Agreements with IHS/638 Facilities and Veterans Administration to strengthen clauses on reimbursement, on-site specialty services, administrative staff (social workers, patient registration, patient benefits, et.al.), on-site mobile units at communities/chapter levels, establish a Veterans center on the Navajo Nation, establish domiciliary care centers for elderly Navajo veterans, and utilization of Navajo traditional practitioners.
- » Ensure all federal agencies fulfill their trust responsibilities to all Indian Tribes in addressing veterans and homelessness needs.
- » Improve interoperability and Health Information Exchange capability between VA and IHS electronic health records systems
- » Expand access to mail-order pharmacy to all Navajo veterans
- » Expand reimbursement agreements with VA to include Navajo IHS and Navajo Nation health programs
- » Provide access to personal medical equipment and supplies – such as hearing aids, dentures, eyeglasses, and prosthetics – to all Navajo veterans through VA systems
- » Expand the VA Patient Navigator and Case Management programs to include specific staff dedicated to Native veterans and their unique issues and challenges.

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Information Technology (IT)

ISSUES

- » VoIP
 - ▶ The Indian Health Service Navajo Area needs improved Telecommunication standards with Voice over Internet Protocol (VoIP). There are currently budgetary as well as IT infrastructure constraints preventing health care to transition from analog to digital.
- » Equipment
 - ▶ Many Service Units will require new servers, switches, and routers for adequate IT support for their respective offices which run the risk of data loss and will impact patient care if these are not remedied timely
- » Information Technology Disaster Recovery Plan / Continuing Of Operations IT
 - ▶ Indian Health Service Navajo Area does not have a viable Information Technology Disaster Recovery Plan (ITDRP) or Continuing Of Operations Planning (COOP)
 - Electrical/Network outage issues
 - Data Recovery policy
 - Shadow Sites do not exist and run the risk of data loss and data integrity

BACKGROUND

- » VoIP
 - ▶ VoIP is a method and group of technologies for the delivery of voice communications and multimedia sessions over internet networks.
- » Equipment
 - ▶ Servers, Routers, Switches, cooling systems all are factors in how Service Units and facilities operate within their respective health care facilities
- » Information Technology Disaster Recovery Plan / Continuing Of Operations IT
 - ▶ Navajo Area and the Service Units under NAO have experienced numerous outages network/electrical in the last few years that have had a negative impact on patient care and has proven costly.
 - Gallup NM has experienced eight power and network outages in the last 4 years which have had a direct impact on businesses and hospitals within the region.
 - Northern Navajo Medical suffered a 16 hour network outage in November
 - Chinle Hospital suffered a 3 day power outage and network outage
 - ▶ Four site and a few facility assessments have shown the lack of data backups and are rarely stored off site securely which will be problematic should we need to do data restorations.

RECOMMENDATION

- » VoIP
 - ▶ The Navajo Area is requesting that additional funding be added for further development of CISCO VoIP phone systems for our health care.
 - ▶ Some of these expanded services could be:
 - ▶ Computer calling
 - ▶ eFaxing
 - ▶ To implement this quickly will require contracting the services. In order to do this, IHS would need to designate a site to develop this program.
- » Equipment
 - ▶ Reevaluate each facility and get a concrete plan of replacement of antiquated equipment
 - Once identified then expedite the purchasing of replacements
 - Navajo Area IT would oversee this project for all Service Units and Facilities
- » Information Technology Disaster Recovery Plan / Continuing of Operations IT
- » There is a need to bring in diesel powered generators for all hospital that will serve as backup power to Navajo Area Hospitals
- » There is a need to bring in mobile satellite trailers to ensure patient care is available in the event of a network outage
 - ▶ These can be stored and maintained at the Navajo Area office and deployed immediately should the network outage be notice.
- » Shadow site for all Service Units will be at Navajo Area and require additional power, cooling, and redundant power sources.
 - ▶ The COOP site will be in Albuquerque NM at the BIA Data Center 1011 Indian School Rd which already houses IHS data.

Information Technology is an essential part of Indian Health Service and is foundational when it comes to direct patient services. Without IT, direct patient care is impacted, financial risks will be extreme and unfortunately incur additional costs should these hot IT items be ignored.

Long Term Care Facilities and Elder Care

ISSUE

The funding of a long-term care facility is an unfunded legislative mandate of the Indian Health Care Improvement Act (IHCIA). Under the, Indian Health Care Improvement Act – 25 U.S. Code CHAPTER 18-INDIAN HEALTH, SUBCHAPTER VI. MISCELLANEOUS, §1680I. Shared services for long-term care, long-term care is mentioned as a health care service that supports the mission of the Indian Health Service (IHS). The



IHS, historically, has not operated long-term care facilities and federal funds have never been designated to IHS to operate/ manage long-term care facilities. Therefore, this need is an unfunded mandate under the IHCIA in spite of a valid and existing health care need for LTC services on the Navajo Nation. There are two (2) methods that can be used to acquire the needed funds using the existing federal appropriation process. They are: 1) the Health Care Facilities Construction major line item account budget category can be infused with new construction funds dedicated to the construction of a long-term health care facility and/or; 2) a specific ear mark of new money can be added to the Hospitals & Clinics (H&C) Program budget category to fund existing tribally operated long-term care facilities and these funds will be released to the Navajo Nation using the Indian Self-Determination and Education Act, PL 93-638, contracting and compacting authority. The Navajo Area and Navajo Nation are requesting a special fund appropriation earmarked for funding long-term care service on the Navajo Nation. This unmet need should be addressed.

BACKGROUND

The report, “2020 Profile of American Indians and Alaska Natives Age 65 and Older” (No date), by the Administration for Community Living (ACL) indicated, “The American Indian and Alaska Native population age 65 and older was 301,418 in 2019 and is projected to grow to more than 648,000 by 2060. In 2019, American Indian and Alaska Natives made up 0.6% of the older population, and by 2060, are projected to make up 0.7% of the population. The number of American Indian and Alaska Natives age 85 and older is projected to increase from 26,916 in 2019 to 118,905 in 2060.” And, “Note: The number of Americans age 65 and older who reported they were American Indian and Alaska Native in combination with one or more races was 702,325 in 2019.” These statistics are alarming since the IHS does not operate or administer any long-term care facilities in Indian Country, thus the burden falls upon Indian tribal governments, communities, families, and individuals to locate resources off-reservation to meet elder health care needs.

As the population ages, the life expectancy likewise increases, driving the needs for frequent, often costly, health care and long-term care services. The aging process comes with chronic disease management that requires recurring routine health care services and medical specialty services, and eventually, long-term care services involving a variety of personal and medical care services given by different caregivers. The Rural Health Information Hub (RHlhub) (No date) report entitled, “*Demographic Changes and Aging Population*”, finds, “It is estimated that 90% of adults over age 65 experience one or more chronic conditions, and need specific treatments and medical care, setting them apart from the rest of the population.” Elder care requires coordination between multiple providers such as physicians, therapists, social workers, mental health workers, etc. to assist an elder with independent living at home or in an assisted living setting until physical and mental debilitations force an elder into a nursing home facility.

When and how long an elder may need long-term care services is not easily determined. The following may be considered determinants for the need of long-term care services: Advancing Age, Gender where a female is at greater risk than a male due to longevity, Marital Status where single individuals more frequently than married persons tend to tap into outside resources for care givers, Lifestyle where poor habits of exercise and diet are perilous to health, and Health and Family History tends to influence well-being (National Institute of Aging; Long-Term Care (No date), *What is Long-Term Care*).

The following is a population profile of age 65 and older AI/AN peoples living in the United States. It should be noted that AI/AN age population profile reports are difficult to locate as well as reports on the Navajo Nation age-specific population profiles which would assist in drawing conclusive findings and projections on these target groups. According to the, Administration for Community Living, Administration on Aging, U.S. Department of Health and Human Services (No date), “*2020 Profile of American Indians and Alaska Natives Age 65 and Older*” report:

- » Residence. In 2019, half (51%) of all older American Indians and Alaska Natives lived in seven states: Oklahoma (36,095), Arizona (28,868), California (25,666), New Mexico (20,649), North Carolina (16,517), Texas (14,825), and Washington (11,523).
 - » Education. The past decade has seen a significant increase in educational attainment among older Americans, including American Indians and Alaska Natives. In 2020, 79% of the American Indian and Alaska Native population age 65 and older had finished high school, and 21% had a bachelor’s degree or higher. This is compared with 89% of all older persons who were high school graduates and 33% who had a bachelor’s degree or higher.
 - » Marital Status. In 2020, 45% of older American Indians and Alaska Natives were married, 29% were widowed, 18% were divorced (including separated and spouse absent), and 8% had never been married.
 - » Grandparents. Among American Indians and Alaska Natives grandparents age 60 and older living with their grandchildren in 2019, 45% were responsible for the basic needs of one or more grandchildren under age 18 living with them, and 55% were not.
 - » Poverty. The poverty rate in 2019 for American Indians and Alaska Natives age 65 and older was 18.7%, more than double the poverty rate for all older Americans of 8.9%.
 - » Leading Causes of Death. In 2018, the top five leading causes of death for American Indian and Alaska Native men, age 65 and older, were heart disease, cancer, chronic lower respiratory diseases, diabetes, and stroke. The top five causes for women were heart disease, cancer, chronic lower respiratory diseases, stroke, and diabetes.
 - » Disability Status. In 2019, 47% of older American Indians and Alaska Natives had one or more disabilities compared with 33.5% of all older adults age 65 and older.
- Furthermore the, Administration for Community Living, Administration on Aging, U.S. Department of Health and Human Services (2020), “*2019 Profile of Older Americans*,” noted the following for the general U.S. age 65 and older population:
- » Racial and ethnic minority populations have increased from 7.5 million in 2008 (19% of the older adult population) to 12.3 million in 2018 (23% of older adults) and are projected to increase to 27.7 million in 2040 (34% of older adults).
 - » In 2018, older women outnumbered older men at 29.1 million older women to 23.3 million older men.
 - » As of 2019, about 28% (14.7 million) of older persons lived alone (5 million men, 9.7 million women). Among women age 75 and older, 44% lived alone.
 - » The need for caregiving increases with age. In 2018, the percentage of older adults age 85 and older who needed help with personal care (21%) was more than twice the percentage for adults ages 75–84 (8%) and five times the percentage for adults ages 65–74 (4%).
 - » The 85 and older population is projected to more than double from 6.5 million in 2018 to 14.4 million in 2040 (a 123% increase).
 - » People age 65 and older represented 16% of the population in the year 2018 but are expected to grow to be 21.6% of the population by 2040.
 - » According to the U.S. Census Bureau’s American Community Survey, 34% of people age 65 and older reported having some type of disability (i.e., difficulty in hearing, vision, cognition, ambulation, self-care, or independent living) in 2018.

- » In 2018, the percentage of older adults age 85 and older needing help with personal care (21%) was more than twice the percentage for adults ages 75–84 (8%) and five times the percentage for adults ages 65–74 (4%).
- » Older adults often also provide care to younger family members. For example, approximately 1.1 million grandparents age 60 and older were responsible for the basic needs of one or more grandchildren under age 18 living with them in 2018.

It is a reasonable assumption to state that the Navajo Nation’s elder population follows or parallels the profile of the U.S. age 65 and older population profile findings. Some unique factors also exist. Navajo individuals reside in rural communities where homes lack indoor plumbing, electricity, and other modern conveniences, and many travel long distances for health care services, work, schools, and basic shopping needs. As the Navajo elder demographic ages, this limits the amount of time that the elders are able to live independently. The unfunded legislative mandate for long-term care services has transferred maximum financial responsibility to the Navajo Nation government. The Navajo Nation government is financially limited in addressing the inequities involving long-term care services for Navajo elders. The prevalence of poverty is significant in the Navajo Nation as compared to the rest of the United States population. Poverty drives inequitable access to resources in the United States and minority elders are the most impacted by disparities.

The progression of elder care begins with assisted or supportive care in the home environment and to a nursing home for skilled or unskilled care services. The Dr. Guy Gorman, Sr. Care Home (aka Chinle Nursing Home), operated by the Navajoland Nursing Home, Inc., is the sole long-term care facility on the Navajo Nation serving the entire Navajo elder population in need of long-term care services. Unfortunately, it is impractical to expect the Chinle Nursing Home to meet the total needs of a growing elder population. The need far exceeds the number of available long-term care beds and funding. The economic pressure on tribal members makes it unfeasible for immediate and extended family members to address the needs of the elders. The historical cultural practice of caring for an elder has diminished considerably due to younger family members relocating from remote rural communities to distant urban communities in search of employment and other opportunities.

The definition for Long-term care is wide-range in the scope of medical and personal services available to elders to support an elder’s daily living functions and activities and medical care needs. According to the Medicare.org (No date) report entitled, “*Different Types of Long-Term Care*”, there are, “3 Levels of Long-term Care” and they are:

1. Skilled care: Continuous “around-the-clock” care designed to treat a medical condition. This care is ordered by a physician and performed by skilled medical personnel, such as registered nurses or professional therapists. A treatment plan is established.
2. Intermediate care: Intermittent nursing and rehabilitative care provided by registered nurses, licensed practical nurses, and nurses aides under the supervision of a physician.
3. Custodial care: Care designed to assist with one’s activities of daily living (such as bathing, eating, and dressing). It can be provided by someone without professional medical skills but is supervised by a physician.

RECOMMENDATION

The Navajo Nation requests of the Indian Health Service to advocate for and inform the Congress of the dire need for long-term care facilities and services throughout Indian Country, and submit a budget proposal to Congress to appropriate monies for long-term care services, as authorized by the IHCA.

Long-term care facility/service is an unfunded federal mandate under the “*Indian Health Care Improvement Act, 25 U.S.C. § 1601. Chapter 18-Indian Health Care, § 1680l. Shared services for long-term care.*” A formal budget request by the IHS leadership, supported by Tribal nations, needs to be submitted to the U.S. Congress to fulfill this mandate as the elder population is growing across Indian Country, and the need to meet the long-term care needs is escalating. Navajo elders prefer to remain on tribal lands among their people and maintain a cultural connection through kinship and relationship networks that support their healing, health, and well-being.

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Purchased/Referred Care

ISSUE

The Purchased Referred Care funding meets only part of the identified need for PRC services. Increased funding for the Purchased Referred Care (PRC) program is needed for eligible patients. The PRC program provides funds for care that cannot be provided at the local I.H.S or Tribal hospital or clinics. It ensures patients have access to healthcare for standard, specialized, and emergency care and procedures not provided or available at the local hospital or clinic. Rural facilities are challenged with limited services related to provider shortages, increased referrals for specialized care such as cancer care, cardiology, or gastroenterology, and geographic distances to tertiary care centers where patients are referred. The geographic distances that patients are required to travel to access the needed care comes with financial cost to patients, their families; and, to the healthcare facilities that may have to send them emergently.

The Navajo Area is requesting an increase in funding for the PRC Program. A major line item account supports Patient Transports or distance factors which is not inclusive of the current PRC distribution formula to support increased costs of air and ground transportation costs across the country. Current PRC distribution formula is inclusive of Inflation, Population growth and Earmark funds.

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 and adversely impacting access to much needed care.

The Indian Health Services website and ‘Disparities’ Fact Sheet, American Indians and Alaska Natives born today have a life expectancy that is 5.5 years less than the United States’ all races population, and die at rates higher than other Americans in many categories including chronic liver disease and cirrhosis, diabetes, and chronic lower respiratory diseases. The lower life expectancy, higher rates of mortality, and largely preventable disease process it is crucial that the U.S government ensure increased funding and health equity for its Native citizens. The Navajo Nation requests PRC funding increase relative to the need for more access to specialized care. Access to services beyond what is available, or can be provided, at a I.H.S/Tribal

hospital, or clinic, is critical to ensuring that a patient’s disease is adequately managed or controlled to avoid progression or worsening of disease. Oncology is one such disease that, if diagnosed timely, and treated early can result in more positive outcomes. Oncology is costly care, and requires recurring visits to specialists. Further, such treatment does have travel expenses associated for the referring facility, and to the families.

Estimated funding needs:

PROJECT	ESTIMATED COSTS
Emergency Ground Transports	\$30m
Air Transports	\$50m
Non-Emergency Ground	\$20m

Additional funds will provide for Inter-Facility Non-Emergent and Emergent Ground Transport Services for patient served at I.H.S and Tribal healthcare facilities and requested by the authorizing official. Ground transports shall include inter-facility transports to regional medical facilities off the Navajo Nation reservation. Services to include Advanced Life Support (ALS) units and Basic Life Support (BLS) and non-emergent transportation for all facilities. The estimated workload at this time for Navajo Area Indian Health Service in total is between 250-500 transports per month, with a ratio of 2:1 ALS to BLS transports.

The Navajo Area such displacement of medical services creates difficulties for staff and patients and increases wait times, resulting in numerous inefficiencies within the health care system which delays care. 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.

RECOMMENDATION

The Navajo Nation requests of the Indian Health Service to advocate for increase in funding for PRC to ensure access to specialized care and associated transportation costs. Support the Purchased Referred Care with an increase in its funding levels, allowing more to access specialized care with consideration for the geographic distances that are travelled to access that care. In determining PRC funding, it is imperative to consider patient distance to hospitals or cost of travel to reflect price variations associated with patient transports. To consider costs adding transportation component to account for geographic barriers and vast distances to access needed health care.

Nursing Recruitment and Retention

ISSUE

The Indian Health Service (IHS) and Tribal health care facilities continue to experience a critical nursing shortage and struggle to recruit and retain qualified nursing professionals to work in facilities serving Indian Country. The nursing shortage is growing at an exponential rate for IHS and Tribal health care facilities. As these critical nursing shortages continue, closures of beds and reduction of services will continue at an alarming rate, affecting the ability of IHS and Tribal health care facilities to provide quality health care to Native American communities.

BACKGROUND

In August 2018, the Government Accountability Office (GAO) published a report, *“Indian Health Service: Agency Faces Ongoing Challenges Filling Provider Vacancies”*, GAO-18-580, which found overall vacancy rates at federal/IHS sites for physicians, nurses, nurse practitioners, certified nurse anesthetists, certified nurse midwives, physician assistants, dentists, and pharmacist to be around 25%, ranging from 13 to 31 percent across these areas. 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 the South and West. Winslow Indian Health Care Center (WIHCC) is experiencing a prolonged shortage with the RN vacancy rate at 50% and one to two nurses leaving per month in FY 2022. As of November 2022, Tuba City Regional Health Care Corporation (TCRHCC) had a RN vacancy rate of 40% with an average of two to three nurses leaving per month. TCRHCC like many health care organizations are facing wage compression with contractor costs for nurses and physicians since the great resignation and are still struggling to fill vacancies since the pandemic of 2020. NAIHS has a vacancy rate of 27% for August 2022 and for FY 2022, 83 permanently employed nurses separated from NAIHS. For NAIHS, this is an average loss of 6-7 nurses per month across 12 health care facilities.

The COVID-19 pandemic has escalated concerns for the nursing shortage. Many nurses stepped away from the bedside in early 2020 at the beginning of the COVID-19 pandemic and greater number of nurses are leaving their permanent positions to work for staffing agencies which further increased the vacancy rates stated above. Also, many nurses opt to apply for positions with less than full-time patient care duties. The lack of bedside nurses in 2021 has been increasing and this has prompted the American Nurses association to ask the US Department of Health and Human Services to declare the nursing shortage a national crisis in 2021 (American Nurses Association, 2021). The current nursing shortage affects our ability to care for patients in our native communities and this will continue to worsen as the pandemic continues with no signs of slowing in sight.

Another aspect to consider when addressing the nursing shortage is the rural setting of our healthcare facilities. Multiple studies have been done looking at attracting nursing to rural areas. Only 16% of RNs live in rural areas so it is important to identify what factors affect a nurse’s decision when choosing to practice at a rural healthcare facility (Terry et al., 2021). A study performed in 2021 entitled, *“The Rural Nursing Workforce Hierarchy of Needs: Decision-Making concerning Future Rural Healthcare Employment,”* identified unique elements for choosing rural nursing which included easy access to education, a livable wage with affordable housing, providing high quality care, and a supportive work environment (Terry et al., 2021). The recommendations listed below address these elements that will improve recruitment and retention in our rural Native healthcare facilities.

Contributing factors impacting the nursing shortage include (American Association of Colleges of Nursing [AACN], 2020):

- » The aging nursing workforce – a significant portion of the nursing workforce is nearing retirement age.
- » The changing demographics – the aging population, increased need for health care, impact of the COVID-19 pandemic.
- » 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. Education is of utmost importance because educating and graduating students will increase the nursing workforce as current nurses retire or move away from the bedside.

In an effort to address these critical issues, a resolution was drafted and approved by WIHCC Board of Directors (BOD) and Management Team on October 1, 2021. This resolution called upon the leadership of the Navajo Nation Council along with the Navajo Nation Government to call attention to the nursing shortage and to address the critical concern of the nursing shortage. In the Summer of 2022, TCRHCC entered an MOA with Northern Arizona University to provide a classroom and SIM lab to aid and recruit American Indian Nurses with the School of Nursing. This agreement will be for five years with an overall goal to increase the number of American Indian nurses to respond to the patient care needs of Indian Country.

Multiple studies (AACN, 2018) have demonstrated positive impacts on patient care if there are adequate levels of RN staffing: every 10% increase in bachelor’s degree nurses was associated with a 7% decrease in patient mortality; higher nurse staffing levels were associated with lower mortality rates, lower failure-to-rescue incidents, lower rates of infection, and shorter hospital stays; decreasing nurse burnout was found to



improve the well-being of nurses and improve the quality of patient care.

Furthermore, new graduate nurses entering into practice have experienced stressful working conditions which has contributed to decrease in retention and job satisfaction amongst newly hired nurses (Eckerson, 2018). Other contributing factors leading to turnover and job dissatisfaction rates are increase in patient acuity levels, lack of confidence in skills and critical thinking (Al-Dossay, et al. 2013). Healthcare leaders acknowledge the criticality of nurse retention as it is vital component to our healthcare system as nurse turnover rate is significantly costly.

RECOMMENDATION

In order to address the critical nursing shortage, it is recommended to increase funding for nursing recruitment and retention:

- » Incorporating nurse residency programs for new nurse graduates.
- » Establishing a directive for all Navajo Nation schools and school boards to strongly promote health field studies for students of all ages.
- » Prioritizing the Navajo Nation Scholarship funding for health field studies with nursing as the top tier.
- » Establish and/or increase nursing scholarship opportunities (loan repayment, funding for undergraduate and graduate nursing degrees).
- » Increase funding and availability for the IHS Scholarship, IHS Loan Repayment Program, National Health Service Corps Loan Repayment Programs, Nurse Corps Loan Repayment Program, and Faculty Loan Repayment Program.
- » Support and pass legislation for Loan Forgiveness Programs for nurses and health care providers.
- » Establish a college of nursing at Dine College and Navajo Technical University and establishing financial support for these programs, promoting enrollment for Navajo and other American Indian students to get into nursing programs and/or other health related fields.

- » Furthering the Navajo Nation MOUs/MOAs with surrounding colleges and universities to increase Native American enrollment in nursing programs.
- » Increase the building budget for hospitals and universities to create classrooms and SIMS labs for instruction and teaching centers to accommodate the partnerships in the rural communities.
- » Increasing access for housing through the Navajo Housing Authority, which is a tribal entity, to build rent-to-own homes on the Winslow and Dilkon Navajo Land Tract (home ownership is one way of ensuring retention of registered nurses who are from local service areas).
- » Increase housing for lower income students undergraduate nursing students who attend the metropolitan universities. Increase aid and funding cost of tuition and housing for aspiring nursing students.
- » Increase funding for ongoing training and skill-building for all existing staff, to maintain quality health care and to keep up with changing health issues, technology, and systems. Support cross-training of existing staff to cover multiple areas. Support training centers and development of learning communities to share challenges and best practices.
- » Increase funding and flexibility for IHS and Tribal health care facilities for salary benefits, and contract costs in order to recruit and retain a competent, skilled nursing workforce.

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Staff Quarters

ISSUE

The construction of new facilities on the Five-Year-Plan, usually justify the construction of new quarter for the new facility. These quarters are justified for the staff of the new facility. This is the only time new quarters are built. The health centers are renovated and expanded as the User Population (patients) grow and a Program of Requirements (POR) and Program Justification Document (PJC) are developed. Though the health facilities continue to be justified for expansion and renovation. The quarters are rarely renovated or new ones built when these expansion and renovation projects take place.

BACKGROUND

The Indian Health Service builds new health care facilities per the Indian Health Service Annual Facilities Planning (Five-Year-Plan). This document consists of Planning studies, Inpatient Facilities, Outpatient Facilities, Small Ambulatory, Staff Quarters Program, Green Infrastructure, Demonstration Projects, and Joint Venture Construction Program.

New Quarters can be built and maintained with Quarters Return (QR) funding and this funding is very limited and only allows the quarters to be maintained at a very minimal level. The QR funds are the rental amounts collected from tenants and can only be used for the operation and maintenance of the existing quarters. Historically, the QR funds can only provide the salary for the personnel maintaining the quarters, trash collections, pay for the utilities of unoccupied quarters.

The QR funds are not sufficient to maintain the quarters, renovate or upgrade the existing quarters, make sufficient needed repairs, and replace appliances or furnishings.

The Health Care Facility Construction-Quarters (HCFC-Quarters) needs to be increased and funded annually. The new facilities are built in rural remote area, on Tribal trust land. While Native American staff can be build and own housing, it is limited to non-existent.

The quarters authorized to be built with the new health care facilities is much less than the number of employees in need of housing. These units become filled quickly with priority given to health care personnel. This leaves few to no options to ancillary staff, i.e. radiology, laboratory, and engineering personnel.

It is common for our health care facilities to interview and select an employee, only to find out housing is unavailable, as these employees try to on-board. These employees elect to take jobs elsewhere, where housing is available.

The HCFC Quarters funds should be increased and funded consistent basis. These funds should be considered to construct:

1. Short-term stay facilities, like a Homewood Suites concept. The rooms are all furnished and available for contract employees to stay short term.
2. RV parks should be built for contract employees to bring their own travel trailers and use these facilities.
3. Multi-family units to house a variety of family sizes.
4. Renovate existing quarters.
5. Repair-by-Replacement of existing quarters.
6. Update and add new playground and add new amenities for families.

The increased quarters funds should be used for maintaining, renovating and upgrading quarters, build new quarters, build RV parks and build amenities with. This will allow employees to form a community.

The Crownpoint South Quarters project is a project funded with HCFC-Quarters funds in FY2017 of \$1,200,000.00 and FY2018 of \$1,700,000.00. This project is to replace 32 1960's trailers. This amount only funds 17.43% of the total project cost of \$16,641,600.00. The design is 100% completed and is the Request for Contract Action is being prepared by Engineering Services.

RECOMMENDATION

The increase of Health Care Facilities Construction – Quarters dollars will allow the IHS to keep all existing health care facilities to maintain, operate and provide quality updated quarters. This will help in the recruitment and retention of health care professionals and ancillary staff. This will help the health facility in meeting Accreditation standards. Given there are few opportunities to replace quarters, maintaining current quarters is imperative. This will allow the IHS, Tribes and Tribal Organizations to continue to provide health care and to increase and improve the health care of the Native American and Alaska Native People. This will allow the IHS to continue to provide health care and meet the GPRA performance targets and outcomes.



Telehealth

ISSUE

The Indian Health Service needs improved capacity to provide telehealth to its patients. There are currently budgetary as well as IT infrastructure constraints preventing a quick transition to having telehealth options available for our patients.

BACKGROUND

Telehealth has become a more acceptable method of providing healthcare over the last decade, particularly in rural setting where many IHS facilities are located. The COVID-19 Pandemic served to accelerate this transition across the United States due to more limited access to in person healthcare visits. During COVID-19 many of our IHS sites transitioned to telephone visit without the capability of a video interface due to lack of infrastructure to support video connections.

RECOMMENDATION

The Navajo Area is requesting that additional funding be added for further development of Telehealth for our patient population. Throughout the pandemic we have used telephone medicine significantly to provide ongoing patient care. Our current network does not have the bandwidth to allow for most of these visits to have a video component, which will be a requirement when the Public Health Emergency Declaration is allowed to expire in order to continue billing and collecting for these visits.

Telehealth capabilities would also allow for IHS to provide expanded subspecialty care that traditionally has required our patients to travel several hours to obtain. Some of these expanded services could be:

- » Virtual Sexual Assault Nurse Examination Services – adult and adolescents
- » Rheumatology
- » Neurology
- » Cardiology
- » Dermatology
- » Behavioral Health – adult and pediatric
- » Gastroenterology/Hepatology
- » Pulmonology
- » Endocrinology
- » Maternal Health
- » Infectious Disease
- » Urology
- » Allergy/Immunology
- » Emergency Department support
- » ICU support
- » Hospitalist Services
- » Respiratory Therapy Support Services
- » Others to be determined by needs

To implement this quickly will require contracting the services. However, IHS could, in the long term, develop its own Telehealth program. In order to do this, IHS would need to designate a site to develop this program.

OKLAHOMA CITY AREA

Oklahoma City Area Narrative

On November 4, 2022, 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 2025 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 Second Chief Del Beaver, Muscogee Nation. Technical representatives are: Melissa Gower, Chickasaw Nation; Melanie Fourkiller, Choctaw Nation; Rhonda Beaver, Muscogee Nation; Kasie Nichols, Citizen Potawatomi Nation; Nicholas Barton, Southern Plains Tribal Health Board, and Ron Grinnell, Iowa 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 tribes are represented within the Area with 38 in Oklahoma, 4 in Kansas, and one in Texas. In FY 2022, the OCA user population was 407,942 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 eight hospitals, 62 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 2021 American Community Survey 5-year report, there are 1,041,479 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 Covid-19, Diabetes and Chronic liver disease-cirrhosis is higher 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 COVID-19 (U07.1)	2 Malignant Neoplasms (C00-C97)
3 Malignant Neoplasms (C00-C97)	3 COVID-19 (U07.1)
4 Accidents (unintentional injuries)	4 Accidents (unintentional injuries)
5 Diabetes mellitus (E10-E14)	5 Chronic lower respiratory diseases
6 Chronic lower respiratory diseases	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 Intentional self-harm, suicide (X60-X84,Y87.0)	9 Intentional self-harm, suicide (X60-X84,Y87.0)
10 Alzheimer's disease (G30)	10 Chronic liver disease cirrhosis (K70,K73-74)

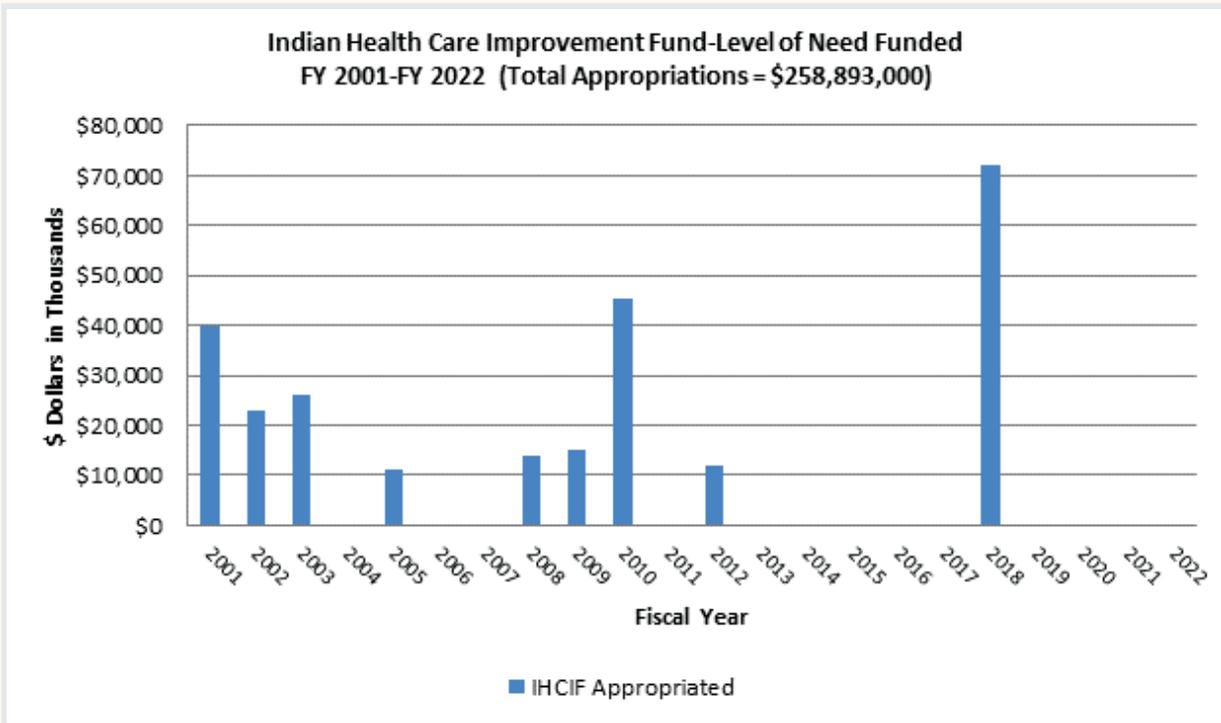
Source: Oklahoma State Department of Health (OSDH), Center for Health Statistics, Health Care Information, Vital Statistics 2021-2022 on Oklahoma Statistics on Health Available for Everyone (OK2SHARE). Ranking based on Age Adjusted Death Rate.

Budget Recommendations

1. 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 Areas in overall IHS funding, in FY 2022 the OCA per capita amount is \$1,999.

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 or FY2022. Given that user population is increasing year over year 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 2025, the OCA requests a substantial increase for the IHCIF. In 2018, the joint Tribal/Federal Workgroup developed recommendations for IHS to consider and make a final determination on the allocation methodology. Those recommendations were to be included in a final report to the IHS Director, which was due in July 2019. In early 2020, the IHS drafted the final report and requested workgroup input, however, to date IHS has not released a report. The OCA strongly suggests the IHS and workgroup complete the report and forward to the IHS Director so a final determination can be made. OCA specifically requests the following:

- » Complete the final report with recommendations on the new allocation methodology for the IHCIF; and
- » Through tribal consultation, the IHS Director adopt the recommendations on the new allocation methodology for better articulation of the IHCIF in the future; and

- » Communicate with all tribes the new allocation methodology for the IHCIF; and
- » Update the data in the IHCIF allocation methodology and release to all tribes annually; and
- » Identify and train new permanent statistical/technical staff as point of contact for future IHCIF need calculations; and
- » 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.

2. 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 \$300.78 per person for FY 2022. 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 2022, the numbers of PRC denied cases were 20,601 and deferred cases totaled 35,376 for those facilities reporting. Of the deferred cases, over 97% were for acute and chronic care. In FY 2022, OCA Catastrophic Health Emergency Fund (CHEF) reimbursed cases was approximately \$8.8 million. Furthermore, in the last five years (2015-2020), the OCA averaged over 17% of funded CHEF cases nationally but was funded at only at 12% on average for the PRC program when compared to all other IHS Areas combined.

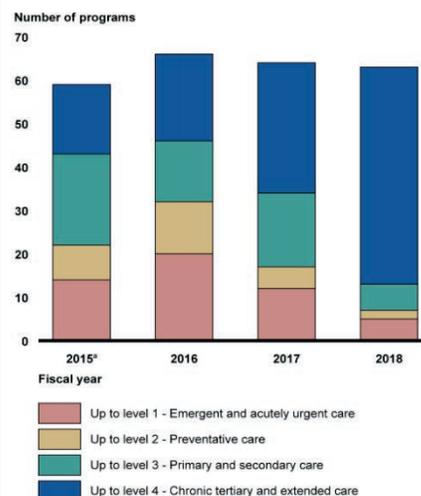
Again, the OCA does not have adequate funding for specialists, such as cardiologists, oncologists and specialized surgeons, readily available. OCA does not have tertiary hospitals and must utilize PRC to provide that aspect of specialty care. The cost of providing such services is disproportionately 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.

Figure 8: Medical Priority Levels Funded through Purchased/Referred Care (PRC) Programs Administered by IHS, Fiscal Years 2015 through 2018



Source: GAO analysis of Indian Health Service (IHS) data. | GAO-19-612

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.⁸⁶

⁸⁶ 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 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.

3. 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 service. Recent Congressional increases to M&I provided for some major repair projects. However, the M&I budget is funded at just over half of need to effectively maintain the physical condition of IHS-owned and tribally-owned healthcare facilities – which further distresses the backlog in essential maintenance and repairs, totaling nearly \$650 million.

The average age of IHS health care facilities is about 40 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 10 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 budget

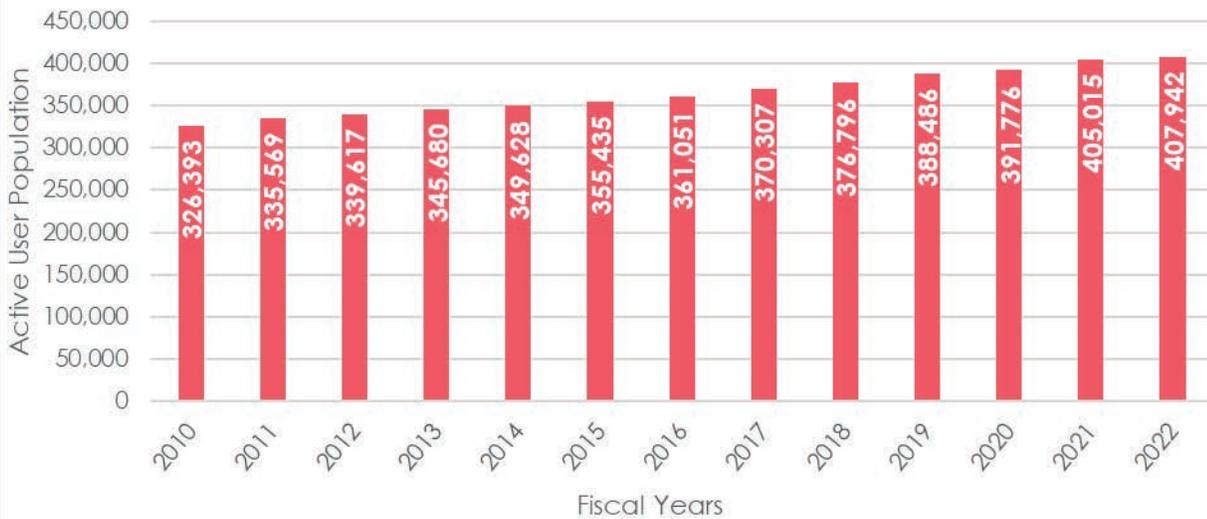
monies. The failure to complete needed repairs will lead to asset deterioration resulting in higher costs, asset failure, and health and safety implications. Geaslin's Inverse-Square Rule for Deferred Maintenance says that maintenance deferred until failure will cost 15 fold the repair value or the original value squared. The OCAIHS is concerned that unless a substantial infusion of M&I funds are provided in the FY 2025 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 October 2020 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.

4. Hospitals and Health Clinics, Including Health Information Technology

Hospitals and Health Clinics (H&HC) in the OCA funds essential personal health services for a user population of 407,942 AI/ANs including medical and general surgical inpatient care, routine and emergency ambulatory care, and medical support services including laboratory, pharmacy, nutrition, diagnostic imaging, physical therapy, and health information management. The IHS system of care is unique in that personal health care services are integrated with community health services. In addition, the program includes public and community health initiatives targeting health conditions disproportionately affecting AI/ANs such as diabetes, maternal and child health disparities, unintentional injuries and communicable diseases including influenza, HIV/AIDS, and hepatitis. Data collection, analysis, and interpretation is done through partnerships with area epidemiology centers throughout IHS service areas leading to the identification of health conditions as well as promoting interventions.

The increase is critically needed to help fund increasing staffing costs, primarily in rural America. The IHS has seen a drastic surge in population over the last 10 years without a sufficient increase in funding to support the added population. The OCA saw a 25% increase in User Population from 2010-2022, as reflected in the table below.

Oklahoma City Area Indian Health Service User Population FY 2010 - FY 2022



The OCA also experiences the ever-rising costs of pharmaceuticals, which have led to decreasing formularies. Over the last three years, the IHS has seen an increase of almost 10% in pharmaceutical expenditures. OCA must continue to provide life-saving medications used to treat heart failure and diabetes, even though drug costs continue to rise. H&HC funding must increase to meet this critical need.

Finally, screening and early detection efforts, which are known to be lifesaving through preventative and managed care, have not historically been funded. Within the OCA, there is an increased need to focus on early detection of cancer, diabetes, and heart disease as well as communicable diseases like HIV and Hepatitis C, so that intervention at an early stage can prevent other chronic conditions from co-occurring or in some cases, cure the disease altogether.

HEALTH INFORMATION TECHNOLOGY

As the COVID-19 Pandemic begins to wane, it is clearer than ever that IHS Health Information Technology (HIT) systems have limited capacity and interoperability to provide sufficient, real-time information to health care providers and partners. HIT improvement remains a top priority for Tribes. This is also a top priority for Legislators who supported HIT modernization and IHS leadership who continue to allocate recent federal funding related to pandemic relief and recovery and infrastructure investments to improve HIT systems. Most recently, the

IHS published a request for proposals to acquire a commercial replacement for the Resource and Patient Management System (RPMS).

Despite these investments, additional and recurring funds are necessary to achieve the plan as described in the Roadmap Report.⁸⁷ Information technology that supports both personal health services, (including the Electronic Health Record, patient portal and telemedicine) public health emergencies and initiatives have historically primarily been funded through the H&HC budget. Due to the complexity of HIT and the need to transition, store, and improve legacy systems, OCA continues to recommend that a new separate line item is essential.

5. 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.

⁸⁷ The Roadmap Report developed by the Department of Health and Human Services (HHS) laid out a number of priorities and plans, including establishment of a Project Management Office and governance structure, acquisition planning, HIT selection and procurement, implementation planning, and testing.



In addition, Urban Indian Organizations (UIOs) do not receive funding from other line items which 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.

Oklahoma City Area Hot Issues

The Oklahoma City Area has a total of 14 Hot Issues. They are as follows and more information on each issue is provided on the following pages:

1. Mandatory Funding
2. Indian Health Care Improvement Fund use for Mandatory Funding
3. Necessity for a Youth Regional Treatment Center
4. Establishment of a Special Cancer Program for American Indians and Alaska Natives
5. Electronic Health Records Modernization
6. Health Care in the Post-Pandemic World
7. Special Diabetes Program for Indians
8. Purchased and Referred Care Formula (Access to Care)
9. Joint Venture Construction Program
10. Indian Health Grant Funding and Contract Support Costs
11. Line Item Funding Flexibility
12. SDS Guidance and Implementation
13. Workforce Development
14. HHS (non-IHS) Program and Operation Flexibility

Mandatory Funding

ISSUE

To fulfill the federal government's trust responsibility to provide healthcare to its First Americans, the funding for IHS must be designated as Mandatory Funding.

BACKGROUND

The President's FY2023 budget request for mandatory funding was truly historic and we appreciate the budget request. We also understand that the FY2023 request was 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.

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 items that need to be worked out between IHS and the tribes to ensure any mandatory proposal is endorsed by both the Administration and Tribes.

RECOMMENDATION

The OCA recommends that IHS, HHS, OMB, and the Administration commit to continue engaging with a joint Tribal Federal- workgroup to develop the mandatory funding proposal. The National Budget Formulation Workgroup appointed a mandatory funding work group to work with IHS and the Administration to develop a mandatory budget proposal for IHS, despite the organization of this workgroup, IHS has not engaged the workgroup to achieve a mandatory funding proposal.

Indian Health Care Improvement Fund use for Mandatory Funding

ISSUE

The Indian Health Care Improvement Fund (IHCIF) budget line item, which has historically targeted funding equity across the Indian Health Service, was inappropriately used for proportional general budget increases using “mandatory funding” as the reasoning in IHS’s FY 2023 congressional justification. The agency proposed mandatory funding increases over five years of \$11.2 Billion to close the funding need gap across the IHS. Yet, the agency proposed the funding increases be allocated among all health service budget line items proportionally to each site. While mandatory funding is a commendable and worthy goal, the “proportional funding distribution” approach would undermine the IHCIF. It is the only budget line item targeted to bring funding parity to poorly funded sites; in fact, the approach would allow for greater increases to sites that already receive more funding per user. For example, the 2018 IHCIF analysis showed the average funding across all IHS sites was about \$4,300 per user; however, one site in one IHS Area received a little over \$1,400 per user to fund its health programs versus a site in another Area who received close to \$9,000 per user for its health programs. Thus, the approach to fully fund IHS will be at the expense of those sites who can least afford it; instead, it would increase rather than decrease such a disparity.

BACKGROUND

It is no secret that IHS is chronically underfunded. However, some tribes are not even funded at the IHS national average of around \$4,000 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 [IHCIF exists to address such inequity](#). It was established 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. 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. 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 National Tribal Budget Formulation Workgroup continues to advocate for full funding for the IHS via a mandatory appropriation; yet, capturing the full health need has been a hurdle. However, in its FY 2023 Congressional Justification, the IHS proposed the use of the IHCIF 2018 “level of need” analysis to close the funding gap over five years at \$11.2 billion. This was the first ever congressional justification that attempted to address the full funding need of the IHS. The problem was that the funding increases were proposed to be “distributed proportionally across the IHS funding lines”; in doing so, historical inequities will only grow.

RECOMMENDATION

Fully funded mandatory appropriations require a new conversation, which should ensure an *equitable* funding distribution to all. Unfortunately, there is no one IHS formula that addresses the full Indian health care need. The IHS Mandatory Funding Workgroup should address two issues: identifying the full funding need and distribution of the full funding using only a fair and equitable methodology. If mandatory increases do occur, funds should be distributed according to the current IHCIF 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.

Necessity for a Youth Regional Treatment Center

ISSUES

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
- » 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.

RECOMMENDATIONS

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.

Establishment of a Special Cancer Program for Indians

ISSUE

Cancer is now the second leading cause of death among AI/AN men, accounting for 15.9% of deaths in 2018; and the leading cause of deaths among AI/AN women, accounting for 17.9% of deaths.⁸⁸ Through recent decades, cancer death rates for AI/ANs increased or did not improve while decreasing for US Whites.⁸⁹ This population has the poorest cancer survival of all racial groups in the U.S.⁹⁰, and limited access to oncol-

88 Heron M. *National Vital Statistics Report: Deaths: Leading Causes for 2018*. Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System; 2018

89 Melkonian SC, Jim MA, Haverkamp D, Wiggins CL, McCollum J, White MC, Kaur JS, and Espy DK (2019). *Disparities in Cancer Incidence and Trends among American Indians and Alaska Natives in the United States, 2010–2015*. *Cancer Epidemiol Biomarkers Prev* 28, 1604–1611.

90 Jemal A, Ward EM, Johnson CJ, et al. *Annual Report to the Nation on the Status of Cancer, 1975-2014, Featuring Survival*. *J Natl Cancer Inst*. 2017;109(9).

ogy services⁹¹. High mortality rates, increasing complexity of care and often inadequate patient assistance place cancer at the top of urgently needed medical interventions. Increased funding towards local, specialized cancer programs for Indians would decrease mortality rates, increase diagnosis at earlier stages, and increase management care.

BACKGROUND

A major contributor to cancer disparities experienced by AI/ANs is diagnosis at a later stage, when recovery is less certain. This, in turn, is often the result of inadequate screening. Compared to US Whites, AI/AN communities experience poorer cancer outcomes, suboptimal cancer screening, and high-risk cancer behaviors. AI/AN cancer patients are less likely to undergo recommended surgeries, adjuvant chemotherapy, and radiation therapy compared to their White counterparts. Disparities occur in prevention, access to cancer treatment, and access to effective supportive and palliative care. An encouraging finding is that some targeted programs have demonstrated mitigation of cancer-related health disparities experienced by AI/AN communities.⁹² Replication and expansion of such programs should result in improved outcomes for AI/AN cancer patients.

Experience with the Special Diabetes Program for Indians (SDPI), established in the Balanced Budget Act of 1997 (P.L. 105-33, Section 4922), demonstrates that significant improvements can be achieved by strengthening local programs. For example, during the years 2000 to 2011, the rate of new cases of diabetes associated kidney failure requiring dialysis declined 43 percent.⁹³ SDPI likely accounted for a substantial proportion of such improvement.

RECOMMENDATION

Recurring appropriation of \$150,000,000 annually is recommended. Like what the SDPI did for reducing the kidney failure rate, the implication for such a special cancer program would likely decrease cancer mortality among other outcomes.

Challenges of cancer diagnosis and management among AI/ANs require greater efforts directed toward several critical points. Applying specific focus on cancer prevention, diagnosis and management will surely result in improved outcomes for AI/AN cancer patients and would likely have benefits that extend beyond malignancies. The time has arrived for the establishment of a dedicated Cancer Program for Indians.

91 Warne D, Kaur J, Perdue D. American Indian/Alaska Native cancer policy: systemic approaches to reducing cancer disparities. *J Cancer Educ.* 2012;27(1 Suppl):S18-23.

92 Guadagnolo BA, Petereit DG, Coleman CN. Cancer Care Access and Outcomes for American Indian Populations in the United States: Challenges and Models for Progress. *Semin Radiat Oncol.* 2017 Apr. 27 (2): 143-149.

93 *Justification of Estimates for Appropriations Committees*; Indian Health Service, Fiscal Year 2017, Rockville, MD 20857; January 11, 2016

Electronic Health Records Modernization

ISSUE

The Secretary should request dedicated and appropriate resources to fully support the modernization of the Indian Health Service (IHS) electronic health record (EHR) as supported by Modernization Focus Group input and generally outlined in the *Strategic Options for the Modernization of the Indian Health Service Health Information Technology (Roadmap)*.

BACKGROUND

In Fiscal Year 2019, the Department of Health and Human Services (HHS) and 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 publication of a request for proposal to acquire a commercial replacement of RPMS. IHS continues to engage tribal and urban Indian organization stakeholders in focus groups to develop HIT governance, data management strategy, and implementation deployment plan.

Congress has made incremental investments in modernization efforts, including recent Pandemic relief and recovery funds and Infrastructure investments. However, to achieve the results that support stakeholder needs, HHS must request and receive dedicated and recurring appropriations to stabilize current RPMS functionality, to address the identified critical infrastructure gaps through acquisition and planning; and to implement and maintain future HIT systems.

RECOMMENDATION

OCA supports continuation of the congressionally appropriated funding for IHS HIT modernization projects. Therefore, OCA recommends that IHS and HHS commit to request 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.

OCA is also supportive of the Focus Group process IHS is using to seek feedback from stakeholders and system-level users. Despite the adopted process, the process for selection, implementation and adoption of a new commercial system is still unclear. As are critical policy decisions around data governance and tribal sovereignty in the process. 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.

Indian Health Care in a Post-Pandemic World

ISSUE

Addressing chronic Indian health conditions has always been a challenge across the Indian Health Service; this is a direct result of continuing underfunding, which causes a rationing of care considering ongoing critical and severe Indian health needs. One issue is overcoming health disparities such as a higher mortality rate in proportion to the general population. This was never more obvious than during the Covid-19 pandemic. Statistics outlined in the OCA's FY2025 budget narrative demonstrate that Covid-19 was a major cause of death for the Area in the mix of ongoing comorbidities such as heart disease, diabetes and cancer. The OCA's tribal communities are committed to long-term *positive* health outcomes but can only do so if properly supported.

BACKGROUND

Our population, compared to other Americans, continues to endure high rates of chronic illnesses largely due to chronic underfunding of the IHS. In FY2021, the IHS spent \$4,140/user. The IHS's spending is caused by limited annual appropriations especially when compared to other health care spending. For example, the 2021 National Health spending per capita is \$10,680 – more than double that of IHS's level. As reported by the [White House](#), "the COVID-19 pandemic exacerbated pre-existing health care inequities facing Tribal Nations and disproportionately affected Native American populations across the country". Natives experienced infection rates over three times higher than non-Hispanic whites, were four times more likely to be hospitalized as a result of COVID-19 and had higher rates of mortality at younger ages.. Historical trauma,

rural settings, poor access to health care, co-morbidities, and poverty have all contributed to the disproportionate burden of the pandemic among AI/AN residents. Many tribes report a demand for culturally relevant public health messaging and COVID-19 surveillance. Mental health issues brought about by the pandemic were evidenced by a 2021 Robert Wood Johnson-led study where three out of four Native American households reported mental health problems. The ongoing health emergencies for AI/AN people during Covid-19 provides unprecedented opportunity to strengthen the public health infrastructure through systemic investment.

RECOMMENDATION

The goal remains the same: to drastically improve the overall health status of our patients. The OCA continues to support the Covid-19 Health Equity Task Force recommendations as follows:

- » Fully-fund the Indian Health Service;
- » Partner with communities to expand testing and vaccination effort including enactment of communication campaigns during public health emergencies to reach AI/AN population, wherever they live and work;
- » Ensure access to clear water and sanitation;
- » Expand telehealth and telemedicine access and reimbursement with household access to affordable broadband internet in medically underserved communities
- » Reduce hospital and health care facility closures that negatively affect AI/AN communities;
- » Invest in data infrastructures to research and collect data on behavioral health; and
- » Create funding for and accessibility to healthy food options.

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 25-year history. The 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 25 years, the SDPI program has endured six short-term extensions; these extensions ranged from several weeks to several months!

SDPI has become a crucial preventative and clinical program for tribal healthcare 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 \$200 million would provide a substantial increase to not only maintain current programs, but it would also allow for an opportunity to bring on new tribal health programs who have not been able to apply for the SDPI previously. 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.

Purchased/Referred Care Formula - "Access to Care"

ISSUE

The Director's Workgroup on Improving Purchased/Referred Care (PRC) has been discussing, at the request of other IHS Area Tribes, a review of the PRC Formula. The basis for the request is a proposal to increase the prominence and weight of the existing "Access to Care" component of the formula to address a perceived need to more highly prioritize IHS Areas

without IHS/Tribal hospitals. This would reduce the allocation of new PRC funding to the OCA, should the Workgroup agree to this proposal to revise the formula in this way.

BACKGROUND

The current PRC formula has been in place since 2001, the product of a Tribal Workgroup and Tribal Consultation. It has three components that were deliberately placed in order of priority to direct new, increased PRC appropriations (not to redistribute any base funding). Congressional earmarks are addressed first, followed by inflationary adjustment, and third are new formula components of population, relative cost and "access to care". Inflationary adjustment was prioritized prior to other elements of the formula on the principle of "do no harm", in an attempt to ensure that the purchasing power of the existing PRC base did not erode over time. Despite this, the per patient level of funding in the OCA has continued to reduce each year, and at \$300.78 in FY2022 remains the lowest PRC funding of any IHS Area.

The "Access to Care" component of the formula was included in 2001 as a proxy to address those Areas without a large amount of direct care services available, such as IHS/Tribal hospitals. No IHS Area is 100% PRC dependent, as all have some number of IHS/Tribal facilities in which direct care is delivered. This was a compromise among Tribes based on anecdotal perception that the level of need for PRC funding is more in these IHS Areas; however, there are no data to support that assumption. In fact, the data actually shows the opposite – that access to care is more complex and this component (which gives priority to those IHS Areas without IHS/Tribal hospitals) does not translate to a greater need for PRC. Observations to support this are:

- » OCA remains the lowest funded PRC program, at \$301 per patient per year;
- » OCA programs continue to only be able to fund Medical Priority 1 in general, and specifically the two IHS hospitals in OCA are the two federally operated hospitals that are only able to approve Priority 1 cases;
- » PRC denials and deferrals in the OCA remain very high, perhaps the highest within the IHS – 55,977 cases in FY 2022;
- » The Level of Need Funded for OCA, which includes PRC and direct care, is the lowest among the IHS Areas, at 38% of funds needed in FY 2018; and,
- » Clearly, the mere existence of IHS/Tribal hospitals in the OCA do not translate to greater access to care, and other factors such as population growth, level of need funded, distance to tertiary care, PRC deferrals/denials, PRC Medical Priorities funded, and others are likely better indicators.

RECOMMENDATION

Should the PRC Workgroup consider changes to the formula, it should analyze the so-called “Access to Care” component carefully. If there is no data that support the inclusion of this factor, the origins of which were more political in nature than scientific, it should be considered for deletion. Further, if an “Access to Care” component is retained, it must be supported by quantifiable data that truly address the access to care within IHS by Native patients in the OCA.

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 (HFPCS) 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 HFPCS 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 healthcare 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. Several examples exist but the latest involves the funding the White House allocated in American Rescue Plan Act resources (\$210 million) to the IHS for “public health workforce activities”, \$47 million of which was for “Public Health Capacity Building in Indian Country” funded as competitive grants. IHS stated that such a competitive grant approach allows the IHS to “track the outcomes and performance of these funds

to demonstrate the effectiveness of critical investments”. Another example was the reissuance of the [IHS Behavioral Health](#) and [Domestic Violence Prevention](#) programs (formerly Methamphetamine and Suicide Prevention Initiative (MSPI) and Domestic Violence Prevention Initiative (DVPI)). The recent decision to distribute this program funding through a granting mechanism is despite tribal consultation feedback where the grant-making process was strongly opposed. The IHS decided to issue 6 grant announcements, some of which are new. 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 practice of grant making should be concluded and a permanent recurring base 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.

Line Item Funding Flexibility

ISSUE

Inability to maximize efficiency of programmatic funds across accounts, especially at federally operated health facilities (direct service) at the service unit level.

BACKGROUND

As stated in our prior Budget Recommendations, current appropriations law creates a barrier for the IHS to fully utilize authorized annual funding. If savings are achieved in a one-year authority account, IHS is limited in its ability to reprogram funding to meet other critical health needs, such as for Purchased/Referred Care or replacement of defunct or obsolete medical equipment. Other impacts include:

- » Limited funding by Continued Resolutions impacting the quality of care provided by federally operated health facilities;
- » Enforcing limited funds for specific programs
- » Inadequate administrative funding and personnel, which leads to restrictive salaries for medical professionals and inadequate support in offices such as procurement, human resources, finance, etc.

RECOMMENDATION

In order for IHS to reduce these disparities in the Indian Health system, the IHS must be granted the following authorities:

- » Receipt of funds in a single allocation at the beginning of the fiscal year so that Tribal nations and health facilities are able to receive quality, timely care unrestricted of limited funding. (Advanced Appropriations and/or Mandatory Appropriations).
- » The ability to reprogram funds between account lines to allow greater flexibility to meet health service delivery priorities, in consultation with Tribes.

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 current 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 IJJA provided up to 3 percent of the funds (\$21 million) for “salaries, expenses, and administration” each fiscal year, yet these funds are 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 important 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](#) 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 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 in 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 IJJA. \$3.5 Billion was set aside to address the full SFC need. In addition, Congress directed IHS to use a potentially very large 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 are only available to support federal costs and tribal administrative costs remain unfunded.

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 current project-based funding and funds large economically infeasible projects most of the unprecedented funding available for SFC under IJJA could consume most of the funds, leaving many economical, feasible, water and sanitation needs still unfunded.

In the long-term, the IHS needs to consider a formula, rather than project-based methodology, for distribution and to recommend a formula that considers population and other existing factors. 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 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, limited access to schools 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 its own recruitment tool. 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 and 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).
- » 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. as like National Service Corp Program, VA or Military.
- » 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) Program and 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 and Health Resources and Services Administration. Agency programs may be similar but do not always complement or work with one another. None allow consolidation. Each requires separate an annual application 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. For example, IHS could enter into Memorandums of Agreements with sister agencies to transfer existing programs and funds while maximizing program flexibility wherever possible.

PHOENIX AREA

Phoenix Area Narrative

The Annual Phoenix Area Indian Health Service (PAIHS) Budget Formulation process was conducted in a hybrid setting (in-person and virtually) on December 05, 2022. The outcome of the session included agreeing on a full funding recommendation for the FY 2025 Indian Health Service (IHS) budget at \$53.8 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 gave the opening prayer. Ms. Carol Chicharello, 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 FY25 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 2023 and FY 2024 Budget Requests. At this meeting, last year's FY 2024 Phoenix Area and National recommendations were presented. 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 and Phoenix Area Dept. of Information Technology. PAIHS Finance staff reviewed the FY 2024 spreadsheet and informed the participants that the formulation process will involve building on the FY 2024 Phoenix Area national budget recommendation of \$51.3 billion in order to develop a budget at the \$53.8 billion level. Attendees were informed that the Inter Tribal Council of Arizona, Inc., PAIHS contractor, will complete deliverables (#2-4) for the budget formulation process.

Ms. Carol Chicharello led the discussion on Hot Topics and Budget Priorities that stemmed from topics submitted by the Tribes/UIOs listing their respective issues. The bulk of the meeting was to discuss 1) Summary of FY 2024 National Recommendations, 2) Overview of Budget Worksheet, and 3) Significance of Full Funding Amount and Current Services and Binding Obligations. The Tribes were able to begin to identify priority line items and recommendations for FY 2025.

The afternoon session continued on with the budget worksheet and budget justification narrative. Jessica Rudolfo, Tribal Health Director of the White Mountain Apache Tribe provided feedback and tribal perspective with regards to completing the worksheet.

The final Tribal/UIO recommendations are as follows:

Recommendation I:

Tribes and UIOs in the PAIHS FY 2025 Budget formulation process concur with and recommend a total budget of \$53.8 billion. The additional \$1.66 billion includes specific adjustments over the Phoenix Area's FY 2024 Tribal budget recommendation, in the following line items:

CLINICAL SERVICES: +\$1.07 billion

Hospitals & Clinics: +\$961 million

Dental Health: +\$100 million

Mental Health: +\$1.2 million

Alcohol & Substance Abuse: +\$1.7 million

Purchase Referred Care: +\$10 million

PREVENTATIVE HEALTH: +\$235 million

Public Health Nursing: +\$2.3 million

Health Education: +\$394,000

Community Health Representatives +\$233 million

OTHER SERVICES: +\$273 million

Urban Health: +\$92.6 million

Indian Health Professions: +\$20 million

Direct Operations: +\$157.4 million

Self-Governance: +\$3.2 million

FACILITIES: +\$81.9 million

Maintenance & Improvement – +\$20,000

Health Care Facilities Construction: +\$81.8 million

Equipment: +\$7,000

Recommendation II:

Priority funding was determined based on the highest percentage changes over the FY 2022 IHS Enacted Budget in many line items 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 (IHCA) (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:

Priority 1 – Hospitals & Clinics +\$961.5 million – The major increase includes several Phoenix Area priorities noted in last year’s FY24 recommendation that we seek to advance in FY25 under H&C.

- » Health Information Technology Modernization / Telehealth
- » Recruitment and Retention
- » Implementation of certain unfunded provisions of the IHCA
- » Extra Support for Small Tribes
- » Long Term COVID-19 Repercussions

Priority 2 - Community Health Representatives +\$233 million - The program increase of \$233 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 IHCA 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

Priority 3 - Direct Operations +\$157.4 million - The program increase of \$157.4 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 IHCA 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

Priority 4 – Dental Health +\$100 million - The program increase of \$100 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 IHCA 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)

Priority 5 - Urban Health +\$92.6 million - The program increase of \$92.6 million identified in FY24 remains a top concern in FY25. This line item has remained static for too long. Services must be aligned and enhanced across the Indian health care system.

The IHCA provisions aligned with this priority are included in the following statutes.

SUBCHAPTER IV—HEALTH SERVICES FOR URBAN INDIANS §1651. et al

Priority 6 - Health Care Facilities Construction +\$81.9 million - The program increase identified in FY24 remains a top concern in FY25. \$81.9 million would fund the following:

- » Maintenance & Improvement: +\$20,000
- » Health Care Facilities Construction: +\$81.8 million
- » Equipment: +\$7,000

The IHCA provisions aligned with this priority are included in the following statutes.

SUBCHAPTER III—HEALTH FACILITIES (§1631 et al)

Priority 7 – Indian Health Professions +\$20 million - The program increase identified in FY24 remains a top concern in FY25. \$20 million will provide funding for needed recruitment and professional development opportunities in order to fill critical vacancies.

The IHCA 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

Priority 8 - Purchased Referred Care (PRC) +\$10 million - The program increase of \$10 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

Priority 9 - Self-Governance +\$3.2 million – The program increase of \$3.2 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

Priority 10 - Public Health Nursing +\$2.3 million – The program increase of \$2.3 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

Priority 11 – Alcohol/Substance Abuse +\$1.7 million – The program increase of \$1.7 million identified in FY24 remains a top concern in FY25. 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

Priority 12 - Mental Health +\$1.2 million – The program increase of \$1.2 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

Priority 13 - Health Education +\$394,000 – The program increase of \$394,000 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

Priority 14 - Maintenance & Improvement +\$20,000 – 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

Priority 15 – Equipment +\$7,000 – The program increase of \$7,000 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

Phoenix Area Hot Issues

Introduction

The Tribes and Urban Indian Organizations in the Phoenix Area recommend a total IHS budget of \$53.8 billion in Fiscal Year 2025, 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, 2022 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 \$53.8 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. Compare this to the actual IHS appropriation of \$6.7 billion in FY 2022. 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:

- » Secure Advanced Appropriations (2-year funding cycles) & Permanent Exemption from Sequestration for the IHS. The Tribal Leaders are appreciative of the supportive authorities for various IHS programs and services which were enacted as part of FY 2023 appropriations.

- » 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 \$10 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, continued funding is requested although no program increases have been recommended above the FY 2024 amount and associated binding obligations.
- » 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 through compacts and contracts.

Fully and mandatorily fund Indian health care improvement act provisions

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 (IHCA). As a part of the IHCA 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 IHCA provisions were driven by the concern that American Indians and Alaska Natives (AI/AN) are especially impacted by disparities in health and healthcare access. Historically, one outcome of treaties between Tribes and the federal government is that all federally recognized Tribes have a right to healthcare 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 \$10 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 \$10 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 increase for FY 2025 for Indian Health Professions is \$20 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 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 will be solicited for simultaneously 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.

SUPPORT FOR FUNDING INCREASES FOR COMMUNITY HEALTH REPRESENTATIVES (CHR) & HEALTH EDUCATION AND NEW APPROPRIATIONS TO ADVANCE THE NATIONAL COMMUNITY HEALTH AIDE PROGRAM (CHAP)

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 FY2025 budget include the necessary resources to provide increases of \$233 million for CHRs and \$394,000 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 of \$2.3 million to support Public Health Nursing in FY 2025.

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 IHCA. 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 (IHCA) 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 IHCA 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 \$92.6 million for FY 2025.

SELF-GOVERNANCE

ISSUE

Additional funding is required to carry out functions supported by the Indian Health Service (IHS) under Self-Governance Funding Opportunities.

BACKGROUND⁹⁴

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

94 Citation: [IHS.gov/SelfGovernance/funding/](https://www.ihs.gov/SelfGovernance/funding/)

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 increase in FY 2025 for Self-Governance funding is \$3.2 million.

ENHANCE DENTAL AND EMERGENCY MEDICAL SERVICES (EMS) 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 an additional \$100 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 MATCH 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 rely 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 COVID REPERCUSSIONS

ISSUE

The COVID-19 National Public Health Emergency (PHE) was a topic addressed by the attendees during the FY2025 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 as 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:

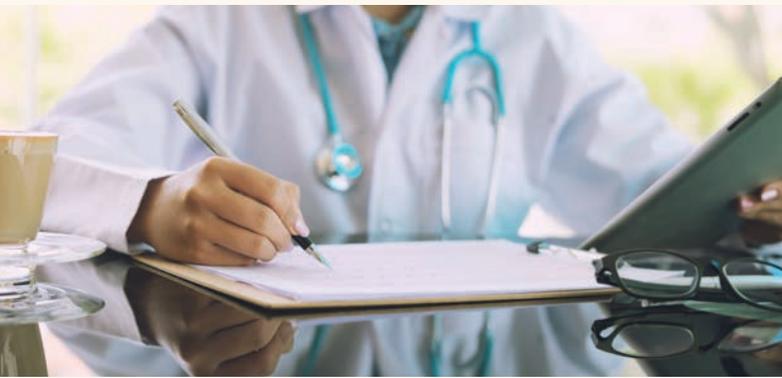
<https://www.ihs.gov/coronavirus/view>

<https://www.cdc.gov/coronavirus/2019-ncov/covid-data/covid-view/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 HEALTH) 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 2025, include a funding increase of \$1.2 million for Mental Health and a \$1.7 million increase 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 IHCA 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 IHCA 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 IHCA provisions in SUBCHAPTER III—HEALTH FACILITIES (§1631 et. al.) that require committed funding. For these reasons, a total of \$81.9 million has been identified as recommended increase for Facilities in FY 2025. Further, increases in funds are encouraged to assure the appropriate SFC engineering workforce to deliver funded projects and associated workload.

PORTLAND AREA

Portland Area Narrative

Portland Area IHS held a virtual consultative meeting on November 3, 2022 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 2025 budget recommendations were established, as highlighted below.

Summary of FY 2025 Budget Recommendations

The national budget mark for FY 2025 is a full funding request of \$54 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 Tribes recommend that the Health Care Facilities Construction Priority System be reformed to ensure equity across areas in new health care facility construction and staffing.

Budget Line	Recommended Percentage Increases
Purchased/Referred Care	70%
Mental Health	10%
Alcohol & Substance Abuse	10%
Hospitals and Health Clinics	5%
Urban Health	5%

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, Healthcare Facilities Construction & Contract Support Costs

The 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 IHS does not support funding for facilities construction and related staffing.

Portland Area IHS supports the Contract Support Cost indefinite appropriations to ensure full funding required to support contracted or compacted programs.

Purchased/Referred Care

Portland Area IHS recommends allocating 70% of FY 25 increases to the Purchased/Referred Care (PRC) budget line item. Portland Area IHS does not have hospitals or specialty care centers. Thirty percent (30%) of the Portland Area IHS budget is comprised of PRC. Tribes must rely on the PRC program for tertiary and inpatient care. The increase would allow tribes to purchase health insurance coverage for their members under Section 152 of the Indian Health Care Improvement Act (IHCA).

Hospital and specialty care provided through PRC funds are needed to support health care to address the following health disparities and unintentional injuries:

Cancer: In the Portland Area, cancer is the leading cause of death for AI/AN people ages 55-64 and the second leading cause of death for AI/AN people of all ages. Despite having similar cancer incidence rates, AI/AN cancer mortality rates are approximately 1.3 times higher compared to non-Hispanic Whites (NHW) in the region, with larger disparities observed for lung, colorectal, and liver cancers (1.5, 2.6, and 3.2 times higher for AI/AN). 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: 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. In the Northwest, approximately 8% of AI/AN adults report ever having a heart attack. Although heart disease was once relatively uncommon in AI/AN populations, it is now the leading cause of death for AI/AN people in the Portland Area. AI/AN mortality rates from major cardiovascular diseases, including stroke, are 1.6 times higher compared to non-AI/AN people in the region. The sharp rise 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. AI/AN people are four times more likely to die from chronic liver disease and cirrhosis compared to the general population. 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 have 2 to 4.5 times the risk of dying from hepatitis C compared to non-Hispanic whites.

Diabetes: In the Portland Area, approximately 15% of AI/AN adults report having been diagnosed with diabetes. 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 non-AI/AN people in the region. 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 during 2021, and was the primary cause for the sharp decrease in life expectancy experienced by AI/AN people in 2020. 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. AI/AN people are 1.6 times more likely to die from influenza and pneumonia compared to non-AI/AN people in the region. 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. A similar disparity in mortality was seen for deaths from viral hepatitis.

Unintentional Injuries: Unintentional injuries are the leading cause of death for AI/AN people from ages 1 to 54, and the third leading cause of death overall for AI/AN people in the Portland Area. AI/AN people experience over twice the mortality rate for unintentional injuries compared to non-AI/AN in the region. Deaths from unintentional injuries among Northwest AI/AN people have increased sharply since 2019, driven by

increases in overdoses, falls, and homicide and suicide deaths involving firearms.

Mental Health

Portland Area IHS recommends allocating 10% of FY 25 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, IHCA allows for expansions to behavioral health programs which have not received substantial funding since enacted. Funding increases would be used to implement IHCA 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 IHCA 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. Over 30% of adult AI/AN people in the Northwest report having been diagnosed with depression. 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: According to the 2014 trends in Indian Health, in comparison to other US races, AI/AN people have a 60% greater chance of suicide. Suicide was the 9th leading cause of death among AI/AN people in the Portland Area in 2021 and accounted for 3% of all deaths among AI/AN people. Suicide mortality rates for AI/AN people are 60% higher compared to non-AI/AN people in the region. The AI/AN suicide mortality in the age group 10-29 is 2-3 times greater than that for non-AI/AN people.

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.

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 10% of FY 25 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, AI/AN people are more than 3.5 times more likely to die from alcohol-related causes than non-AI/AN people, and almost 2.5 times likely to die from a drug overdose than non-AI/AN people. Opioids are involved in 80% of AI/AN overdose deaths, and methamphetamine is involved in over 30% of AI/AN overdose deaths in the Northwest. Opioid-related overdose rates among AI/AN people in the Northwest have increased by 320% since 2018. During the first year of the COVID-19 pandemic, emergency department visits for overdoses increased sharply among young AI/AN people less than 17 years of age.

Hospitals and Clinics

Portland Area IHS recommends allocating 5% of FY 25 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 IHCA 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 5% of increases in FY 25 to the Urban Indian Health budget line item, in part, to allow Urban Indian Organizations to purchase insurance for their users.

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 IHS budget request demonstrates a commitment to maintain health programs by funding current services. The Portland Area IHS recommendations funding initiatives to address the health disparities that exists 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.

Portland Area Hot Issues

Indian Health Service Appropriations

BACKGROUND

Indian Health Service (IHS) is currently funded through discretionary annual appropriations. Lapses in appropriations and continuing resolutions jeopardize the health of American Indian/Alaska Native (AI/AN) people and is harmful to the Indian health system.

RECOMMENDATION MANDATORY FUNDING

Mandatory funding would ensure adequate, stable and predictable funding annually.

ADVANCED APPROPRIATIONS

Advanced appropriations would ensure two years of funding, reduce administrative costs and allow federal and Tribal health programs to formally plan and address emergent health issues. This has benefited the Veterans Administration and could similarly benefit IHS and the Tribes that operate programs under Public Law (P.L.) 93-638.

Medicaid and Medicare Reimbursements

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.

RECOMMENDATION COMMUNITY HEALTH AIDE PROVIDER REIMBURSEMENT

Dental Health Aide Therapists (DHAT), Behavioral Health Aides/Practitioners, and Community Health Aides/Practitioners will need to be reimbursed at the OMB Encounter Rate by Medicaid and Medicare to ensure sustainability in the system.

MEDICARE OUTPATIENT ENCOUNTER RATE

Tribes urge CMS to allow all outpatient Tribal health programs to be paid for their Medicare services at the OMB Encounter Rate.

FOUR WALLS

Tribes request that the interpretation of “clinic services” to allow Indian Health Care Providers (IHCP) to be reimbursed for services furnished outside their four walls.

TRADITIONAL HEALING AND ALTERNATIVE CARE

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.

Mental Health & Substance Use Disorder (SUD)

BACKGROUND

The COVID-19 pandemic 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. During the first year of the COVID-19 pandemic, emergency department visits for overdoses increased sharply among young AI/AN people less than 17 years of age. Since 2018, opioid-related overdose rates among AI/AN people in the Northwest have increased by 320%.

RECOMMENDATION COMPREHENSIVE OPIOID/ FENTANYL RESPONSE

Tribes request cross-collaboration of governmental agencies to comprehensively address the opioid/fentanyl crisis in Tribal communities. Tribes also request federal and state agency support of a Tribally-driven, multi-year plan, with the end goal of ending this crisis. Tribes recommend the following federal agencies to 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, and Department of Interior.

Tribes are interested in replicating successful models to treat opioid misuse such as the Swinomish Tribal Community's didgʷálič Wellness Center “Integrated Care” model. Capital funds are needed to build facilities to replicate this model program in Tribal communities; and Tribes are interested in innovative interventions, such as Narcan vending machines.

PREVENTION AND TREATMENT FUNDING

Tribes request a 5% Tribal set asides of Substance Use Mental Health Services Administration funding to increase support prevention and treatment services available to Tribes, with funding provided directly to Tribes through interagency agreements between SAMHSA and IHS so that funds can be transferred to Tribes through ISDEAA compacts and contracts. Tribes also request that State Block Grant funds allocated for Tribes to be retained by SAMHSA and transferred to Tribes through ISDEAA compacts or contracts or directly to Tribes.

SUICIDE

Tribes recommend increased funding to reduce suicide rates and increase Tribal capacity to prevent suicide throughout Indian Country. Tribes request 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

Fully fund the National Tribal Behavioral Health Agenda to improve the behavioral health of AI/AN people. This includes acknowledging and supporting the development of Tribal-based, traditional Indigenous knowledge and cultural practices in prevention and interventions.

BEHAVIORAL HEALTH AIDES (BHA)

Tribes request partnership with SAMHSA and IHS to support the Behavioral Health Aide 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

While much has been done to address the opioid epidemic throughout the country, funding and access to inpatient treatment programs for AI/ANs with alcohol, methamphetamine, and/or opioid misuse are still needed. The use of methamphetamine is causing tremendous cost to the Indian health care system. Studies show that to be effective, Tribes need to pay for 180-day inpatient treatment, as well as after care and housing. Tribes also need access to secure detoxification centers. Tribes recommend increased funding.

YOUTH RESIDENTIAL TREATMENT CENTERS, AFTERCARE AND TRANSITIONAL LIVING SUPPORT

Tribes request consultation 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.

NATIONAL TRIBAL BEHAVIORAL HEALTH AGENDA

Fully fund the National Tribal Behavioral Health Agenda to improve the behavioral health of AI/AN people. This includes acknowledging and supporting the development of Tribal-based, traditional Indigenous knowledge and cultural practices in prevention and interventions.

YOUTH BEHAVIORAL HEALTH AGENDA

Stress the importance of in-person and virtual behavioral health resources (for example: THRIVE Mental Health Needs Assessment and Adolescent Health Tribal Action Plan 2021), which include addressing expansion of youth-friendly telehealth services and tailored mental health and alcohol & drug prevention messaging.

TRADITIONAL HEALING

Traditional healing among AI/ANs 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 Indigenous populations. Tribes request equitable funding for traditional healing practices, evidence-based practices, and reimbursement by Medicaid and Medicare.



Community Health Aide Program (CHAP) Expansion

BACKGROUND

Indian Health Service and Northwest Portland Area Health Board, with the support of the Portland Area Tribes, have established a CHAP Certification Board, Dental Health Aide Therapist (DHAT) and Behavioral Health Aide (BHA) education programs. NPAIHB has successfully worked with the states of Idaho, Oregon and Washington and the Tribes to lay the foundation for integration of these providers into our health systems.

RECOMMENDATION

CHAP was funded at \$5 million in FY 2020 and IHS awarded \$7.7 million to support national expansion in FY 2021. Tribes request funding for the national CHAP expansion at \$60 million with \$10 million for Portland Area to continue to expand CHAP. The Tribes recommend that the Portland Area is included for any CHAP education funding to support our education programs for Dental Health Aide Therapists and Behavioral Health Aides. Tribes request that CHAP providers, including Dental Health Aide Therapists, Behavioral Health Aides, and Community Health Aides to be eligible health professions for IHS Scholarship and Loan Repayment Programs. Tribes request capital funds to support CHAP expansion education facilities.

Regional Specialty Referral Center

BACKGROUND

Portland Area Indian Health Service doesn't have hospitals or specialty centers, requiring Tribes to rely on Purchased and Referred Care (PRC). Tribal members, 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. The Portland Area Office, in consultation with the Portland Area Facilities Advisory Committee, a local Tribal advisory group, are moving forward on the first center. The facility is anticipated to provide medical and surgical specialty care, specialty dental care, audiology, physical and occupational therapy, advanced imaging and outpatient surgery. This facility could provide services for approximately 50,000 users within the regional service area as well as an additional 20,000 in telemedicine consults.

RECOMMENDATION

Tribes request funding for the other two Portland Area Regional Specialty Referral Centers with one designated as an inpatient and outpatient mental health facility, and/or that provides comprehensive inpatient and outpatient mental health services.

Staffing, Recruitment and Retention

BACKGROUND

Both federally operated and Tribally operated facilities 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 PRC funding for services. For example, if IHS has a dental provider vacancy, a Tribe may pay for dental care using their PRC funding.

RECOMMENDATION RECRUITMENT AND RETENTION

Recommend full funding of IHCA 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. Tribes request the same competitive advantage as the VA to grant higher levels of annual leave accrual to providers under Title 38 PDP.

REIMBURSEMENT

Direct Service Tribes request reimbursement from IHS for services that are not provided by federal IHS staff due to staffing shortages and that are paid for by PRC funding.

TUCSON AREA

Tucson Area Narrative

The Tucson Area is submitting a National Budget Increase as requested by the Tribal Budget Formulation Workgroup at the 4.74% level over the FY 2024 National Budget Recommendations to achieve National Needs Based Funding amount of \$53.8 billion by 2025. The Tucson Area Office (TAO), Tohono O'odham Nation (TON), Pascua Yaqui Tribe (PYT) and the Tucson Indian Center (TIC) recommend the 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 2025 National Budget when fully funded; these include but are 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.

TOP BUDGET PRIORITIES AND INCREASES

1. *Purchased/Referred Care (PRC)*

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 case, 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 diagnoses 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. In addition, the designation of Arizona as a state-wide purchased/referred care delivery area (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 will be required. Increased funding is 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 healthcare services.

2. *Hospitals & Health Clinics (H&HC) Dental Equipment*

The Tucson Area recommends to preserve, protect and expand new services under the new provisions of the Indian Health Care Improvement Act (IHCA). With a fully funded budget, the access to quality health care would be possible and would provide funding to support expanding services in the IHCA (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 healthcare, due to global issues.

The lack of state reimbursement in Adult Dental Services causes 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. With the supply chain challenges, PPE and sterilization supplies are difficult to acquire due to demand and price increases.

Equipment upgrades are needed throughout the facilities and in mobile units.

3. 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 2023. 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.

4. New/Replacement Equipment

Tucson Area recommends funds for new and replacement equipment in order to provide quality medical services to diagnose and treat certain medical illnesses. Bio- medical life expectancy of current equipment has been surpassed and does not meet current healthcare 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.

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 licenses, wireless and local area network connectivity, communication systems and upgrading the data infrastructure for mobile health care units.

5. Mental Health (MH)

There is a need to expand Public Health services to respond to the broad 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 and provide adequate behavioral health training and community educational programs.

The recent increases in behavioral health funding have 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. There are time constraints in the grant process to award funding which creates a barrier to address behavioral health crises and interventions. Due to limited availability of services, 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.

American Indians and Alaska Natives fall victim to violent crime at more than double the rate of all other U.S. citizens. At least 70% of violent victimization experienced by American Indians and Alaska Natives is committed by non-Natives, usually while they are drinking. 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.

According to the CDC, the following factors increase 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 request direct funding to implement new specialized providers, therapists, clinicians and physicians to enhance services, which include developing interventions for pre and post suicidal preventive programs.

6. 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 public health nurses, 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 health promotion and outreach. Without the fundamental services CHRs provide, Native Americans right to quality healthcare would suffer and most individuals would be unable to access their healthcare 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 the COVID-19 response team; 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.

7. 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.

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.

8. Expand Urban Program

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.

9. Long Term Care/Assisted Living Services

The Tucson Area requests 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; increased funding is direly needed 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.

10. Sanitation Facilities Construction

The Tucson Area requests additional SFC funding to continue meeting existing and future 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 33 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 18 homes that lack access to safe water or



adequate sewer. These 18 homes are identified on the FY 2023 Sanitation Deficiency System (SDS) list as having no indoor plumbing or adequate sewer.

IHS funded 3 of 13 eligible projects in FY 2022, while adding six new projects to the list. For FY 2023, 12 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 60-80 homes over the past four fiscal years (FY19-FY22). 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 multi-generational 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. This includes 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.



Tucson Area Hot Issues

Summary

1. Behavioral Health Infrastructure: Appropriated funds for behavior health service facilities to address behavior health care shortfalls.
2. Aging Health Facilities and IT/Infrastructure in Remote Areas: Build state-of-the-art health facilities and identify a timeline of exploring alternative Health Care IT System with a comprehensive approach to Tribe's needs, including aligning with the commercial package of DOD and VA.
3. Cancer Prevention and Education: Establishing permanent funding and expanding programs
4. EHR System – Full Implementation and Timeline: The need for continuous technical support for RPMS/Electric Health Record system when RPMS is no longer supported by IHS.
5. Urban Health Line Item: Fully fund the Urban Health line item at no less than \$1 billion to address critical health disparities.
6. SDPI: Establish permanent funding and remove competitive grant process

Cancer Prevention and Education

BACKGROUND

Cancer rates are continuously increasing. 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 breast, uterus, kidney, prostate, liver, and cervix. 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. Prevent cancer

2. Detect cancer early
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, increased mental and physical activity, and prevention.

Behavioral Health Infrastructure

ISSUE

Behavioral Health is challenged with aged buildings and inadequate space to accommodate clients and personnel for improved access to care services.

BACKGROUND

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. These buildings lack adequate space for client privacy, personnel, and storage space.

RECOMMENDATION

In order to address the inadequate buildings, appropriated funds for behavior health service facilities need to be set aside within the national budget to address all behavior health care shortfalls.

Addressing COVID-19 to include Long-term COVID

ISSUE

The COVID vaccine has been successful in preventing many deaths since its inception in December 2020. However, some individuals that recovered from COVID infections are experiencing Long-term COVID (long haul COVID), for which the impact is not fully understood.

BACKGROUND

Indigenous people in the United States have been disproportionately impacted by COVID-19 virus and its variants in the form of greater number of deaths and hospitalizations compared to other groups. The lingering effects of the virus are not fully known and it will take some years to understand the impact of the COVID-19 virus.

RECOMMENDATION

It is strongly recommended that any health issues related to Long-term COVID be covered and addressed in a comprehensive approach by IHS and insurance companies without reservation. Currently, some health insurance companies do not recognize the Long-term COVID impact and therefore do not cover treatment for the illness. This creates a further burden upon Indigenous people. It is further recommended that a proactive approach be taken by the Administration to address COVID-19 health impacts and provide the necessary funding to address appropriately.

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 Database for the Nation. The current Electric Health Record system RPMS has been challenging to acquire for all users to do 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 established by Congress was to have Health Information Systems that would be able to easily communicate between all government-run health care systems, including Department of Defense (DOD), Veterans Affairs (VA), and Indian Health Services (IHS). Much effort in money, time, and human talents were expended in completing this task, with little success.

With that in mind, Tucson Tribes, ardent users of RPMS, need 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 of DOD and VA.

Provide funding to research different packages and IT support to link to the legacy system.

IT EHR

ISSUE

The need for on-going technical support and an Electric Health Record system when RPMS is no longer supported by IHS.

BACKGROUND

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RECOMMENDATION

Identify a timeline of exploring alternative Health Care system with a comprehensive approach to Tribe's needs, including aligning with the commercial package of DOD and VA.

Provide funding to research different packages and IT support to link to the legacy system.

