

Indian Health Service  
**FY 2023 National Tribal Budget Formulation Work Session**  
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# FY 2023 National Tribal Budget Formulation Work Session

February 10, 2021 – February 12, 2021

## Wednesday, February 10, 2021

	<b>Zoom:</b> <a href="https://us02web.zoom.us/j/84110650532?pwd=amdrZTZPUmVIMzJyam9sUVB0WHZSdz09_C">https://us02web.zoom.us/j/84110650532?pwd=amdrZTZPUmVIMzJyam9sUVB0WHZSdz09_C</a> <b>Conf. Line:</b> 888-790-2011 <b>Participant Code:</b> 4639610 <b>*You must dial into the conference line. Dial-in using computer audio is disabled</b>
2:00 ET	Welcome & IHS Budget Updates <input type="checkbox"/> Ms. Jillian Curtis
3:00	IHS Electronic Health Record Modernization Update <input type="checkbox"/> Mr. Mitch Thornbrugh
4:00	Tribal Caucus: Election of FY 2023 NTBFW Tribal Chairs <input type="checkbox"/> Tribal Representatives

## Thursday, February 11, 2021

	<b>Zoom:</b> <a href="https://us02web.zoom.us/j/83360229114?pwd=Snd0VmdwclBianA0WmZhSTIDMUcyQT09">https://us02web.zoom.us/j/83360229114?pwd=Snd0VmdwclBianA0WmZhSTIDMUcyQT09</a> <b>Conf. Line:</b> 888-790-2011 <b>Participant Code:</b> 4639610 <b>*You must dial into the conference line. Dial-in using computer audio is disabled</b>
1:00 ET	Invocation, Welcome, Introductions, Review Agenda <input type="checkbox"/> Co-Chairs
1:15	IHS Leadership Welcome <input type="checkbox"/> Mr. Randy Grinnell
1:30	Area Reports: 5 Minutes per Area <input type="checkbox"/> Group
2:30	Break: 15 minutes
2:45	Review, Discuss, & Determine one set of NTBFW Budget Recommendations <input type="checkbox"/> Group
5:00	Adjourn (Day can be extended if the workgroup wishes to continue.)

## Friday, February 12, 2021

	<b>Zoom:</b> <a href="https://us02web.zoom.us/j/83152262342?pwd=dINXdXN2NXREVWVEOW5PZ0ZCN2hZZz09">https://us02web.zoom.us/j/83152262342?pwd=dINXdXN2NXREVWVEOW5PZ0ZCN2hZZz09</a> <b>Conf. Line:</b> 888-790-2011 <b>Participant Code:</b> 4639610 <b>*You must dial into the conference line. Dial-in using computer audio is disabled</b>
1:00 ET	Review previous day & prepare for presentation to the IHS Acting Director <ul style="list-style-type: none"><li>Determine theme for the FY 2024 National Budget Recommendation</li></ul> <input type="checkbox"/> Group
1:30	IHS Acting Director Address <input type="checkbox"/> Ms. Elizabeth Fowler
2:00	Present and Discuss Summary with IHS Acting Director <input type="checkbox"/> Group
3:00	Additional time to Review, Discuss, & Determine one set of NTBFW Budget Recommendations <input type="checkbox"/> Group
4:00	Adjourn

FY 2023 National Tribal Budget Recommendation: 12 Area Rollup Level over FY 2022 National Tribal Budget Recommendation

Planning Base (FY 2022 National Tribal Budget Recommendation): \$12,759,004	Average 1/	Total	Alaska 2/	Albuquerque	Bemidji	Billings	California	Great Plains	Nashville	Navajo	Oklahoma	Phoenix	Portland	Tucson
<b>Current Services</b>														
Federal Pay Costs	42,648	469,128	0	42,648	42,648	42,648	42,648	42,648	42,648	42,648	42,648	42,648	42,648	42,648
Tribal Pay Costs	43,555	479,105	0	43,555	43,555	43,555	43,555	43,555	43,555	43,555	43,555	43,555	43,555	43,555
Inflation (non-medical)	5,987	65,857	0	5,987	5,987	5,987	5,987	5,987	5,987	5,987	5,987	5,987	5,987	5,987
Inflation (medical)	18,203	200,233	0	18,203	18,203	18,203	18,203	18,203	18,203	18,203	18,203	18,203	18,203	18,203
Population Growth	86,665	953,315	0	86,665	86,665	86,665	86,665	86,665	86,665	86,665	86,665	86,665	86,665	86,665
<b>Total Current Services</b>	<b>\$197,058</b>	<b>\$2,167,638</b>	<b>\$0</b>	<b>\$197,058</b>										
New Staffing for Newly-Constructed Facilities	75,000	825,000	0	75,000	75,000	75,000	75,000	75,000	75,000	75,000	75,000	75,000	75,000	75,000
Contract Support Costs-Need	100,000	1,100,000	0	100,000	100,000	100,000	100,000	100,000	100,000	100,000	100,000	100,000	100,000	100,000
Health Care Facilities Construction (planned)	100,000	1,100,000	0	100,000	100,000	100,000	100,000	100,000	100,000	100,000	100,000	100,000	100,000	100,000
105(l) Lease cost Agreements	30,682	337,500	0	337,500	337,500	337,500	337,500	337,500	337,500	337,500	337,500	337,500	337,500	337,500
<b>Total Binding Obligations</b>	<b>\$305,682</b>	<b>\$3,362,500</b>	<b>\$0</b>	<b>\$612,500</b>										
<b>Services</b>														
Hospitals & Health Clinics	6,618,767	72,806,437	0	7,286,820	4,484,443	6,836,751	5,990,969	5,341,393	11,547,111	9,257,705	3,171,690	9,384,846	3,866,151	5,638,558
Electronic Health Record	388,130	4,269,431	0	282,488	749,987	0	1,762,050	0	981,102	0	0	0	493,804	0
Dental Services	1,643,092	18,074,007	0	2,558,402	1,731,400	3,629,823	3,876,510	2,275,778	2,085,786	0	0	404,000	102,669	1,409,639
Mental Health	3,525,515	38,780,664	0	5,775,794	2,431,197	6,378,620	4,933,739	6,130,717	2,672,553	5,431,187	0	504,000	1,703,578	2,819,279
Alcohol and Substance Abuse	2,518,311	27,701,421	0	3,559,431	2,007,893	3,876,510	3,524,100	5,797,035	2,861,632	1,481,233	0	706,000	1,773,128	2,114,459
Purchased/Referred Care (formerly CHS)	5,699,343	62,692,769	0	4,927,387	3,924,445	2,713,557	5,286,149	1,973,217	6,023,424	0	5,286,149	1,000,000	21,690,966	9,867,475
Indian Health Care Improvement Fund	2,357,909	25,937,003	0	731,031	820,022	1,409,640	1,057,230	106,902	667,580	0	21,144,598	0	0	0
<b>Total, Clinical Services</b>	<b>22,751,067</b>	<b>250,261,732</b>	<b>0</b>	<b>25,121,353</b>	<b>16,149,387</b>	<b>24,844,901</b>	<b>26,430,747</b>	<b>21,625,042</b>	<b>26,839,188</b>	<b>16,170,125</b>	<b>29,602,437</b>	<b>11,998,846</b>	<b>29,630,296</b>	<b>21,849,410</b>
Public Health Nursing	684,563	7,530,195	0	1,119,129	450,835	2,713,557	0	1,337,650	492,892	1,213,788	0	0	202,344	0
Health Education	704,746	7,752,205	0	992,197	259,018	2,819,280	0	1,653,240	572,894	1,213,788	0	71,200	170,588	0
Community Health Representatives	1,273,279	14,006,071	0	1,688,340	844,726	2,819,280	2,114,460	1,971,755	967,195	1,213,788	0	233,400	38,668	2,114,459
Community Health 3/	167,849	1,846,336	0	1,791,336	40,000	0	0	0	0	0	0	15,000	0	0
Alaska Immunization	1	16	0	0	16	0	0	0	0	0	0	0	0	0
<b>Total, Preventive Health</b>	<b>2,830,438</b>	<b>31,134,823</b>	<b>0</b>	<b>5,591,002</b>	<b>1,594,595</b>	<b>8,352,117</b>	<b>2,114,460</b>	<b>4,962,645</b>	<b>2,032,981</b>	<b>3,641,364</b>	<b>0</b>	<b>319,600</b>	<b>411,600</b>	<b>2,114,459</b>
Urban Indian Health	657,191	7,229,097	0	0	715,946	2,043,978	0	606,694	483,705	617,180	352,410	92,600	1,259,348	1,057,236
Indian Health Professions	213,532	2,348,851	0	0	917,366	0	0	0	199,306	0	0	71,200	1,160,979	0
Tribal Management Grants	186,032	2,046,350	0	277,778	24	0	1,762,050	0	6,498	0	0	0	0	0
Direct Operations	21,430	235,735	0	0	2,771	0	0	0	190,262	0	0	0	42,702	0
Self-Governance	47,891	526,805	0	277,778	102	0	0	0	247,884	0	0	0	1,041	0
<b>Total, Other Services</b>	<b>1,126,076</b>	<b>12,386,838</b>	<b>0</b>	<b>555,556</b>	<b>1,636,209</b>	<b>2,043,978</b>	<b>1,762,050</b>	<b>606,694</b>	<b>1,127,655</b>	<b>617,180</b>	<b>352,410</b>	<b>163,800</b>	<b>2,464,070</b>	<b>1,057,236</b>
<b>Services Total</b>	<b>\$26,707,581</b>	<b>\$293,783,393</b>	<b>\$0</b>	<b>\$31,267,911</b>	<b>\$19,380,191</b>	<b>\$35,240,996</b>	<b>\$30,307,257</b>	<b>\$27,194,381</b>	<b>\$29,999,824</b>	<b>\$20,428,669</b>	<b>\$29,954,847</b>	<b>\$12,482,246</b>	<b>\$32,505,966</b>	<b>\$25,021,105</b>
<b>Facilities</b>														
Maintenance & Improvement	2,052,402	22,576,423	0	411,145	9,391,998	0	2,114,460	1,097,951	1,530,910	0	5,286,149	1,144,750	1,599,060	0
Sanitation Facilities Construction	1,620,857	17,829,427	0	1,241,826	2,486,288	0	352,409	534,512	997,839	6,665,547	0	2,600,000	484,131	2,466,875
Health Care Facilities Constr./Other Authorities	3,912,786	43,040,650	0	2,222,222	3,530,503	0	2,466,870	3,207,076	1,759,485	7,406,164	0	18,860,000	64,232	3,524,098
Facilities & Environmental Health Support	154,449	1,698,943	0	0	51,156	0	0	0	713,821	740,616	0	0	193,350	0
Equipment	792,920	8,722,120	0	97,892	400,860	0	0	3,207,076	239,117	0	0	154,000	394,257	4,228,918
<b>Facilities Total</b>	<b>\$8,533,415</b>	<b>\$93,867,563</b>	<b>\$0</b>	<b>\$3,973,085</b>	<b>\$15,860,805</b>	<b>\$0</b>	<b>\$4,933,739</b>	<b>\$8,046,615</b>	<b>\$5,241,172</b>	<b>\$14,812,327</b>	<b>\$5,286,149</b>	<b>\$22,758,750</b>	<b>\$2,735,030</b>	<b>\$10,219,891</b>
<b>GRAND TOTAL</b>	<b>\$48,000,000</b>	<b>\$400,409,960</b>	<b>\$0</b>	<b>\$48,000,000</b>										
\$ Change over Planning Base	35,240.996	387,650.956	0	35,240.996	35,240.996	35,240.996	35,240.996	35,240.996	35,240.996	35,240.996	35,240.996	35,240.996	35,240.996	35,240.996
% Change over Planning Base	276.20%	3038.25%	0.00%	276.20%	276.20%	276.20%	276.20%	276.20%	276.20%	276.20%	276.20%	276.20%	276.20%	276.20%

Will be added in addition to full funding

1/The Average is calculated using 11 Areas instead of 12 since the Alaska Tribes elected not to submit a budget worksheet.

## Document 1a

### INDIAN HEALTH SERVICE FY 2023 Summary of National Tribal Budget Recommendation

<b>Planning Base (FY 2022 National Tribal Budget Recomm.)</b>	<b>\$12,759,004</b>
<b>Total Current Services - All 12 Areas recommend full funding</b>	<b>\$197,058</b>
Staffing Costs for Newly-Constructed Facilities Health Care Facilities	<b>\$75,000</b>
Contract Support Costs Need (estimate)	<b>\$100,000</b>
Health Care Facilities Construction Projects Priority List (estimate)	<b>\$100,000</b>
105(l) Lease Cost Agreements	<b>\$30,682</b>
<b>Total Binding Obligations</b>	<b>\$305,682</b>
<b>Total Binding Obligations &amp; Current Services - All 12 Areas recommend full funding</b>	<b>\$502,740</b>

Rank	Program Expansion	Increase Amount
1	Hospitals & Health Clinics	6,618,767
2	Purchased/Referred Care (formerly CHS)	5,699,343
3	Health Care Facilities Constr./Other Authorities	3,912,786
4	Mental Health	3,525,515
5	Alcohol and Substance Abuse	2,518,311
6	Indian Health Care Improvement Fund	2,357,909
7	Maintenance & Improvement	2,052,402
8	Dental Services	1,643,092
9	Sanitation Facilities Construction	1,620,857
10	Community Health Representatives	1,273,279
11	Equipment	792,920
12	Health Education	704,746
13	Public Health Nursing	684,563
14	Urban Indian Health	657,191
15	Electronic Health Record	388,130
16	Community Health	167,849
17	Indian Health Professions	213,532
18	Tribal Management Grants	186,032
19	Facilities & Environmental Health Support	154,449
20	Self-Governance	47,891
21	Direct Operations	21,430
22	Alaska Immunization	1
<b>Total (Program Expansion)</b>		<b>\$35,240,996</b>

<b>Total (Planning base + Program Expansion)</b>	<b>\$48,000,000</b>
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Percent over Planning base 276%

<b>Total ( Base + Current Services+Program Expansion)</b>	<b>\$48,502,740</b>
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Percent Over Planning Base 280%

## Deliverable #2

# Indian Health Service FY 2023 Area Budget Instructions **Albuquerque Area Budget Recommendation Narrative**

## H&C

The Mescalero Service Unit tribes considers that, 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 hire additional staff.

Increased H&C funding is greatly needed for IHS to become further competitive with the salaries for physicians in regards to recruitment and retention. Recruiting, and more importantly, retaining a core of primary care providers is essential to successfully achieve improved clinical outcomes, maintain a Patient Centered Medical Home status, and continuity of care.

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.

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 to Hospitals and Health Clinics (H&HC) to the IHS Budget in FY23. Because H&HC is the least restrictive budgetary line item, an increase would result in the most good and assist in meeting the Mission of the Agency, along with the Goals and Priorities of the IHS Strategic Plan. There continues to be a great need for comprehensive, culturally appropriate personal and public health services that are available and accessible to American Indians and Alaskan Native (AI/AN) people (IHS Strategic Goal #1). 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. Funding for H&HC across the Indian Health Service does not meet current need and IHS and tribal health care facilities require large supplementations from tribal funds and third party collections each year to operate. 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 continuity of care suffers. With increased funding in H&HC, the direct access to specialty services and high quality health care increases,

relieving the burden to patients and the tribe. Moreover, with an increase in funding to H&HC, the ability of the IHS to recruit highly qualified staff (people) also rises resulting in an innovative Indian Health System that promotes excellence and quality (IHS Strategic Goal #2). (see also, IHCIA Chapter 18, Subchapter I-II).

*IHS Strategic Plan: Goal 1. Reform, strengthen, and modernize the Nation's Healthcare System. 1.2 Expand safe, high-quality healthcare options, and encourage innovation and competition. Goal 2. Objective 2.2 Provide care to better meet the health care needs of American Indian and Alaska Native communities.*

Ysleta del Sur Pueblo recommends an increase in H & C to support current services and expand new services. Ysleta Del Sur Pueblo envisions future direct healthcare delivery as a “one stop shop” providing needed primary care and supporting ancillary services within the Pueblo to resident tribal members, descendants and family members. The projected mission population for 2025 is 2,677 users, a number based on anticipated aggressive tribal membership growth as driven by both internal and external factors. Projection of population assumes growth rates (30.6% incremental, or 3.4% annually) applied to 2012 resident tribal members.

At the Santa Fe Service Unit, the Tribal Leaders/Tribal Representatives (TL/TR) recommend that one fifth of all budget increases be directed towards Hospitals and Health Clinics, a share that is the same as last year's recommendations. These funds are used primarily to support staffing and services within the service unit. Although the SFSU is fortunate to be fully staffed or nearly fully staffed in most critical clinical departments, the TL / TR recognizes it is critical to offer regionally competitive salaries and state-of-the-art services to ensure high quality care within all of the service unit's facilities.

At ASU, the Hospitals and Clinics (H&C) Line item continues to be underfunded in order to meet the true level of need. Funding of H&C supports the foundational operations of IHS is needed to support current services, for the expansion of services, to purchase of necessary supplies and equipment and hire additional staff.

IHS and tribally operated (638) facilities located on the reservations are often the only place that Native American patients can obtain healthcare. In the urban setting, such as the Albuquerque Metropolitan Area, the Urban Indian population heavily relies of facilities such as the Albuquerque Indian Health Center and First Nations Community Healthsource to obtain direct healthcare services. By the year 2050, it is anticipated that the Native American population will reach approximately 8 million, thereby requiring us to increase access to care by hiring additional and expanding services to help meet the need.

Increased H&C funding is also greatly needed in order for IHS to become more competitive with the salaries for physicians in regards to recruitment and retention. Recruiting, and more importantly, retaining a core of primary care providers is essential

to successfully achieving improved clinical outcomes, maintaining a Patient Centered Medical Home status and continuity of care.

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

The Zuni Pueblo, Ramah Navajo Tribe and Zuni–Ramah Service Unit, recommends continued increase to the Hospital & Clinic (H&C) line item budget for the FY 2023. The level of funding for the Hospital & Clinic budget line item continues to be inadequate in keeping up with the inflation costs to cover all necessary costs in providing critical and basic healthcare services to the Native American/Alaska Native population further hindering Tribes and Indian Health Service facilities to meet the IHS' Mission in raising the physical, mental, social and spiritual health of American Indians and Alaska Natives including the agency's GPRC clinical measures. Funding levels have never been increased to a level to cover 100% of operational costs to meet the needs of a patient populations served, unlike federal prisons that receive more funding per capita to provide medical care to their inmates. It is well known that the Native Americans/Alaska Native are considered a high risk population affected by diabetes, kidney failure, and other conditions that affects the overall quality of life of Native peoples.

The Affordable Health Care Act (AHCA) is still at risk for all Native American/Alaska Natives who may lose healthcare coverage if repealed. Such action will have an adverse effect to the revenue generation operations of the Zuni Hospital and the Pine Hill Health Center that will directly impact on the patient population served. Accreditation of hospitals and clinics may also be affected. The Zuni-Ramah Service Unit not only provides services to its patient population of 11,000+, but an additional 3,000+ Native Americans/Alaska Natives who chose Zuni Hospital and/or Pine Hill Health Center as their primary healthcare provider.

The Taos Pueblo supports and increase in H & C to support current services and continued access to quality Health Care and to support Patient Centered Medical Home (PCMH).

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 Hospital 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.

The Pueblo of Acoma Budget Formulation Workgroup recognizes that adequate funding for the H&C is the base funding for the ACL Hospital 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 that 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 Hospital 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 rapid 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.

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.

## **H&C- EMS SUPPORT**

The Pueblo of Acoma stated that 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 ACLSU 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.

Consider this scenario: ACL Hospital defers a patient and the next closest 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 justify the existence of 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/NA community deserves

The Pueblo of Acoma also stated that H&C EMS is needed for the 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 2023 for maintenance and repairs of ambulances line as this allocation has not received an increase to their base funding for years.

## **Mental Health**

At the Mescalero Service Unit, Mental Health issues continue to plague our community. There are several mental health related disparities that still exist. Recruiting and retaining professional and culturally sensitive healthcare professionals remains challenging. There is a great need for counseling/therapy services. It has been estimated that depression is quite prevalent in the outpatient primary care setting, and an estimated 50% of some type of mental healthcare delivery occurs in the primary care setting. Healthcare has an increasing focus on prevention and wellness, and more must be done to address mental health, which impacts co-morbid conditions and outcomes related to chronic illness. Increased funding in the area of mental health would allow for expansion of and integration of behavioral health into the primary care clinics so that there is focus on the physical *and* mental health. Mental Health services are crucial for adolescents and adults that have severe mentally ill-complicated drug profiles. Acute hospitalization for suicidal ideations and long-term residential treatment is lacking and greatly needed. Coordination with other agencies and community outreach suffers under the current short staff situations as the program operates in crisis mode. Funding increase will improve the capacity for the behavioral health department to increase staffing which will allow our staff to reach a large number of community members. There are very limited space available for mental health treatment resulting in transferring our patients 100 miles away for treatment.

The Southern Ute Indian Tribe and Ute Mountain Ute Indian Tribe recommends an increase to the Mental Health Programs line item. The tribe recognizes a huge need within Indian Health for Mental Health Care and its link to the Opioid Epidemic and Alcohol and Substance Abuse. American Indians/Alaskan Natives have serious mental health disorders, including anxiety, depression, suicide and substance abuse compared to other ethnic groups stemming from Historical Trauma. A very small proportion of the budget has been devoted to addressing this need and many health care facilities do not provide mental health services according to the American Foundation of Suicide Prevention. The seemingly insurmountable need for mental health professionals to address the many scars due to historic trauma is apparent in light of increased suicides and attempted suicides as well as increased substance abuse. Within the reservation boundaries, the scarce mental health services available are pulled in many directions, such as to the Bureau of Indian Affairs Detention Center in the community of Towaoc, CO, to community initiatives and addressing the increased needs of Tribal Adults and Children in local schools. In addition, the recent closure of the Alcohol and Substance Abuse Recovery Center in Ignacio, CO (Peaceful Spirits) left a huge void in the area with the nearest available residential treatment facility many hours away. (see IHCIA Chapter 18, Subchapter III, 1638c and IHS Strategic Plan, Objective 1.3: Increase access to quality health care services).

*IHS Strategic Plan: Goal 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 and Alaska Native communities.*

The Ysleta Del Sur Pueblo stated that additional funding is necessary to address the growing mental health concerns and issues for treating and expanding services. New funds would allow an increase in professional workforce to address a growing population, increase behavioral health training, and community education programs.

At SFSU, for most of the past decade, our TL / TR has asserted 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. As a proportion of total budget increases, this is not changed from last year's recommendations. However, the TL / TR recommends that these conditions be considered as one priority rather than as two separate health priorities as would be implied by the separate line items. The rationale for this consolidation comes from a recognition that untreated mental health issues 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. By addressing these simultaneously in this budget proposal, the TL / TR hopes to highlight their significance.

At ASU, Mental Health issues continue to plague many Native American communities. There are several mental health related disparities that still exist. Recruiting and retaining professional and culturally sensitive healthcare professionals remains challenging. There is a great need for counseling/therapy services. It has been estimated that depression is quite prevalent in the outpatient primary care setting, with estimates of 9% to 16% of general medical outpatients. An estimated 60% of mental healthcare delivery occurs in the primary care setting. Healthcare has an increasing focus on prevention and wellness, and more must be done to address mental health, which impacts co-morbid conditions and outcomes related to chronic illness. Increased funding in the area of mental health would allow for expansion of and integration of behavioral health into the primary care clinics so that there is focus on the physical *and* mental health.

The Ramah Navajos and the Pueblo of Zuni priorities as any other American Indian/Alaska Natives is the reduction of the health disparities of chronic diseases in our Tribal Nations. Ramah Navajos 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.

*“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*
- *2<sup>nd</sup> 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 training on delivering trauma informed care to effectively reduce the health disparities in AI/AN populations.

The Ramah Navajo and Pueblo of Zuni supports the increase funding for Mental Health and Alcohol and Substance Abuse Prevention Programs to help reduce the health disparities in our AI/AN communities.

At Taos Pueblo, the pandemic has increased the need for mental and behavioral health services, both in terms of quantity and severity of the need. Unfortunately, we are anticipating that some of the long-term effects of the pandemic will be increased mental health needs in dealing with the depression and other related issues in clients due to the economic, social, cultural, and physical trauma caused by the pandemic.

The Pueblo of Laguna stated that increased funding will allow for the expansion of mental health services in I.H.S. and Tribal services to address a myriad of mental health issues impacting Native Americans.

Addressing mental health issues in the communities through direct services, from qualified, licensed, Therapists, Counselors, traditional Healers and lay providers is critical. Depression, suicide ideation, co-occurring disorders and other more serious mental health issues are ongoing in the community. There is a dire shortage of mental health providers and alternate models of care are necessary. Increasing integration of mental health services into primary care is critical to promote health and wellness from disease. A major concern is the access and cost to inpatient mental health facilities. Laguna Behavioral Health recorded over 1,600 patient therapy encounters in 2019 and over 2,203 as of November 2019 for therapy and counseling services. In spite of the COVID19 restrictions for in- person sessions, BHS will account for 1,274 patient encounters. These services were provided through the tribal programs’ trained staff, contracted providers and through intern program participants.

The community of To'Hajiilee has experienced an abnormal increase in the rate of youth and adult suicidal ideation and completions in the last three years. Moreover, but only anecdotally, the number of deaths due to long-term alcohol abuse has been suspected because there is a lack of data in the actual causes of death. Nonetheless, there is an increase in the number of patients, physician and court referrals, for mental health, alcohol and substance abuse services in the past year. We have integrated primary care and behavioral health providers into the clinic setting in order to quickly identify and address mental health/substance abuse issues. However, we remain short staffed for mental health therapists because of insufficient funds.

Mental Health continues to be a significant priority for FY 2023 for the Pueblo of Acoma. This increase would allow for the Pueblo of Acoma to further develop innovative and culturally appropriate treatment programs that are so greatly needed in the community. Funds are needed to support infrastructure development and capacity in tele-behavioral health, workforce development training, recruitment and staffing, integrated and trauma informed care, long-term and after-care programs, screening, and community education programs. Mental Health program funding supports community-based clinical and preventative response as well as triage, case management services, community-based prevention programming, outreach and health education activities.

After-hours and emergency services are generally provided through local hospital emergency rooms which will no longer be available therefore the increase expenses related to care is expected to rise. Inpatient services are generally purchased from non-IHS facilities or provided by state mental health hospitals. Transitional living services and intensive case management is sometimes available, but generally not as an IHS program. Pueblo of Acoma seeks to encourage the integration of primary care and behavioral health services with the inclusion of our Tribally operated 638 Behavioral Health Department, suicide prevention and child and family protection programs and use of the RPMS Behavioral Health Management Information System. Stabilization services are needed to address short and long-term care to provide access to a multi-disciplinary team of providers including psychiatrists, clinical psychologists and other behavioral health providers.

Lack of behavioral health resources is evident in the disproportionate number of suicides, acts of domestic violence and drug and alcohol addiction within the Pueblo of Acoma. Furthermore, one of the main risk factors known to contribute to psychological distress and behavioral health concerns among the AI/AN population is historical trauma which continues to manifest through our population and specifically today's generation through intergenerational trauma.

## **Purchase Referred Care**

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. There is concern about Medicaid Expansion in the State of New Mexico continuing under the current administration. We are recommending this increase be used to try to maintain current priority level.

Next, patient access to services beyond what can be provided as direct care at MSU is critical to ensuring that medical conditions that range from chronic and ongoing care, cancer treatment, in-home care and catastrophic medical conditions are treated. Ongoing specialty care for chronic medical conditions can become very costly. Additionally, only 1 or 2 CHEF cases or patients with a diagnosis such as cancer requiring very expensive medications, treatments, prolonged hospitalization can quickly utilize much of the budget. The Mescalero Service Unit recommends that 20% of all funding increases go to Purchased/Referred Care. It is crucial that there are funding increases in this line item to ensure tribal members have access to provision of care outside the I.H.S. via referrals, to private sector facilities.

The Southern Ute Indian Tribe recommends an increase to Purchased/Referred Care (PRC) line item (IHCIA Chapter 18, Subchapter III, 1638c). The Service Unit recognizes the need for increased access to specialty services both within the clinic (direct care/contracted specialists) and referral services for secondary and tertiary care for all American Indians and Alaskan Natives (AI/AN). The Southern Ute Indian Tribe (SUIT) greatly augments its PRC activity with tribal funds. Specialty services at both clinics consist of Nephrology, Rheumatology, Psychiatry, Optometry and Podiatry, but do not meet the current demands and needs of the patients. Additional specialty services such as Orthopedics, Chiropractor, Acupuncture and alternative pain management, Traditional Medicine and Dialysis are greatly needed and could be procured with additional PRC funding. Some Areas within the IHS have benefited from Medicaid Expansion and have been able to cover more PRC Medical Priorities, many AI/AN within the IHS system do not enjoy these benefits. In addition, recent changes to the Affordable Care Act are negatively affecting access to specialty services especially in rural areas. In order to align with the IHS Priority: Partnership and Resources, and Goal #1, Objective 1.2 and 1.3 the IHS needs to recruit/retain specialists and enhancing relationships with outside partners to improve upon the care of AI/AN patients.

Ysleta del Sur Pueblo recommends an increase to PRC. YDSP ranks PRC as a priority, due to the increased cost of specialty services that must be contracted due to the limited scope of services provided at the health clinic. The increase will address the specialty services required to meet the population growth and patients referred from the health center.

At the SFSU, the TL / TR recommends that 20% of all funding increases go to Purchased/Referred Care. Although this is a proportion of the proposed increases, it continues a trend of incremental decreases over the past several years. Specifically, it is an absolute proportionate increase of 5% compared to last year's recommendations.

Beneficiaries in the SFSU who are PRC eligible have benefitted significantly since the full implementation of the Affordable Care Act just over five years ago, albeit indirectly. Specifically, PRC 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 sizeable PRC surpluses in the SFSU, allowing virtually 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.

At ASU - The Purchased & Referred Care Line Item has been underfunded for many years. Patient access to services beyond what can be provided as direct care at an IHS facility is critical to ensuring that medical conditions that range from chronic and ongoing care, cancer treatment, in-home care and catastrophic medical conditions are treated. Ongoing specialty care for chronic medical conditions can become very costly. Additionally, only 1 or 2 CHEF cases or patients with a diagnosis such as cancer requiring very expensive medications, treatments, prolonged hospitalization can quickly utilize much of the budget. Increased funding for PRC programs not only allows for the more secondary and tertiary care, but also increases the ability to provide more preventative screenings for things such as colon and breast cancer.

The Zuni Tribe and the Ramah Navajo Tribe recommends continued increase to the 2023 IHS Budget for PRC to assure that eligible Native American/Alaska Natives have access to medical services not available at IHS and Tribal facilities for medically necessary and specialty service. The increase will also to ensure that resources are consistently available to cover the cost of medically necessary services that continue to be on the rise; and continued uncertainty of the Affordable Care Act (ACA) if repealed. A total of 11,000+ patients relying on Zuni-Ramah Service Unit will be impacted if ACA was lost.

Continued increases in PRC budget will ensure that Native Americans/Alaska Natives will have access to medically necessary care to prevent loss of life and limb, receive timely diagnostic services to prevent further complications of diseases/injuries, and maintain quality of life. The increase will continue IHS' efforts in elevating the health status of our patient populations supporting the IHS Mission and achieving the target goals of GPRA.

The Pueblo of Laguna stated that funding increases in this line item are critical to ensure tribal member and other Native Americans have access to provision of care outside the I.H.S. via referrals, in private and Tribally-operated facilities through the acquisition of health care and medical services that are otherwise not available. PRC allows for the purchases of medical care and urgent health care services from private, local, and community health care providers that include hospital care, physician services, outpatient services, laboratory, dental, radiology, pharmacy, and transportation services. Increase in funding for PRC will allow for a wider scope of emerging industry standards of direct care to be provided to treat medical conditions and illnesses of Native American patients.

The payment rate methodology will be applicable to the Tribal run health systems and increase flexibility for payments for specialized services.

At CBNHC, due to the uncertainty of the longevity of the ACA and Medicaid expansion in New Mexico, we must anticipate a rise in PRC expenditures should the health insurance availability to our beneficiaries change. Any loss in health insurance will be a devastating blow to the patient and family but also to Tribal and IHS organizations that rely heavily on third party reimbursements to supplement the deficiencies in Congressional funding.

Purchased and Referred Care Services (PRC) are recommended to be a top funding priority for the Pueblo of Acoma. The ACL Hospital 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 Hospital.

The significant increase to ACL Hospital 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.

## **Alcohol and Substance Abuse**

Inadequate funding for alcohol and substance abuse services has shown a rippled effect on other funding sources. Alcohol and substance abuse cause an increase in the number of injury related patient visits to our hospital as well as to the private sector and local emergency departments. An increase in funding is necessary to allow opportunities for our members to participate in 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 to include alcohol, methamphetamines and opioid abuse 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 to 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.

YDSP recognizes the high prevalence of Alcohol & Substance Abuse and recommends a budget increase to expand current services and fund New Programs related to Behavioral Health under the IHCIA. YDSP recognizes the high prevalence of Alcohol & Substance Abuse, Depression, Suicidality, and Violence occurring among the community. New funding would expand the scope of treatment, such as establishing group homes or inpatient treatment facilities and hiring more clinicians and case managers to address the alcohol & substance abuse problems.

At the SFSU, for most of the past decade, our TL / TR has asserted 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. As a proportion of total budget increases, this is not changed from last year's recommendations. However, the TL / TR recommends that these conditions be considered as one priority rather than as two separate health priorities as would be implied by the separate line items. The rationale for this consolidation comes from a recognition that untreated mental health issues 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. By addressing these simultaneously in this budget proposal, the TL / TR hopes to highlight their significance.

At ASU, the Alcohol and Substance Abuse Line Item has also been underfunded for many years. There is a great need for additional inpatient and intensive outpatient services. Funding is needed to support the current services and the expansion of additional prevention, outreach and education services. There is currently an IHS initiative to reduce the abuse and misuse of opiates in Indian Country. This "legal" form of substance abuse is becoming widely recognized as a form of substance abuse that negatively impacts our patient population. There are also ongoing challenges to with

alcohol abuse and other illicit drugs and more alcohol and substance abuse services are needed.

The Southern Ute Indian Tribe and Ute Mountain Ute Indian Tribe recommends an increase to the Mental Health Programs line item. The tribe recognizes a huge need within Indian Health for Mental Health Care and its link to the Opioid Epidemic and Alcohol and Substance Abuse. American Indians/Alaskan Natives have serious mental health disorders, including anxiety, depression, suicide and substance abuse compared to other ethnic groups stemming from Historical Trauma. A very small proportion of the budget has been devoted to addressing this need and many health care facilities do not provide mental health services according to the American Foundation of Suicide Prevention. The seemingly insurmountable need for mental health professionals to address the many scars due to historic trauma is apparent in light of increased suicides and attempted suicides as well as increased substance abuse. Within the reservation boundaries, the scarce mental health services available are pulled in many directions, such as to the Bureau of Indian Affairs Detention Center in the community of Towaoc, CO, to community initiatives and addressing the increased needs of Tribal Adults and Children in local schools. In addition, the recent closure of the Alcohol and Substance Abuse Recovery Center in Ignacio, CO (Peaceful Spirits) left a huge void in the area with the nearest available residential treatment facility many hours away. (see IHCIA Chapter 18, Subchapter III, 1638c and IHS Strategic Plan, Objective 1.3: Increase access to quality health care services).

*IHS Strategic Plan: Goal 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 and Alaska Native communities.*

At Taos Pueblo, the pandemic has increased the need for mental and behavioral health services, both in terms of quantity and severity of the need. Unfortunately, we are anticipating that some of the long-term effects of the pandemic will be increased mental health needs in dealing with the depression and other related issues in clients due to the economic, social, cultural, and physical trauma caused by the pandemic.

The community of To'Hajiilee has experienced an abnormal increase in the rate of youth and adult suicidal ideation and completions in the last three years. Moreover, but only anecdotally, the number of deaths due to long-term alcohol abuse has been suspected because there is a lack of data in the actual causes of death. Nonetheless, there is an increase in the number of patients, physician and court referrals, for mental health, alcohol and substance abuse services in the past year. We have integrated primary care and behavioral health providers into the clinic setting in order to quickly identify and address mental health/substance abuse issues. However, we remain short staffed for mental health therapists because of insufficient funds.

The Pueblo of Acoma continues to be affected with the epidemic of alcohol and drug abuse/misuse. The Pueblo of Acoma Budget Formulation Workgroup recommendation continues to be of high priority for the FY 2023. The Pueblo of Acoma Budget Formulation Workgroup recommends a program increase of additional funds to meet the needs of the community as well as those served within the wider service unit area. Alcohol and substance abuse have severe impacts that ripple across Tribal communities causing upheaval and adverse experiences. The problems range from individual, social and medical health loss to community distress, from unintentional injury to domestic violence to suicide and/or homicide. Increasing resources to combat Alcohol and Substance Abuse is needed to break the cycle and reduce the disease and cost burden currently experienced within the Pueblo of Acoma. The increase of funding will allow for a comprehensive array of preventative, educational, and treatment services that are community driven and culturally competent.

Current approaches to the treatment of substance use disorders and addictions are consistent with evidenced-based approaches to treatment as well as traditional healing techniques designed to improve outcomes and align the services provided with the valuable cultural practices and individual and community identity.

This added addition of funds will increase the number of residential substance use treatment beds and access to care. Additional adult and youth residential facilities and placement contracts will be accessed. It will also allow for the Pueblo of Acoma to address the gaps in service for detox beds with the rising number of heroin, methamphetamine and opioid addictions.

In addition to the funding needed to support detox, rehabilitation services and adolescent treatment facilities the Pueblo of Acoma has a critical need for aftercare services. Time and again, Tribal members are re-entering the community 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 would be directed to support groups, sober-living opportunities, job placement and other resources to encourage a clean and drug-free lifestyle.

## **Dental**

The Southern Ute Indian Tribe and the Ute Mountain Ute Indian Tribe recommend an increase to Dental Services funding. The Tribes recognize a need for dental professionals to provide high quality dental care particularly aimed at preventative services and dental hygiene to preserve teeth versus extractions, and we have been lucky to keep the staff that we have as long as we have. Increased access to specialty services within the clinic such as dental hygienists, endodontics and orthodontics is needed and will assist in meeting dental GPRA measures. (see IHCIA, Chapter 18, Subchapter 2, 1621 and IHS Strategic Plan, Objective 1.3: Increase access to quality health care services).

Ysleta del Sur Pueblo recommends an increase to support current services and expand new services. Ysleta Del Sur Pueblo envisions future direct healthcare delivery as a “one stop shop” providing needed primary care and supporting ancillary services within the Pueblo to resident tribal members, descendants and family members. The projected mission population for 2025 is 2,677 users, a number based on anticipated aggressive tribal membership growth as driven by both internal and external factors. Projection of population assumes growth rates (30.6% incremental, or 3.4% annually) applied to 2012 resident tribal members.

Additional priorities include dental services to meet the current demand of dental health screening, early intervention, treatment and prevention as well as funding the increased population and medical inflation needs. The importance of the promotion of healthy lifestyles is a high health priority.

At the SFSU, three years ago, the Health Board recommended that 20% of all budget increases should be directed towards expanded dental services. In the past three to four 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. Last year, the Health Board recommended continued support of dental programs within the SFSU, but recommended budget increases that were proportionately half of the previous year’s recommendations. This priority and its associated recommended proportionate increase remains unchanged this year.

At ASU, there is a critical need for all dental services among all tribal and federal sites across the Albuquerque Service Unit, particularly for the Urban Indian, and uninsured population. Dental exams are a standard of care for all adult, but particularly for pregnant women, diabetics and those with HIV. Many Urban Indian patients have to make a long drive to find a dental clinic located on the surrounding reservations, but very often cannot make the long drive to the outlying dental clinics and cannot get dental services, other than being seen for a dental emergency. Similarly, patients living in smaller more remote communities lack the transportation and resources to get to the nearest town for dental services. Oral health is an important component of overall

chronic disease management, as well as a foundational point of overall wellness in children.

At Zuni Service Unit, oral health 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. Poor dental health can affect self-esteem of individuals.

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 appointments; and resources to support dental supplies and equipment. School based screening and education activities can become sustainable with consistent and adequate staff resulting in increased access to dental services at both the clinic and community levels. New technologies are available that can provide same day crowns, bridges and veneers onsite allowing patients to return to work with fewer lost days. The capacity for surgeries allows for implants, when coupled with dentures, patients experience better outcomes and quality of life.

Supporting legislation is found in 25 USC §1602, which directs programs to raise the health status of Indians to levels set in the Healthy People 2020 Initiative and into 2030. The Healthy People 2020 goal is the prevention and control of oral and craniofacial diseases, conditions, and injuries and improve access to related services. Making a comparison to the 2020 goals and objectives is difficult since IHS published data is not formatted or collected according to Healthy People 2020.

Healthy People 2020 compared to IHS				
Measure	Age	IHS	2020	2020 Objective
Dental Caries	3-5	76%	30%	OH-1.1
Dental Caries	35-49	64%	25%	OH-3.1
Dental Caries	65-74	45%	15.40%	OH-3.2
Dental Caries	75+	48%	34.10%	OH-3.3
Missing Teeth	45-64	83%	68.80%	OH-4.1
Periodontitis	55+	49%	40.80%	OH-5
Dental Access	All	29.20%	49%	OH-7

Chart 1. Select Healthy People 2020 objectives compared to IHS data from GPRA and Data Briefs.

At Taos Pueblo, we feel the Dental program is under staffed. The focus is of our dental program is almost exclusively on preventive care and acute dental issues. Dental Health is tied to overall health and early warning signs of other diseases can be caught.

CBNHC is asking for additional dental funds based on community needs. There are several community members that are diabetic and who suffer from periodontal disease which leads to loss of teeth and thus a need for partials and dentures. A significant number of children in the community are in need of fillings, braces and 78% have dental caries. We also see a significant number of patients from outlying communities and urban Indians from the Albuquerque Area. Our current dental budget is \$242,000 which is insufficient considering the current dental health needs of the community as well as other Native American beneficiaries in surrounding communities.

Increased funding will enable both CBNHC and IHS to meet their shared mission of raising the health status of Native Americans/Alaska Natives. Additional funding would increase our capacity to enhance our patient-centered care model and patient/family/tribal engagement and partnership effort. With additional Federal funding the CBNHC can fulfilling the Federal Government's trust responsibility to provide quality health care to the Canoncito Band of Navajos.

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 Hospital 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.

## **Health Care Facilities Construction**

The Jicarilla Apache Tribe would like to see construction dollars specifically for Mental Health and Alcohol & Substance Abuse programs. The Jicarilla Apache Health care programs have a very large Behavioral Health staff. Services provided include Outpatient program, Domestic Violence Program, Prevention Program, Social Services (Foster Care Services, Indian Child Welfare Act (ICWA), Child and Adult Welfare), Crisis Intervention Service and Detoxification Service. Other services include tele-psychiatry services and transportation services to many clients.

Currently, the department is located in four different office buildings within the community of Dulce, NM. The different services available and ensuring clients understand which building to go to for specific services has become a challenge. To integrate the services for all of the clients served, it is recommended that funding be available to build one building to house all of these services. It is also recommended that the building be located in an area in town that provided a higher level of patient privacy.

This request is in line with Goal 1 in the Indian Health Service Strategic plan as noted below:

Goal 1: To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people  
Objective 1.1: Recruit, develop and retain a dedicated, competent, and caring workforce  
Objective 1.2: Build, strengthen, and sustain collaborative relationships  
Objective 1.3: Increase access to quality health care services

The Pueblo of Acoma Budget Formulation Workgroup recommends a program increase for Health Care Facilities Construction (HCFC) line item. The ACL Hospital 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 way 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, the ACL Hospital has not been able to keep pace with available new and emerging health care technologies, including the use of tele-medicine and tele-health as solutions to address access issues. The ACL Hospital is in a remote and undeveloped area adding to the challenges we face. Increased funding for healthcare facility projects will provide greatly improved access to quality health care.

## **Community Health**

The Dulce School programs in partnerships with parents are very active in identifying major areas that would support the growth and well-being of the students served ranging from Head start to High School grade levels. Due to the COVID 19 pandemic, the schools have transitioned to online courses. Some students reside in a local dormitory and due to online school services, have little access to a safe location to interact with other students. This limitation also applies to the students who are accessing classes on line in their homes. The lack of exercise available lead the Parent/teacher discussions to identify the many health concerns especially related to diabetes and obesity affecting the students. The Jicarilla Apache community leaders are interested in funding to support developing a community park to include a skate park, playground equipment, walking and biking trails and a basketball court. The locations would be locations that would be accessible to the students. Once the parks are completed, a combined community campaign would be announced such as a grand opening with themes such as “Your Steps Matter” and designated walls to allow students to contribute to painting and decoration. Creating this environment of community, safety and partnership with other health related programs would be the foundation to expansion such as incorporating cultural programs.

This request is in line with Goal 1 in the Indian Health Service Strategic plan as noted below:

Goal 2: To promote excellence and quality through innovation of the Indian health system into an optimally performing organization

Objective 2.1: Create quality improvement capability at all levels of the organization

Objective 2.2: Provide care to better meet the health care needs of American Indian and Alaska Native communities.

The Southern Colorado Ute Service Unit recommends an increase to the Public Health Nursing (PHN), Community Health Representative (CHR) and Community Health line items. 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 in 2020 and beyond and transportation needs for patients to and from vital appointments and referral services. The activities performed by the PHN, CHR and CHAP departments 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 experienced by AI/AN.

The Service Unit acknowledges a staffing shortage coupled with an increase demand of the services provided by the CHR program, particularly due to the increase of the scope of work as it pertains to elderly care. The CHR department provides assistance to patients and the community in promoting healthy lifestyles and disease prevention as well as transportation services to and from clinic and referral appointments. As mentioned, the demand for services have increased and are integrally tied to access to care and in increasing Public Health in our communities and meeting GPRA measures within our clinics and hospitals. In addition, it is anticipated with better funding this demand will

continue to increase. (see IHCIA, Chapter 18, Subchapter I, 1616 and IHS Strategic Plan, Objective 1.3, Strategies, Health Care Service Access Expansion).

*IHS Strategic Plan: Goal 1. Reform, strengthen, and modernize the Nation's Healthcare System. 1.2 Expand safe, high-quality healthcare options, and encourage innovation and competition. 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 and Alaska Native communities.*

## **Community Health Representatives (CHR)**

The Southern Colorado Ute Service Unit recommends an increase to the Public Health Nursing (PHN), Community Health Representative (CHR) and Community Health line items. 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 in 2020 and beyond and transportation needs for patients to and from vital appointments and referral services. The activities performed by the PHN, CHR and CHAP departments 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 experienced by AI/AN.

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Ysleta Del Sur Pueblo requests additional funding for the CHR program to continue meeting the expanded support efforts for health education activities and community education. The program continues to support the diabetes prevention program that is not part of the SDPI.

At the SFSU, the TL / TR and their SFSU Governing Body colleagues endorse adding Community Health Representatives (CHR) to the list of our top five priorities for budget decrease. Although located entirely within tribal communities, CHRs are a vital link between our agency's clinical services and our beneficiaries. A non-exhaustive list of regular CHR duties include non-emergency medical transport, assisting in chronic medication management, regular visits to homebound patients, community-based health and wellness education, and liaison work between patients and medical professionals. Despite the exceptional value they add to our agency, their funding has been vulnerable in recent years, as evidenced by the following trends:

- National tribal CHR budget recommendations: \$92.2 million (FY 2019) → \$83.2 million (FY 2020) → \$136.6 million (FY 2021)
- President's initial proposed CHR budget: \$58.9 million (FY 2018) → \$0 (FY 2019) → \$24 million (FY 2020)
- Enacted CHR budget: \$60.3 million (FY 2017) → \$62.9 million (FY 2018) → \$62.9 (FY 2019)

In summary, over the past four years, national tribal budget recommendations have trended towards incremental increases in the CHR line item, whereas the President's initial proposed budgets have reflected a dramatic decrease in funding (actually, complete defunding in FY 2019). Ultimately, the actual CHR budget has remained fairly constant, but the SFSU TL / TR maintains that it is critical to include this as a top priority for future budget increases in order to secure stable future program resources.

At ASU, nearly all 638 programs heavily rely on community health representatives. They are typically members of the community who speak the language and know the community they serve. CHRs are often an essential bridge between the medical/clinical/dental staff and patients in the community. They help to monitor and ultimately improve the health status of patients served. There is a need for additional funding to support additional CHR positions so that people can have a bigger role and increased participation in improving the overall health of their own community.

The Taos Pueblo recommends an additional increase for the CHR program. This is a vital program for our communities and for IHS. This program supports culturally appropriate health services and preventive care. As noted above, the CHRs have been instrumental in the battle against COVID-19, providing individual support, contact tracing, community education, and logistical support to the Emergency Management Team. Once again, CHRs have shown how vital they are to the communities they serve by completing a wide variety of health-related services, COVID and non-COVID related, in the community.

The Pueblo of Laguna stated that CHR programs are community-based health care providers that provide a unique, culturally sensitive scope of services to community and tribal members. CHRs are the critical first line of coordination care between many patients in rural reservations and clinical providers at I.H.S. and clinicians. In the Pueblo, the CHR program had over 3,733 documented patient care contracts ranging from health education, case management, patient care and transportation in 2019. Increased funding will allow for CHRs to continue to expand their roles in critical areas such as point of care testing, home visitation, transportation, care coordination and advocacy. An area of concern that arose in 2019 is the potential threat to not fund the CHR program while advocating for the CHAPS model as a more viable alternative for all tribal communities. Both the CHR and CHAP program should be presented as options for Tribal governments to contract based on the needs of the community. Both programs provide critical clinical care linkages and direct clinic care linkages necessary for addressing health problems in the community. Future funding for the CHR program will be strengthened when

Department of Labor and Medicaid recognize and authorize reimbursement for direct services by CHR's.

The Pueblo of Acoma stated that CHR's help to bridge the gap between individuals and health care resources through outreach by specifically trained Tribal/community members. The CHR's are the frontline public health workers who are typically a trusted member of the Pueblo. This trusting relationship enables the worker to serve as a liaison, to link and be an 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. These representatives provide services such as in-home patient assessments of medical conditions, providing glucose testing or blood pressure tests to determine if the patient should seek further care, and providing transportation for medical care. They also help interpret prescriptions which is critical to patient safety. Without these services and the people who provide them, many Tribal members will not receive the care or attention they require. The result will be reduced health outcomes and patient safety issues for the most vulnerable and remote Tribal members of the Pueblo of Acoma.

## **Sanitation**

The Mescalero Apache Tribal community lacks adequate water and sewer services for about 35% of its tribal members that are needing this assistance for new homes; a current waiting list of approximately 26 established homes pending water and sewer services; with an additional 20-25 homes projected per year that will require water and sewer supply. The tribe requires supplementary resources to meet the current needs. Overall, the current water and sewer capabilities are inadequate with constant breaking/leaking of lines that undermine the ability to get ahead of the issues at hand. The solution is to address the overall sanitation through a competent and maintained infrastructure that will deliver adequate and safe services to the community and to the Mescalero Service unit.

The Southern Ute Indian Tribe and the Ute Mountain Ute Indian Tribe recommend an increase for Sanitation Facilities Construction (IHCIA Chapter 18, Subchapter III, 1632). The Service Unit identified an inconsistency of modern sanitation facilities and services between most of the citizens of the United States and American Indians/Alaskan Natives. Sanitation, good hygiene and safe water are fundamental to health. There should be every effort made to ensure proper sanitation facilities are available to each AI/AN community. In particular, in the Ute Mountain Ute Tribal communities in Towaoc, CO and White Mesa, UT, many elders' homes need better infrastructure; connected to sewer and water utilities. With an increase in funding particularly to Sanitation Facilities Construction, this gap can be bridged; allowing increased public health. (see also, IHS Strategic Plan, Objective 1.3, Strategies, Health Care Service Access Expansion, 14. Develop and coordinate environmental engineering, environmental health, and health facilities engineering services to provide effective and efficient public health services...) The Service Unit would also like to request an increase in the Maintenance & Improvement category for the replacement of the roof at the Southern Ute Health Clinic, as it had been deemed not adequate to carry the snow load during the winter. The difficulty in replacement and building new health care facilities necessitates the need for the increase in M&I. The Ute Mountain Ute Tribe within the Southern Colorado Ute Service Unit would also like to see an increase in the Equipment line item to assist in replacement of aging medical equipment.

In FY 2023, the Pueblo of Acoma Budget Formulation Workgroup recommends an increase for sanitation Facilities Construction. The Sanitation Facilities Construction has been an integral component of IHS disease prevention activities.

Many homes within the Pueblo of Acoma continue to need some form of sanitation facilities improvements. This increase will enable more projects to be funded thereby improving the overall health for Tribal members.

The Sanitation Deficiency System (SDS) scoring system with over 25 Albuquerque Indian Tribes with a combined number of over 100 projects alone makes it difficult for all Tribes to get one project funded per year. There is a huge need for water service improvements, wastewater system improvements and solid waste improvements. Funding includes cleaning of illegal dump sites, but this has never been addressed nor funded by IHS.

## **Public Health Nursing**

The Albuquerque Service Unit stated that the Public health nurses play a critical role within tribal communities. 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 Pueblo of Acoma stated that Public Health Nursing (PHN) is a community health-nursing program that focuses on promoting health and quality of life and preventing disease and disability. The PHN program provides quality, culturally sensitive primary, secondary and tertiary health promotion and disease prevention nursing services to Tribal members. These home-based services are most often related to chronic disease management, safety and health maintenance care for elders, investigation and treatment of communicable disease, and screening for early diagnosis of developmental problems. The request for the increase is primarily based on an expansion of services and promotion of well-being, health promotion and health education.

The Southern Colorado Ute Service Unit recommends an increase to the Public Health Nursing (PHN), Community Health Representative (CHR) and Community Health line items. 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 in 2020 and beyond and transportation needs for patients to and from vital appointments and referral services. The activities performed by the PHN, CHR and CHAP departments 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 experienced by AI/AN.

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*services. Goal 2. Objective 2.2 Provide care to better meet the health care needs of American Indian and Alaska Native communities.*

At the TPSU, the Public Health Nurse has arguable been one of the most important positions for Taos Pueblo in addressing the medical needs of the community during the pandemic. The PHN has been responsible for case investigation, contact tracing, and leading the contact monitoring team during the crisis. The PHN has also been a continuous point of contact for clients in the community affected by COVID-19, and has been the communication bridge between community and the service unit. The pandemic has highlighted the critical role community nurses (and Community Health Representatives) play in our community, and this capacity must be increased moving forward.

The Pueblo of Laguna stated that the introduction and maintenance of a solid public health program in the tribal community is key to the prevention of the spread of communicable diseases and the management of chronic diseases requiring medication management and education. The PHN program has a significant role in working with tribally funded prevention and early intervention programs such as CHR, SDPI, Head Start and Community Paramedics to implement screenings, training, and support for direct medical needs. Increasing the funding for PHN will aid in the development of quality care teams in the community, which will bridge services and communications between clinical providers and the community. The PHN scope allows for nursing level services to be provided in home and in the community based on physician/provider orders. PHN's are able to support patient's post-hospitalization and post-partum delivery to prevent costly re-hospitalization of patients and ensure quality, culturally competent medically directed services in the community. The Pueblo of Laguna has one PHN, that provided 910 documented direct patient services encounters ranging from Home visiting to direct patient care in community. Critical aspects of the PHN program involve the PHNs ability to engage a public health response for disease threats and out breaks such as Pertussis and to consult with Medical Doctors and Medical Providers on specific medical orders for patients and families. Public Health Nurses working in collaboration with CHRs and other field base providers can create a circle of health security for patients and strengthen care coordination and case management, which leads to positive patient health outcomes

## **Health Education**

YDSP requests additional funding to continue to develop and support programs that promote healthy lifestyles and reduce risk of chronic disease across the lifespan, such as promote prevention and treatment of Diabetes, health screenings, early intervention, treatment and prevention classes, prenatal classes, and nutrition classes that promote traditional farm to table food.

At Taos Pueblo, Health Education is already underfunded and threatened with cuts, continuous health education is vital for our community. The pandemic has highlighted the need for continuous health education as it has affected those with underlying medical conditions disproportionately. We must dedicate ourselves to greater preventative health education to establish overall healthier communities.

The Pueblo of Laguna stated that increases in funding for health education and Health Educator positions in Tribal communities will significantly impact the ability to translate information in culturally meaningful ways linguistically and related to cultural norms. Complex health information and meanings are often lost in translation to patients that are not from the community. Right Messaging for health behaviors is key. The Pueblo initiated a 638 contract in 2017 to bring the shares to the tribe to implement a successful Health Education program at the Pueblo. The program is staffed by an educated tribal member who has successfully implemented health campaigns and introduced messages for key population. Critical to the community now is the messaging on COVID19 and what this pandemic is and how we prevent the spread the disease. The Health education program has been key in developing over 100 printed and video messages on COVID for the community; the Health Education program has been key in serving as the Public Information officer for the E.O.C.

The Health Education program is vital to bridge primary care with community health outreach and education. The focus of this program is to provide the Pueblo of Acoma with education and awareness relating to preventative health, emergency response, and public health, including communicable diseases.

In addition, health educators serve as the system liaisons between individual, health care providers, and community organizations to coordinate resources and services which promote health education programs. It is known that most chronic diseases that impact Tribal members are preventable with guided behavior changes. If unhealthy behaviors go unattended, the consequences are high health costs for treating these preventable diseases. Health promotion, health education and prevention are good IHS investments which produce effective and efficient approaches in addressing primary, secondary, and tertiary prevention, as well as, bridging community, school, workplace, and clinical settings.

The Pueblo of Acoma Health Promotion Model incorporates a holistic model which starts with promoting individual behavioral changes and includes community-based support to

impact health outcomes through promotion of nutrition, physical activity, car safety, and emotional well-being.

Overall, health promotion and health education results justify the value of this investment by comparing cost of programs against measurable health benefits; for example, weight loss to address obesity, increased fruit and vegetable consumption to combat chronic internal diseases, lives saved when using infant/toddler car seats, screening for early intervention of cancers, traditional healing to promote well-being, improved activity to promote fitness, and expanding the number individuals trained in healthy lifestyles to spread community awareness.

Lastly, health promotion and health education improve the overall quality of life and well-being of Tribal members. The request includes inflation over the FY 2017 base in program expansion.

## **Indian Health Care Improvement Act**

The Pueblo of Laguna stated that increased funding in this area will allow the tribes to address significant shortages and issues of deficiencies that impact the inability to advance the health status of AI/AN people. These funds are used to address the deficiencies in health status and health resources of all Indian tribes in funding for both direct care and contract health service programs and augment the ability of the Indian Health Service to meet the health service responsibilities with respect to those Indian tribes with the highest levels of health status and resource deficiencies. A major concern is the impact of COVID19 on tribal communities and how the I.H.S. will respond to providing direct care and resources after the CARES funds have ended.

The CBNHC 638'd clinic operations July 1, 2016. CBNHC increased the encounter rate by 65% in 2019. Anytime a patient is seen by clinic staff on a face-to-face basis it is considered an encounter. This is a different calculation in how billable visits are calculated. Since we fully contracted IHS services in July 1, 2016, there is a 3.4 fold increase realized - 7,377 in 2017 to 24,772 encounters in 2019. With increased funding in IHCIF, CBNHC could certainly be able to hire additional clinic and behavioral staff to meet the increased demand from not only the To'Hajiilee community but other surrounding communities, including urban Indians residing in Albuquerque, NM. There are approximately 15,000 urban Navajos living in Albuquerque who are not from the To'Hajiilee community and many of them visit the CBNHC for health care services. With the COVIC-19 pandemic in 2020, many urban Navajos are now visiting the CBNHC medical facility. CBNHC does not receive additional funding for serving these additional populations which is basis of our request to fund IHCIF.

## **Maintenance and Improvement (M&I)**

The Southern Ute Indian Tribe and the Ute Mountain Ute Indian Tribe recommend an increase for Sanitation Facilities Construction (IHCIA Chapter 18, Subchapter III, 1632). The Service Unit identified an inconsistency of modern sanitation facilities and services between most of the citizens of the United States and American Indians/Alaskan Natives. Sanitation, good hygiene and safe water are fundamental to health. There should be every effort made to ensure proper sanitation facilities are available to each AI/AN community. In particular, in the Ute Mountain Ute Tribal communities in Towaoc, CO and White Mesa, UT, many elders' homes need better infrastructure; connected to sewer and water utilities. With an increase in funding particularly to Sanitation Facilities Construction, this gap can be bridged; allowing increased public health. (see also, IHS Strategic Plan, Objective 1.3, Strategies, Health Care Service Access Expansion, 14. Develop and coordinate environmental engineering, environmental health, and health facilities engineering services to provide effective and efficient public health services...)

The Service Unit would also like to request an increase in the Maintenance & Improvement category for the replacement of the roof at the Southern Ute Health Clinic, as it had been deemed not adequate to carry the snow load during the winter. The difficulty in replacement and building new health care facilities necessitates the need for the increase in M&I.

The Ute Mountain Ute Tribe within the Southern Colorado Ute Service Unit would also like to see an increase in the Equipment line item to assist in replacement of aging medical equipment.

## **Electronic Health Record**

Since the Indian Health Service is needing to upgrade its electronic health record to meet current guidelines and since the VA is transitioning to a commercial package, the Ute Mountain Ute Indian Tribe requests additional funding in the EHR line item. A modern user friendly Electronic Health Records system will assist providers and allied health professionals in appropriately sharing information with patients, providers within the IHS and specialty providers and referral entities.

The Pueblo of Acoma stated that a reasonable adequately resourced IHS Electronic Health Record System (EHR)/Health Information Technology (HIT) program is critical to ensure quality and safe care as well as to save costs related to inefficient processes and unnecessary duplication of services. The gains of deploying electronic health records (EHRs) in the clinical setting as well as a rural setting are numerous and important including: easier access to clinical data; the ability to establish and maintain effective clinical workflows; improved patient care coordination; and stronger real-time support for clinical decision-making.

IHS provides the technology infrastructure for a nationwide health care system, including a secure wide area network, enterprise e-mail services, and regional and national Help Desk support for approximately 20,000 network users with the exception for Tribal 638 Programs. A properly resourced IHS EHR/HIT program(s) directly supports better ways to: 1) care for patients, 2) coordinate referral services, 3) support clinical decision-making and reporting, resulting in better care, wiser spending of our health dollars, and healthier Tribal communities.

This meaningful investment of into the EHR/HIT system aids in addressing innovative ways to improve health care delivery and modernize administrative functions. It is also used for making significant improvements to current IT infrastructure in order to support the deployment of a new or modernized EHR solution. IHS must enhance cybersecurity, improve IT service management, expand storage and computing capacity, and increase network bandwidth at dozens of rural locations to enable a successful EHR transformation to both IHS facilities as well as Tribal 638 Programs.

## **Tribal Management**

The Taos Pueblo stated that Tribes must be given support in order to accurately weigh and assess the benefits and disadvantages of assuming different programs, services, functions, and activities. Without the ability to work with subject matter experts on these decisions, Tribes are forced to make decisions regarding their provision of health care without complete and total information.

The Pueblo of Acoma stated that 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.

## **Self-Governance**

The Taos Pueblo stated that the right to self-govern must be maintained and supported through the Indian Health Service.

The Pueblo of Acoma stated that 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.

## **Equipment**

The Southern Ute Indian Tribe and the Ute Mountain Ute Indian Tribe recommend an increase for Sanitation Facilities Construction (IHCIA Chapter 18, Subchapter III, 1632). The Service Unit identified an inconsistency of modern sanitation facilities and services between most of the citizens of the United States and American Indians/Alaskan Natives. Sanitation, good hygiene and safe water are fundamental to health. There should be every effort made to ensure proper sanitation facilities are available to each AI/AN community. In particular, in the Ute Mountain Ute Tribal communities in Towaoc, CO and White Mesa, UT, many elders' homes need better infrastructure; connected to sewer and water utilities. With an increase in funding particularly to Sanitation Facilities Construction, this gap can be bridged; allowing increased public health. (see also, IHS Strategic Plan, Objective 1.3, Strategies, Health Care Service Access Expansion, 14. Develop and coordinate environmental engineering, environmental health, and health facilities engineering services to provide effective and efficient public health services...)

The Service Unit would also like to request an increase in the Maintenance & Improvement category for the replacement of the roof at the Southern Ute Health Clinic, as it had been deemed not adequate to carry the snow load during the winter. The difficulty in replacement and building new health care facilities necessitates the need for the increase in M&I.

The Ute Mountain Ute Tribe within the Southern Colorado Ute Service Unit would also like to see an increase in the Equipment line item to assist in replacement of aging medical equipment.

The Pueblo of Acoma stated that the ACL Hospital 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.

## Urban Indian Health Programs

- The FY2023 Albuquerque Urban Indian Health Programs include the Denver Indian Health and Family Services, Inc. and Albuquerque's First Nations Community HealthSource. Our urban programs budget proposal focuses on funding activities that will continue to build capacity and technology infrastructure to provide the best possible support for the delivery of clinical care services at all levels through enhanced systems, evaluation, technical assistance, training, and policy and health care services.
- Pay, Inflation, Population Growth: This funding item is critical for addressing the demand/need for health services by the urban Indian communities. An estimated 83,000 urban Indians reside in Denver and 55,000 reside in Albuquerque. More than 150 tribes are represented in each of these areas. Our urban populations are relatively young and tend to move back and forth between their homelands and the urban areas. With the Affordable Care Act, our programs have enrolled thousands of urban Indians in Medicaid however, we also continue to serve a large uninsured urban Indian population. As the urban Indian population grows, the demand and need for accessible and quality health services will grow. Urban programs must be funded to meet this need.  
*Effects of previous years funding*: In Fiscal year 2019, both programs were able to allocate funds into recruitment and retention.
- Improved Information Systems and Reporting: This funding item is important to address the increasing electronic trends and requirements in the health care environment and the need for urban programs to be equipped to meet these changes. Examples of the integration of health IT with health care currently include a variety of electronic methods such as the management and documentation of patient health information and the formulation of clinical decision support through electronic health record systems, linkages to needed medications through e-prescribing, improved access to health services through telehealth, quality care standards through meaningful use, and chronic disease monitoring through disease registries. These examples underscore the increasing health information technology trends and the need for urban programs to ensure their readiness and compliance to meet these changes. Adherence to these changes will also ensure urban Indian program support of IHS's reporting system requirements and overall mission.  
*Effects of previous years funding*: In Fiscal year 2019, funds were used for continued support of our electronic health record.
- Improving the Quality of Health Programs: This funding item is important for urban programs to effectively address the health care needs of the urban Indian communities. Quality encompasses a range of areas including access, clinical effectiveness, and integration of services, cultural competence, and coordination and continuity of services. Given the disproportionately high rates of chronic diseases and health disparities experienced by the urban Indian populations,

quality health programs are vital for improving their wellness and health outcomes. Hence, the budget increases will not only assist programs in achieving quality health services but will support IHS' commitment of providing quality health services.

Effects of previous years funding: Continued commitment of providing culturally responsive services.

- Expanding Technical Assistance Training, and Policy: Budget increases in this area are being requested to help urban programs develop and deliver cost effective and quality models of care that address the holistic (including cultural) needs of its patients and communities and to develop and implement policies that promote wellness and positive health outcomes. Trainings through webinars, workshops, conferences, metric toolbox kits, etc. will assist urban programs in enhancing the capacity of their staff and formulating and implementing effective policies. This increase will also support IHS' overall mission to provide quality care and will allow for an effective use of resources and staffing.
- Prioritizing Health Care Services: Budget increases in this area are being requested to assist urban programs in prioritizing health care services by conducting assessments such as community needs assessments, health care assessments, surveys, town halls, self-assessments, etc. to assist them in prioritizing health care services that best meet the needs of their communities. Budget increases in this area will also enable urban programs to provide community-wide health education and disease prevention activities that address the prioritized health care services.

#### **The linkage to IHCIA provisions, where applicable**

Urban programs will continue to support the provisions to expand health coverage, improve the quality of healthcare for all American Indians/Alaska Natives and engage in disease prevention and health promotion activities.

#### **Linkage to GPRA performance targets and outcomes?**

- The recommended budget increases were based on a review of multi-year GPRA and national urban Indian health programs' data trends in comparison to IHS benchmarks which are used to assess need, performance and quality. The areas being recommended for budget increases address the provision of quality of health services (e.g., using standard performance metrics such as GPRA), infrastructure (including technology) needs related to quality such as data reporting and tracking, trainings to increase capacity through education on best practices for providing effective and culturally appropriate services, and anticipated increases in population growth of urban Indians over the next ten years. Funding recommendations also address the prioritization of health care services (e.g., diabetes, cardiovascular disease, oral health, etc.) which is critical for addressing the significant health disparities experienced by the urban Indian communities and, most importantly, for ultimately improving their health

outcomes. Additional funding to meet performance targets and outcomes will allow programs to achieve these goals.

**Link requests to Indian Health Service Strategic Plan:**

- Our programs will use the budget recommendations to be in full alignment of the 2019-2023 IHS Strategic Plan. Funding will be prioritized to ensure that comprehensive, culturally appropriate services are accessible to our American Indian/Alaska Native families. Areas of improvement will promote excellence and quality through a strategic quality improvement plan, strengthen program management and operations within our programs, and improving communication by continuing to enhance our IT infrastructure.

## **Indian 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 and 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-born 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.

INDIAN HEALTH SERVICE  
FY 2023 Bemidji Area Budget Formulation Session

National Tribal Budget Recommendation is for Full Funding of the Indian Health Service

**Budget Narrative / Justification**

Each Area will submit a Narrative document that describes and supports the agreed upon budget recommendation as follows:

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.
2. The linkage to IHCIA provisions, where applicable.
3. How will each of these increases improve a facet of the HHS Secretary's priorities; people, partnership, and patients?
4. Linkage to GPRA performance targets and outcomes.

**BUDGET INCREASES**

1. H&C +\$4.484B

The Bemidji Area recommends 12.7%, or \$4.448B, of the increased funding available 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.

The Bemidji Area continues to list as one of their "hot topic" issues the need for a regional treatment center, specifically targeting psychiatry adolescent care and opioid addiction recovery. An increase of H&C funds could be used to address this enormous need. Currently, inadequate funding prohibits the advancement of a center as authorized by the IHCIA, Section 708. The center would increase adolescent care and family involvement services to address the increased disparities with opioids and drug addiction habits. A regional center would help alleviate the travel burden for patients and family members who now need to travel extensive distances to seek these services. The need for families to participate in the patient's recovery is crucial for a successful outcome. 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.

2. Purchased/Referred Care (PRC) +\$3.924B

The Bemidji Area recommends 11.1%, or \$3.92B, of increased funding available be applied to the Purchased/Referred Care (PRC) budget line item. The Bemidji Area Tribal programs are heavily dependent on PRC. Historically, the Bemidji Area Tribal programs were primarily PRC programs as part of the Great Plains Area when Bemidji was a Program Office. Approximately 2/3 of the Area Tribes are considered 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.

### 3. Mental Health +\$2.432B

The Bemidji Area recommends 6.9%, or \$2.432B of funding available be applied to the Mental Health (MH) budget line item to address the root causes of community members' mental health issues. As the Bemidji Area has found, the inability to address the root cause has manifested into an increasing problem of prescription and synthetic drug abuse/misuse as well as experimentation and addiction to illicit drugs. This funding recommendation supports Section 127 of the IHCIA for increasing the number of mental health providers and funding training/education as well as Sections 704 and 705, which advance the behavioral health programs and programming to address community issues.

Bemidji Area Tribes expressed Mental Health program increased funding needs specifically to be for long-term treatment and after-care facilities/staffing to combat mental health diseases. Strengthening funding for Section 702 of the IHCIA would include support in meeting these needs.

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.

### 4. Alcohol & Substance Abuse (ASA) +\$2.008B

The Bemidji Area recommends 5.7%, or \$2.008B, of the funding available be applied to the Alcohol & Substance Abuse budget line item to address the drug abuse issues of the Area. The impact of alcohol and substance abuse within the Area is having a dramatic negative effect on lives, families and communities of the native people. There is a huge demand for increased funding to combat this adverse societal condition. Several Tribes within the Bemidji Area have declared a "state of emergency" with the growing epidemic of increased abuse of alcohol and drugs, particularly opioids. This is a multifaceted problem, which requires involvement of multiple agencies from Tribal Leaders, law enforcement, education and health care professionals, to States, Federal Agencies and the community to solve. There is also a need for alternative resources such as physical therapy, behavioral health and buy-in to pain treatment utilizing alternatives to abused medications along with a regional treatment center. The recent opioid crisis has led to large federal funding levels to combat this emergency, however, Bemidji Area Tribes have found the opioid grants to be very restrictive and too specific to combat the overall epidemic of alcohol and other substance addictions. There needs to be greater flexibility with the opioid grants to combat this issue as a whole.

There is a compelling case in the Bemidji Area for increased funding of IHCIA, Section 708, authorizing adolescent care and family involvement services, primarily targeting Psychiatry Adolescent Care. Currently, there is inadequate funding available which attributed to the increased disparities with opioids and drug addicted habits.

There is also insufficient funding for after-treatment care to break the rehab treatment - prior situation cycle. Funding Sections 708 would be beneficial in advancing support in achieving greater success rates and breaking the addiction cycle.

5. Dental +\$1.731B

The Bemidji Area recommends 4.9%, or \$1.731B, of the funding available be applied to the Dental budget line item to address the Area and Tribal program needs. Dental services are a growing need in the Area and a recent analysis of the funding received showed that the current level of funding equates to only \$20 per individual in the Bemidji Area. In the Bemidji Area specifically, Tribal programs are establishing and expanding dental program operations but the limited funding 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.

6. Indian Health Care Fund +\$820MM

The funding requested in the Indian Health Care Fund line will also contribute providing current unfunded programs and services as authorized by the Indian Health Care Improvement Act (IHCIA). The IHCIA further establishes the Indian Health Care Improvement fund (IHCIF). The IHCIF is to help eradicate deficiencies in health resources which addresses American Indian and Alaskan Natives (AI/AN) health disparities. The limited resources now being received is not enough to even cover the basic primary and urgent care needs of AI/AN. The health care disparities of AI/AN with cancer, diabetes, heart disease, suicide, injury and substance abuse is well documented. To achieve notable and meaningful health outcomes it has to be understood the need for increased funding

7. Electronic Health Record (EHR) Upgrade +\$750M

The Electronic Health Record Upgrade for the Indian Health Service has been pending for many years with the current system not adequately keeping up with commercial EHR packages. Many tribes have ventured on their own to upgrade their EHR systems which is very costly, along with very expensive service agreements to maintain the systems. 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.

8. Urban Health+\$716M

The Bemidji Area recommends 2%, or \$716M, of the funding available be applied to the Urban Health budget line item to provide critical funding for health care to the large AI/AN populations in the urban settings of large cities. This increase in funding to Urban Health would align with authorized new programs and services of the IHCIA Title I – Subtitle E: Health Service for Urban Indians, Sec. 164 – Expand Program Authority for Sec. Urban Indian Organizations {25 U.S.C. § 1660e}.

Along with congressional appropriations Urban Health programs are highly reliant on grants to maintain operations. Many times grants are restrictive, specific in scope, changing

requisite, reduced or eliminated. This changeable condition makes it difficult to plan and maintain a balanced level of facility operations. Increases of recurring budget appropriations would enable urban programs to maintain a more uniform level of services for their patients.

9. Community Health Representative +\$845M

The Bemidji Area recommends 2.4% or \$845M of funding available be applied the Community Health Representatives (CHR) budget line item. The CHRs are one 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.

10. Public Health Nursing +\$451M

The Bemidji Area recommends 1.3% or \$451M, of increased funding available to the Public Health Nursing (PHN) budget line item. The increased funding for PHN will greatly benefit healthcare outcomes by increased staff and resources for improved disease prevention and early detection of health disorders. The instances of early detection of disease and prevention will have greater enhanced outcomes and decrease demands for other patient care budget line funding.

11. Health Education +259M

The Bemidji Area recommends 0.7% or \$259M, of increased funding available to the Health Education (HE) budget line item. The HE programs provide basic health information to not only the providers working with patients but also provides valuable wellness training and guidance to the AI/AN communities. Health promotion is instrumental in emphasizing wellness through health promotion and disease prevention by encouraging positive behavior and important lifestyle choices thus improving the lives of individuals and their communities.

12. Direct Operations +2.8M

The Bemidji Area recommends .01% or \$2.78M, of increased funding available to the Direct Operations budget line item. The Bemidji Area tribes are aware of the challenges facing the IHS in carrying out its responsibility of providing leadership, oversight, executive direction and administrative support to the 12 regional areas. Additional funding will be needed to assist the IHS with the large increase of duties and obligations to the AI/AN as a move towards full funding materializing.

13. Self-Governance +\$102,000

The Bemidji Area recommends \$102,000, of increased funding available to the Self-Governance budget line item. This funding is critical in providing necessary oversight of the IHS Tribal Self-Governance Program by providing information, technical assistance, and policy coordination and service as an advocate for Tribal concerns regarding the delivery of health care. These funds are a key factor in providing the guidance needed for Tribes as they transition to self-reliance in providing quality health care for their people.

14. Community Health +\$40M

The Bemidji Area recommends .1% or \$40M, of increased funding available to the Community Health 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.

15. Tribal Grants Management +\$24,000

The Bemidji Area recommends \$24,000, of the funding available be applied to the Tribal Grants Management budget line item. This funding will be used to provide oversight and assistance to federally-recognized Tribes and Tribal organizations (T/TO) in assuming all or part of existing IHS programs, services, functions, and activities to further develop and improve their management capability.

Tribal Management Grants are competitive grants available to T/TO for:

- obtaining technical assistance from providers designated by the Tribe (including tribes that operate mature contracts) for the purpose of planning and evaluation, including the development of any management systems necessary for contract/compact management and the development of cost allocation plans for indirect cost rates; and
- planning, designing, and evaluating Federal health programs serving the tribe, including Federal administrative functions.

16. Alaska Immunization Program +\$16,000

The Bemidji Area recommends \$16,000 of funding available be applied to the Alaska Immunization Program budget line item to address the need for immunizations in the vast Alaska Area. Numerous vaccines are given and monitored among the Alaska Native peoples through outpatient clinics, video-conferences and field clinics. This funding is very important in keeping this program well-funded to provide high vaccine coverage along with providing technical support and prevention materials.

17. Maintenance and Improvement +\$9.392B

The Bemidji Area recommends 26.7%, or \$9.392B, of the funding available 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.

18. Sanitation Facilities Construction +\$2.486B

The Bemidji Area recommends 7.1%, or \$2.486B, of the funding available be applied to the Sanitation Facilities Construction budget line item. These increase of funds are greatly needed for essential sanitation facilities including water supply, sewage, and solid waste disposal facilities to AI/AN homes and communities. Clean water and sewage disposal are key in providing safe health environments for AI/AN populations. Sanitation facilities construction needs for tribes are prioritized using a database which contains needed water, sewer, and solid waste projects for all existing homes; plus

sanitation needs for new homes. There is very large backlog of economically feasible projects and full funding will eliminate the backlog.

19. Hospitals and Clinics Facilities Construction +\$3.53B

The Bemidji Area recommends 10% or \$3.53B, of the funding available be applied to the Hospitals and Clinics Facilities Construction budget line item.

20. Facilities Environment Health Support +\$51.2M

The Bemidji Area recommends .1%, or \$51.2M, of the funding available be applied to the Facilities Environment Health Support budget line item. Facilities and Environmental Health Support - supports personnel who provide facilities and environmental health services throughout IHS at the Area, district, and service unit levels, and to pay operating costs associated with provision of those services and activities. FEHS has three sub-activities in which these funds will provide: Facilities Support – provides for staff and management activities. Environmental Health Support – provides support to sanitation facilities construction. Office of Environmental Health and Engineering Support – provides for headquarters management activities and real property asset management.

21. Equipment +\$401M

The Bemidji Area recommends 1.1%, or \$401M, of the funding available be applied to the Equipment budget line item. This funding will be used to fund maintenance and replacement of biomedical equipment at IHS and Tribal health facilities. Equipment purchased through this budget line item also include much needed ambulance replacement and provides for the transfer of excess Department of Defense medical equipment to IHS and tribal programs. Annual replacement need is in excess of \$23M, considering useful life of the equipment averaging six years.

22. Indian Health Care Improvement Act Scholarship +\$917M

The Bemidji Area recommends 2.6%, or \$917M, of the funding available be applied to the Indian Health Care Improvement Act (IHCIF) Scholarship budget line item. This increase of funding for this budget line item would greatly enhance the ability of Indian health care programs to attract highly qualified providers. Presently, funding and benefits for young providers is much less than the private sector or other health care agencies in the federal government. This funding would enable the IHS to competitively compete against those entities to fill the numerous vacancies throughout Indian Country in providing the highest possible health care to the underserved AI/AN population.

In Bemidji Area, our full funding budget priorities are ...

1. Hospital and Health Clinics +\$4.484B
2. Purchased/Referred Care (PRC) +\$3.925B
3. Mental Health (MH) +243M
4. Alcohol and Substance Abuse (ASA) +\$2.008B
5. Dental Service +1.731B
6. Indian Health Care Fund (IHCF) +\$820M
7. Electronic Health Record (EHR) +\$750M
8. Urban Health +\$716M
9. Community Health Representative (CHR) +\$845M
10. Public Health Nursing (PHN) +\$451M
11. Health Education (HE) +\$259M
12. Direct Operations (DO) +\$2.77M
13. Self-Governance +\$102,000
14. Community Health +40M
15. Tribal Grants Management +\$24,000
16. Alaska Immunization +\$16,000
17. Maintenance and Improvement (M&I) +9.392B
18. Sanitation Facilities Construction +2.486B
19. Facilities Construction +\$3.531B
20. Environment Health Support +\$51M
21. Equipment +\$401M
22. Indian Health Care Improvement Act (IHCIA) Scholarship +917M

## Deliverable #2

# Indian Health Service Billings Area FY 2023 Area Budget Instructions Budget Recommendation Narrative

## 1. Mental Health

Mental Health is the #1 priority for the Billings Area for the FY 2023 Budget Formulation. In 2019, the tragedy of suicide continued with suicide clusters on several reservations. The Billings Area Office (BAO) of the Indian Health Service (IHS) and Tribal Behavioral Health Departments are striving to increase behavioral health services. The BAO has devoted personnel and resources to assist behavioral health delivery in all of the service units. The Community Health Aide Program (CHAP), passed through the Montana Legislature in the spring of 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. Community Health Aides will work in the areas of Behavioral Health, Dental, and Medical.

The Tribes of Montana and Wyoming see as 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 four times more likely to commit suicide compared to the national average. American Indians communities did not fare as well as other communities for several socio-economic indicators, including lower high school graduation rates, higher unemployment, and lower household income (Montana Department of Public Health and Human Services, 2017). The report indicates in Montana:

- 66% of American Indian students graduate high school in 4 years;
- nearly 2 in 5 children live in poverty;
- 84% American Indian adults reported one or more adverse childhood experience;
- Suicide rate for American Indians is estimated at 29%;
- 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.

In 2018, on the Chippewa Cree Tribe of Rocky Boy conducted a Community Health Assessment (CHA) Report with the Center for Health Equity, Education, and Research (Center for Health Equity, Education, & Research, 2019). In 2018, the CHA reports:

- 216 patients have been diagnosed with Anxiety Disorder, 141 Depression and 70 Post Traumatic Stress Disorder (PTSD);
- 15% of people that took the CHA survey had been told that their child should receive mental health services;

- 27% of students in Box Elder High School reported attempting suicide within past 12 months and 38% reported attempting suicide in Box Elder Middle school;
- 37% of students in Rocky Boy High School reported attempting suicide within past 12 months and 34% reported attempting suicide in Rocky Boy Middle school;
- 32% of people that took the CHA survey reported that a friend/relative tried to commit suicide;
- 1 in 5 experienced symptoms of depression, 32% had friend or relative who attempted suicide;
- 39% experienced 4 or more traumatic events during their childhood; and
- 68% of participants had experienced trauma as an adult and 44% reported having unresolved grief.

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 dollars will assist with the Billings Areas 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 people into the mental health workforce.

In FY 2020, the Billings Area has not met the Government Performances and Results Act of 1993 (GPRA) measures for Depression Screening or Mood Disorder, 12-17 years old and 18 years and older, at 34.30% and 39.92% consecutively. Mental Health Services is authorized by the Indian Health Care Improvement Act, 25 U.S.C. § 1621h. The Mental 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 American Indian/Alaska Native (AI/AN) communities.

## **2. Alcohol and Substance Abuse**

Alcohol and Substance Abuse (ASAP) issues continue to plague our communities as a severe health care crisis and epidemic. Without the proper treatment and recovery support, Substance Use Disorders (SUDs) negatively affect the health and well-being of individuals, their families and communities throughout their lifespan and have a high societal toll on public and private systems. Our healthcare providers are working towards building an integrated behavioral health approach, embedding mental health and SUD efforts as mental health trauma can be seen as a catalyst for our people choosing alcohol and substance abuse as a means of coping.

Studies conclude that Alcohol is still the most abused drug among AI/AN communities followed by the use of methamphetamine (meth). In the state of Montana, we are seeing

increases in meth offenses, driving under the influence (DUI) of meth and meth trafficking offenses. Methamphetamine use is overwhelming our foster care system; the need for inpatient treatment and long-term outpatient and recovery services is needed. Methamphetamine use is burdening primary health and mental health care due to increase of addictions within families as it is normalized in homes and communities, increasing violent crime and property crime, and overcrowding our jails.

In June 2019, Montana released the statewide Community-Level Needs Assessment Report and determined that Montana is primarily a rural state with a total population of just over 1 million (Montana Department of Public Health and Human Services, 2019). One in seven Montanans live in Yellowstone County, which is located in the state's south central region (population 156,332). Billings, the state's largest urban center (population 109,550), is also located here. The Northern Cheyenne and Crow Nation reservations border Yellowstone County. Yellowstone County is a regional hub for healthcare services, with individuals from across Montana and Northern Wyoming traveling to Billings to access medical care, including SUD treatment. The AI/AN population has grown by 20% in the City of Billings from 2010-2017. Substance misuse and abuse are common in the Yellowstone County/Billings community with more than 4,000 individual's aged 12 years or older dependent on or abusing illicit drugs. Youth with trauma histories and access to illicit substances in their home and social networks, are initiating substance use early in adolescence and are at increased risk for developing SUDs. Methamphetamine users report that the drug is easy to obtain in Yellowstone County and that the potency and availability of the drug is driving addiction. Women using methamphetamine, particularly those of childbearing age, are over-represented in the drug treatment courts, Montana Department of Corrections treatment facilities, and in probation and parole.

Substance misuse and abuse exacts a substantial toll on individuals and families in Indian Country, as well as the health, human service and justice systems that serve these communities. Methamphetamine use, and its associated criminal and social impacts, have increased rapidly in recent years, demanding a community level response to stem the tide of this growing epidemic. Drug overdose is the 10th leading cause of death in Yellowstone County and the two hospital systems in the area recorded more than 15,000 visits for SUDs in 2018.

Nationally for AI/AN's overdose deaths are 2 times greater than the national average and there is a 519% increase in overdose deaths from 1999-2015. Within our AI/AN communities on the reservations in Billings Area, ASAP health services consist of outpatient levels of care that include intensive outpatient, aftercare, relapse prevention and referrals to inpatient treatment. The Blackfeet Tribe operates the Crystal Creek Treatment Lodge Center which is the only program of the (8) AI/AN treatment service providers in Montana offering Primary Residential Inpatient treatment with a total of 16 beds. The severity of our addicted population who need inpatient treatment have limited funding and resources to send people needing this level of care on all our reservations.

Data from the Rocky Boy Health Care (RBHC) Community Health Assessment (CHA) reports from participants surveyed that (Center for Health Equity, Education, & Research, 2019):

- 23% those prenatal screening reported on using opioids and 96% agreed that Drug

- use is a big problem;
- 29% of RBHC patients, age 9 to 75 years old, were screened for problem with alcohol use and in FY 2018, 34% were screened for same problem;
- Among youth (born 1994-2017) who received substance use evaluations at White Sky Hope Center (WSHC):
  - 46.4% reported alcohol use
  - 28.6% reported marijuana use
  - 8.9% reported opiate use.
  - 1.8% reported amphetamine use; and
  - 59.7% out of 504 WSHC client's intakes reported alcohol as their number 1 choice of substance abuse.

**DATA METRICS PROVIDED BY THE MONTANA SUBSTANCE USE DISORDERS TASKFORCE:**

**Montana Child and Family Services administrative data, 2018.**

- Children in foster care statewide increased 66% (2377 to 3951) from 2014 to 2018
- 44% of all open Child and Family Services placements have meth indicated
- In almost 65% of those cases, at least one primary caregiver abused meth
- Average age of child removed was 6 years old; and
- 42% of Yellowstone County children removed in 2018 were Native American.

**Montana Statistical Analysis Center, Department of Corrections Crime Control Bureau. 2018 Crime in Montana Summary.**

- 100% increase in meth violations from 2014-2018
- Statewide meth offenses up 313% from 2012-2016
- Meth DUI cases up from 73 to 301 from 2011-2016
- US Attorney's Office prosecutions of meth trafficking offenses up by 1/3 from 2017-2018, and are about 95% of Federal drug prosecutions
- 35% of all drug violations are for meth
- 44% of all drug violations are for marijuana
- 570 heroin/opioid arrests in 2018, up from 4 in 2005

**Montana Office of Public Instruction, Youth Risk Behavior Survey, 2019.**

- 21% of high school students report marijuana use in the last month

**Montana Department of Public Health and Human Services, Prevention Needs Assessment. 2018.**

- 53% of Montana youth perceive smoking marijuana once or twice a week as harmful to themselves (physically or in other ways)

**SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2016 and 2017.**

- An estimated 79,000 Montanans age 12+ have a substance use disorder
- 64,000 Montanans aged 18+ have a current alcohol use disorder
- 171,000 Montanans aged 12+ were estimated to have used marijuana in the last year
- 31,000 Montanans were estimated to use illicit drugs other than marijuana in the last month
- 6% of young adults aged 18-25 report using cocaine in the last year
- 92% of Montanans with a substance use disorder are not receiving treatment

**Montana Department of Public Health and Human Services (MT DPHHS) and Centers for Disease Control and Prevention (CDC). Behavioral Risk Factor Surveillance System Survey Data. Helena, MT: Montana Department of Public Health and Human Services, Public Health and Safety Division, 2018.**

- 18% of Montana adults report binge drinking in the last year

**National Highway Traffic Administration. (2019). 2018 fatal motor vehicle crashes: Overview.**

- 43% of all traffic fatalities in Montana are attributable to alcohol-impaired driving

**Montana Department of Public Health and Human Services Injury Prevention Program, Drug Poisoning Deaths in Montana, 2007-2018.**

- 35% of all overdose deaths are attributable to opioids
- The Montana opioid poisoning rate was 2.7 per 100,000 residents in 2017-2018

**Montana Department of Public Health and Human Services Injury Prevention Program, Opioid Prescribing Practices in Montana, 2012-2017.**

- Montana has 89 opioid prescriptions for every 100 residents

**Montana Office of Public Instruction, Youth Risk Behavior Survey, 2019.**

- Over one in ten high school students has taken a prescription drug without a doctor's prescription

**Montana Department of Public Health and Human Services, Montana Vital Statistics Analysis Unit, 2007-2018.**

- Between 2006-2018, more than 600 Montanans have died from opioid overdose

**Montana Department of Public Health and Human Services Injury Prevention Program, Opioid Prescribing Practices in Montana, 2012-2017.**

- 89 opioids (excluding buprenorphine) per 100 Montanans
- 49.7 Mean daily morphine milligram equivalents (MME)

**Montana Office of Public Instruction, Youth Risk Behavior Survey, 2019.**

- Youth lifetime pain prescription misuse: 12.8%
- Youth alcohol use, past 30 days: 33.4%
- Youth marijuana use, past 30 days: 21.1%
- Youth electronic vapor product use, past 30 days: 30.2%

**Montana Medicaid and Substance Abuse Management Information System (SAMS), 2019**

- 8,133 adult and youth client admissions annually to state-approved substance use treatment providers

**SAMHSA, Center for Behavioral Health Statistics and Quality, Buprenorphine Practitioner Locator, 2020.**

- 155 providers with an x-waiver for buprenorphine

**HRSA, Health Center Program, Montana Data, 2018.**

- 1,819 patients treated for SUD at HRSA health centers
- 48 buprenorphine-waivered providers at HRSA centers
- 187 patients receiving Medication-Assisted Treatment through HRSA health centers

**Montana Department of Public Health and Human Services STD/HIV Program, Get Tested Montana: 2019.**

- 8 safe syringe programs

**Montana Department of Public Health and Human Services Addictive and Mental Disorders Division, Internal Data, 2019**

- 1,283 naloxone units distributed annually

- 538 Naloxone master trainers

**Montana Supreme Court Office of Court Administrator, Montana Drug Courts: An Updated Snapshot of Success and Hope, 2019.**

- 37 treatment courts statewide; 8 are tribal

**Montana Department of Public Health and Human Services and Montana Department of Corrections, Internal Data, 2019**

- Montanans recently released from a Department of Corrections facility are 27 times more likely to die from an overdose than the average Montanan

For these reasons, the Billings Area Tribal Leaders request additional funds and resources to continue to build capacity and provide quality treatment services.

In FY 2020, the Billings Area did not meet the three GPRA ASAP screening measures: Tobacco-27.36% and Alcohol-37.19%. The third screening measure, Brief Intervention and Referral to Treatment (SBIRT) decreased to 5.14% in comparison to 28.33% for FY 2018. 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.

### **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.

Telehealth services are currently being offered at three service units in the Billings Area. Billings Area strives to expand telehealth services to provide telehealth specialty clinics at all service units (Crow, Blackfeet, Northern Cheyenne, Ft. Belknap, Fort Peck and Wind River).

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 statutes 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, see Appendix A. 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. Purchased/Referred Care (PRC)**

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.

## **5. Dental Services**

Dental is a top ten priority for the Billings Area because of ongoing access to Dental Care. We continue to recognize the various health care disparities associated with poor dental health. Despite the recent additional Purchase/Referred Care funding into the dental programs in the Billings Area, it will take time for Service Units to reach a preventive state to address the poor dental care for adults, children, and the elderly. Dental and Oral Health is underfunded each year as community user populations increase from the Urban tribal population needs for Direct Care Services. Most, if not all Billings Area Service Units do not meet the Dental Access Government Performance and Results Act of 1993 (GPRA) measure due to Covid-19 restrictions, insufficient number of dental providers, dental assistant and other support staff. Dental services are limited to the number and type of dental providers at each service unit. Emergency care dental cases take priority over preventative care and education when compared to the private sector dental model.

Preventative and restorative services can be a struggle due to funding shortages for staffing and/or updated dental equipment needs at each service unit in the Billings Area. Preventive care and education begins with the newborn age. Pediatric Dentists have little time to educate. Studies show that good preventative dental care in children has a lasting effect on good oral health and decreasing other medical health disparities as adults.

Budget increases will improve and help expand dental programs to become more preventative by early interventions in the schools and community outreach efforts. Additional funding will increase recruiting efforts, staff stability and retention, preventative education programs and services, which ultimately can improve future dental and medical health of all AI/AN patients we serve.

In FY 2020, the Billings Area did not meet the GPRA measures for Dental: General Access, Sealants, and Topical Fluoride at 26.59%, 16.47%, and 30.18% consecutively. Many of the community-based programs had to be cancelled due to the Covid-19 pandemic limiting all GPRA numbers. 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.

## **6. 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.

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.

## **7. Public Health Nursing (PHN)**

The Public Health Nursing program is a community health nursing program that focuses on the goals of promoting health and quality of life and preventing disease and disability. The PHN provides quality, culturally sensitive health promotion and disease prevention nursing care services to AI/AN communities. PHN's 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 provide communicable disease assessment, outreach, investigation, and surveillance to manage and prevent the spread of communicable diseases. PHN's contribute to the several of the IHS prevention efforts by providing communicable immunization clinics, public health education and engaging their AI/AN people in healthy lifestyles. PHN's conduct home visiting services for: maternal and pediatric populations, elder care services including 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.

In FY 2020, PHN activities are documented in several Billings Area for which GPRA screening measures have not been met: Tobacco-27.36%, Domestic Violence-38.94%, Depression-12-17 years old 34.30%, Depression Screening-18+ years 39.92%, and Alcohol- 37.19%. The GRPA measure has been met for Adult Influenza-27.49%. PHN is 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.

## **8. Urban Indian Health**

The urban health centers in Billings Area receive approximately \$3,735,021 dollars a year. The U.S. Census Bureau reports that in 2019, approximately 30,000 American Indian and Alaska Natives resided in the catchment areas of five urban centers. The Little Shell Tribe received federal recognition in December 2019, adding approximately 5,000 AI/AN

members to the Billings Area service population. A majority of Little Shell tribal members reside in Cascade County and North Central Montana with the Little Shell Tribal offices located in Great Falls, MT. Funding levels throughout Indian Health Service for the urban centers is not adequate for the needs the urban population presents. Our urban centers see a user population similar in size to what direct service or tribal facilities might see in the same year while operating on an average annual budget of \$607,000. The Billings Area I/T/U group is advocating and in support of a 5% increase for FY 2022, which is a national budget increase to \$136,405,000 as a collective recommendation.

<b>URBAN INDIAN ORGANIZATION</b>	<b>User Population by Tribal Affiliation</b>
<b>All Nations Urban (Missoula County)</b>	Blackfeet (292, 34%); CSKT (112, 13%); Fort Peck (78, 9%); Rocky Boy's (60, 7%); Fort Belknap (52, 6%); Northern Cheyenne (35, 4%); Crow (26, 3%); All Other Tribes (36, 4%); Non-Indian (146, 17%) Unknown/Refuse (25, 3%) = 862 active users, 691 Native users
<b>Billings Urban Indian Health &amp; Wellness Center (Yellowstone County) Total Panel: 1495</b>	Crow (637); N. Cheyenne (493); Fort Belknap (104); Rocky Boy (40); Sioux (28); Assiniboine (26); Fort Peck (26); Blackfeet (24); Hidatsa (20); Turtle Mountain (17); Other Tribes (80)
<b>Helena Indian Alliance (Lewis &amp; Clark County) Total Panel: 1031</b>	Blackfeet (22%); Chippewa-Cree (18%); Fort Belknap (15%); Salish & Kootenai (13%); N. Cheyenne (11%); Assiniboine/Sioux (12%); Little Shell (4%); Assiniboine (3%); Crow (3%);
<b>Indian Family Health Clinic (North Central Montana/Cascade County)</b>	Blackfeet (24%); Rocky Boy (17%); Little Shell (12%); Fort Belknap (9%); Fort Peck (6%); Turtle Mountain (5%); Salish & Kootenai (3%); Crow (3%) Northern Cheyenne (2%); Other Tribes (19%).
<b>North American Indian Alliance (Silver Bow County) Total Panel: 322</b>	Fort Peck 6%; Blackfeet, 12%; Rocky Boy 8%; CSK 7%; Crow 6%; Fort Belknap 5%; Northern Cheyenne 5%; Turtle Mountain 5%; Other Tribes 11%; Unspecified & Non-Tribal 25%; non-Indian/non-Recognized Tribe 10%

### **URBAN INDIAN ORGANIZATION ISSUE(S)**

The five Urban Indian Organizations share similar and different issues. Many challenges are associated with the current budget allocations as previously mentioned. Shared issues include the following topics:

- IHS budget allocation does not permit UIOs to use for facilities maintenance, needed service expansion, unexpected repairs, etc., which restrict and create new barriers to navigate. These gaps often lead to UIO's providing transportation to IHS Service Units or 638 Tribes (I/Ts) for healthcare in which UIO's absorb the travel expense yet the I/T facility obtains an encounter rate for the service.
- Distinctions between UIO's negotiated reimbursement (PPS) rates (average \$170 per encounter) and the IHS Service Units and 638 Tribes all-inclusive encounter rates

(average \$480 per encounter). The difference is estimated at 35.5% between reimbursement opportunities to build more adequate UIO health services in comparison.

- Federal Medical Assistance Percentages (FMAP) <sup>1</sup>: Urban Indian Health Programs continue to seek parity in relation to FMAP. Despite being Indian Health Care Providers stipulated in section IV of the Indian Health Care Improvement Act (IHCA), today, Urban Indian Health Program (UIHP) facilities are the only part of the Indian healthcare system that are not eligible for 100% FMAP payment.

Different issues include the following top priority topics:

**Billings Urban Indian Health and Wellness Center (BUIHWC), Billings:** BUIHWC provides primary medical, behavioral health (mental health & addictions counseling), integrated care, community outreach and health education, COVID-19 testing services, and linkage to care/supports. Top priorities include:

- **Information Technologies/Telecommunications:** BUIHWC continues to experience challenges and barriers associated with technologies, electronic health record access, updates, upgrades, and connectivity. This includes extensive gaps in set up of the Vista Imaging technologies, procurement of new servers, end user trainings, and efficiency. These challenges directly impact the overall opportunity to provide reliable care to patients, as well as secure third-party revenue generation. With the increased need to telehealth and telecommunication due to COVID-19, reliability is of critical importance.
- **Behavioral Health:** COVID-19 not only created physical health complications but also increased emotional/mental stressors, grief and loss, anxiety, fears, and relapse risks. In addition, provider fatigue and pressures to work through the most complex situations. These challenges directly impact individuals, families, our community and our providers indicating an increased need for behavioral health providers and provider support through Employee Assistance Programming.
- **Facilities:** BUIHWC has maxed out the current facility space which creates significant impacts on the operating budget. These impacts make it increasingly challenging to add services or expand accordingly. The result is gaps in service for our community members, especially given the increase in behavioral health and primary medical care needs as a result of COVID-19.

**Indian Family Health Clinic (IFHC), Great Falls.** IFHC is located in Great Falls and offers primary health care, mental health, chemical dependency, integrated care, community outreach and support services, as well as specialized COVID-19 support. It is a time of great change and unknown. As a result, IFHC's challenges are related to the core services and anticipated influence, growing and changing needs related to COVID-19. IFHC's top three priorities include:

- **Mental Health.** COVID-19 pandemic has brought many changes to American Indian people and changed lives, including uncertainty, altered routines, financial pressures, social isolation, and mental health challenges to name a few. Many Indian people and

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<sup>1</sup> Federal Medical Assistance Percentages (FMAP) are reimbursement rates set by the Federal Government for state and some tribal expenditures on certain programs including Medicaid—an income-based public health insurance program. FMAP rates are determined by formulas set in the Social Security Act (SSA) 1905(b) and updated periodically through statute or annual review. Since 1976, Congress has authorized 100% FMAP for American Indian and Alaska Native Medicaid encounters at Indian Health Service (IHS) and tribal facilities to supplement the chronic underfunding of trust and treaty health care obligations to American Indian and Alaska Native citizens.

families who have been impacted by COVID directly are worried about continued sickness and loss. Grief has impacted all of our communities, as well as stress, anxiety, fear, sadness, and loneliness which results often in mental health disorders and exacerbates existing conditions. We are seeing a greater number of suicide attempts.

- **Alcohol & Substance Abuse (Chemical Dependency):** A secondary effect of COVID-19 has yet to be fully realized and the increase in substance abuse in relation to the pandemic and the increased rates of addiction afterward or during COVID due to stress of isolation, boredom, decreased access to resource, unemployment, and many more contributing factors. Based upon IFHC's increased request for mental health, and chemical dependency support, we anticipate the increases will continue and grow for support in the area of alcohol and substance abuse.
- **Facilities & Maintenance:** COVID-19 has significantly impacted the need to respond to growing and changing needs of patient care and services. Consequently, a major issue and challenge for IFHC is the lack of funding and support for facility maintenance, improvement, repair and hazardous material remediation.

## **RECOMMENDATION**

The Urban Indian Organizations recognize the IHS Billings Area's shared issues as identified below.

- Exemption from Sequestration
- Advance Appropriations
- Preservation of Medicaid, IHCIA and other Indian-specific provisions
- CHR/CHAP Expansion
- FMAP Parity Funding and flexibility in UIO contracts for Facilities & Maintenance

The UIOs agree that the overall challenges create barriers to care within the growing Urban AI/AN community. Given these constraints, Urban Centers work diligently to navigate the challenges and provide the best possible care. However, it is apparent that a budget increase and inclusion of the UIOs top priorities would undoubtedly better support UIOs service needs.

Urban Indian Health is authorized in the Indian Health Care Improvement Act, 25 U.S.C. § 1651. Urban Indian 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.

## **9. Indian Health Care Improvement Fund (IHCIF)**

The IHCIF is a priority for the Billings Area to expand needed services and to allow for increased access. The need for expanded services is apparent, and any additional funding helps increase access and services. IHCIF funds will be utilized to ensure comprehensive, culturally appropriate personal and public health services are available and accessible to AI/AN people through recruitment and retention. Also, funds are used to build staff capacity which strengthens, and sustains collaborative relationships, increases access to quality health care services, and increases health care service access expansion. The IHCIF promotes excellence and quality through innovation of the entire IHS, Tribal and

Urban (I/T/U) into an optimally performing organization, creates quality improvement capability at all levels within the organization, and helps provide better care to the community. Improving access and services helps strengthen programs and management of the I/T/U.

The health resources available to an Tribes or Tribal Organizations includes health resources provided by the IHS as well as health resources used by the Indian tribe or tribal organization, including services and financing systems provided by any Federal programs, private insurance, and programs of State or local governments.

The IHCIF is authorized on the Indian Health Care Improvement Act, 25 U.S.C. § 1621. The IHCIF supports the IHS Strategic Plan FY 2019-2023, Goal 1 and Objective 1.3: Increase access to quality health care services.

## **10. Health Education**

The need for ongoing community health education is imperative to the wellbeing of AI/AN in the Billings Area. The Tribal Health education is the backbone of preventive health care. The program focuses on the importance of educating patients to make positive choices in their lifestyles and how they utilize health services. Numerous studies have shown correlations between low health literacy and poor health outcomes. The Tribal Health programs in the Billings Area currently offer Diabetes, Nutrition, Special Supplement Nutrition Program for Women, Infants, and Children (WIC), Diabetes prevention and a formal Health Education program. Due to restrictive funding annually, community outreach to improve health literacy is not at the desired level. School based health education can also get a message out to our youth to reinforce health education at the earliest levels. Informing younger generations about the consequences of unhealthy lifestyles will greatly affect their overall lifestyles. Increased funding could offer more opportunity to provide additional community outreach activities in order to improve health education within the Billings Area, ultimately improving health disparities that may exist.

Health Education is linked to several authorized programs on the Indian Health Care Improvement Act, 25 U.S.C. § 1621b, 1621c, 1621h, 1621n and 1665i. Health Education supports the 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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INDIAN HEALTH SERVICE  
FY 2023 California Area Budget Formulation Session

**Budget Narrative/Justification**

The California Area is submitting a Budget Recommendation at the \$48 Billion funding level. The California Area Office and California Area Tribal Leaders support funding the California Area's Top 14 Budget Funding Priorities: Purchased/ Referred Care, Behavioral Health , Obesity/Diabetes , Dental , Methamphetamines/Suicide/ Domestic Violence, Community Health Representative, Maintenance and Improvement, Urban, Health Information Technology, Joint Venture, Pharmacy, Indian Healthcare Improvement Fund, Small Ambulatory, and Sanitation Facilities Construction.

The California Area Office and California Area Tribal Leaders also support and recommend 105(l) leases be a separate appropriation and an additional budget line item going forward, similar to Contract Support Costs.

**BUDGET INCREASES**

1. Purchased/Referred Care +5.286B

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 2017, only 25 of the 38 health programs reported deferred and denied data.

2. Behavioral Health +4.933B

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 2017 Government Performance and Results Act (GPRA) Data. Over 2,500 youth and almost 10,000 AI/AN patients were not screened for depression at tribal programs in the California Area. Of patients that were diagnosed with depression, only 30% received a prescription for antidepressants with enough medication (with refills) to last 12 weeks, and only 10% received enough medication (with refills) to last 6 months. Additionally, over 4,000 women were not screened for domestic violence and over 13,000 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 +4.933B

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. Dental +3.876B

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.

5. Methamphetamines/Suicide/Domestic Violence +3.524B

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 8<sup>th</sup> leading cause of death among AI/AN of all ages. An estimated 45% of AI/AN women and 1 in 7 men experience intimate partner violence yet, according to our 2017 Government Performance and Results Act (GPRA) data, over 4,000 women at California tribal health programs were not screened for domestic violence. In 2017, 5 California health programs received IHS Domestic Violence Prevention Initiative funding and 14 received IHS Methamphetamine/Suicide Prevention Initiative 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.

6. Community Health Representative +2.114B

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. Maintenance and Improvement +2.114B

Maintenance and Improvement (M&I) funds are the primary source for maintenance, repair, and improvements for facilities which house IHS funded programs, whether provided directly or through P.L. 93-638 contracts/compacts. The M&I program funding is distributed through a formula allocation methodology. Annual M&I funding is usually less than the amount needed for Preventive, Routine and Non-Routine Maintenance. The backlog of deferred maintenance is about \$570 million, which if unaddressed could cost significantly more if systems fail. Maintenance costs increase as facilities and systems age. Available funding levels are impacted by:

- 1: Age and condition of equipment may necessitate more repairs and/or replacement;
- 2: Lessened availability of service/repair parts for aging equipment and limited vendor pool in remote locations;
- 3: Supportable space has increased 3.5 percent per year;
- 4: Increased costs due to remote locations;
- 5: Costs associated with correcting accreditation-related deficiencies;
- 6: Increasing regulatory and/or executive order requirements; and Environmental conditions impacting equipment efficiency and life.
- 7: An increase in M&I funding would ensure functional health care facilities that meet building/life safety codes, conform to laws and regulations and satisfy accreditation standards.

#### 8. Urban +1.762B

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/rancherias. 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.

#### 9. Health Information Technology +1.762B

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.

#### 10. Joint Venture +1.409B

The Joint Venture Construction Program (JVCP) authorizes IHS to enter into agreements with Tribes that construct their own health care facilities. The Tribe provides the resources, whether from their own funds, through financing, grants, contributions, or a combination thereof, for the construction of their health facility. IHS health care facility construction appropriations are not used for construction of facilities in the JVCP but may be used to equip the health care facility. Tribes apply for the JVCP during a competitive process and the approved projects are entered into agreements with IHS. Based on the date of projected completion of construction by the respective Tribe, the IHS agrees to request a funding increase from Congress for additional staffing and operations consistent with a fully executed beneficial occupancy of the health care facility.

#### 11. Pharmacy +1.057B

The net prices for drugs are increasing four-times faster than the rate of inflation (approximately 133% from 2007 to 2018). 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 as 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.

12. Indian Healthcare Improvement Fund +1.057B

California Tribal Leaders strongly encourages and supports additional funding to eliminate inequities, deficiencies and backlogs in the provision of healthcare services to all AI/AN

13. Small Ambulatory +1.057B

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.

14. Sanitation Facilities Construction +.3B

The California Area recommends that IHS continue increasing funds for the Sanitation Facilities Construction (SFC) Program to support a wide range of community-based public health activities focused on improved water supply and sanitation facilities, increasing tribal capacity to operate and maintain O&M) the facilities, in addition to supporting tribes during emergency responses. According to the SFC STARS database, the California Area has an unmet need of over \$63 million for 1,221 homes with water-related and 1,649 with sewer-related Deficiency Level 3 and higher needs. The SFC Program provides on-site trainings and has developed innovative approaches such as Tribes-Helping-Tribes to increase tribal O&M capacity. The California Area tribes have and will likely continue to experience impacts from drought, wildfires, winter storms and most recently utility power shutoffs. The SFC Program partners with federal and state agencies and technical assistance providers to coordinate resources and provide technical and financial assistance to tribes during the emergency responses

**INDIAN HEALTH SERVICE**

**GREAT PLAINS AREA**

**FY 2023 BUDGET  
FORMULATION**

**DECEMBER 3, 2020**



## IHS GREAT PLAINS AREA FY 2023 BUDGET FORMULATION CONSULTATION

### Executive Summary

Tribal leaders representing the Tribes/tribal organizations, and Urban Clinics of the Great Plains Area met virtually on December 3, 2020, to develop the Indian Health Service Great Plains Area FY 2023 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 are as follows: FY 2023 IHS Great Plains Area National Budget Recommendations at full funding of program increase and restoration of funds taken for Leases (1051). (Dollars in thousands)

1.	Mental Health	\$6,130,717
2.	Alcohol & Substance Abuse	\$5,797,035
3.	Hospitals & Clinics	\$5,678,893
4.	Health Care Facilities Construction	\$3,207,076
5.	Medical Equipment	\$3,207,076
6.	Dental Services	\$2,275,778
7.	Purchase/Referred Care	\$1,973,217
8.	Community Health Representatives	\$1,971,755
9.	Health Education	\$1,653,240
10.	Public Health Nursing	\$1,337,650
11.	Maintenance & Improvement	\$1,097,951
12.	Urban Health	\$ 606,694
13.	Sanitation Facilities Construction	\$ 534,512
14.	Indian Health Care Improvement Fund	\$ 106,902

# GREAT PLAINS BUDGET JUSTIFICATION NARRATIVE

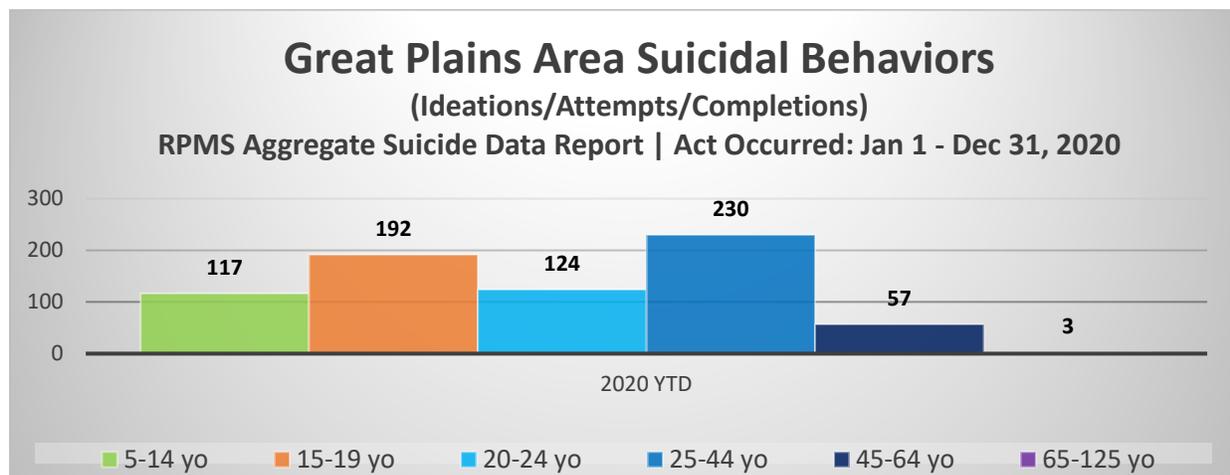
## 1. MENTAL HEALTH

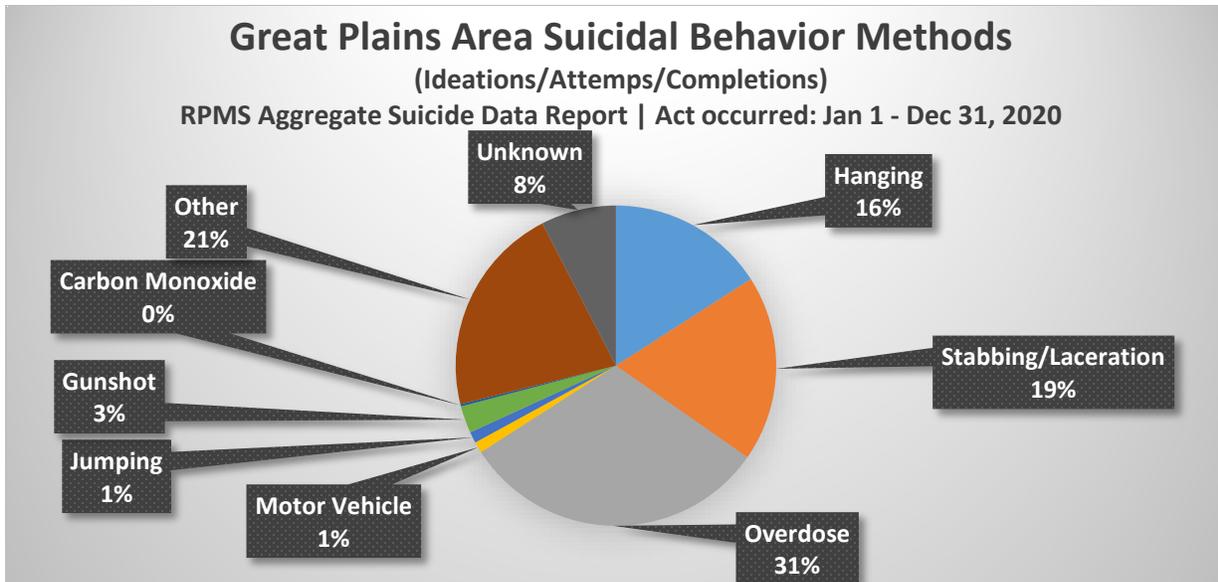
Native Americans with serious mental illness experience high rates of morbidity and mortality. This adversely affects our tribal members' quality of life and contributes to premature death. Particularly concerning is the rising rate of suicides and suicide attempts in this area. The Great Plains Area (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. 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.

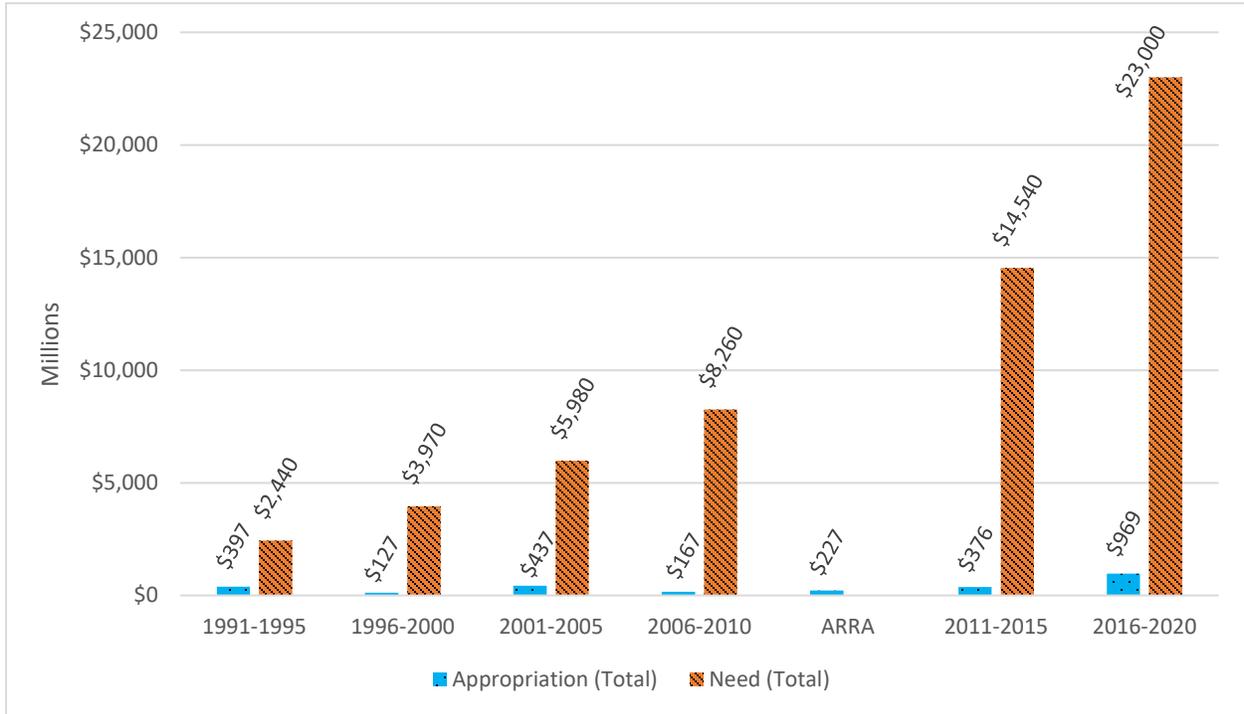
#### 4. HEALTH CARE FACILITIES CONSTRUCTION

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.

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



**5. MEDICAL EQUIPMENT**

Medical equipment reliability declines as equipment ages. Medical and laboratory equipment, which has an average useful life of approximately six years, are used over twice as long in IHS facilities. The FY 2020 medical equipment appropriations were \$28.1 million. Potential consequences, such as service disruptions and facility downtime, are compounded in isolated rural settings where many older IHS facilities are located.

The IHS and tribes manage approximately 90,000 biomedical devices valued at approximately \$500 million requiring routine maintenance, repair, and replacement on an average six-year schedule. These are a diverse array of devices consisting of laboratory, medical imaging, patient monitoring, pharmacy, and other biomedical, diagnostic, and patient equipment. Reliable equipment is especially important in the isolated settings where most IHS care is delivered.

Medical device management has become complex as a result of increased sophistication and specialization of equipment, integration with electronic health records, expansion of services into telemedicine, and increasing requirements for compliance, safety, reliability, and accuracy. Many health care services require special medical equipment to meet their mission. Renewal is necessary to replace outdated, inefficient, and unsupported equipment with newer electronic health record-compatible equipment to enhance speed and accuracy of diagnosis and treatment.

The \$28.1 million FY 2020 equipment appropriation includes:

- \$5 million to support the initial purchase of equipment for tribally-constructed health care facilities
- \$500,000 to acquire excess medical equipment from Department of Defense or other sources through Project TRANSAM, a Civilian-Military Cooperative Action Program concerning distribution of medical equipment and supplies obtained from the closure of military bases as well as other sources such as the GSA Excess program
- The remaining amount funds medical equipment in support of existing IHS and tribal programs

A fully funded, sustainable IHS equipment program is estimated to cost \$125 million annually. The FY 2020 medical equipment appropriation was \$28.1 million. The current total medical equipment need is \$454 million. The Great Plains Area Indian Health Service equipment need along is \$30 million annually.

## 6. DENTAL SERVICES

Great Plains Indian Health Service currently has 21 dental programs with six program locations within hospitals. There are federally- and tribally-run facilities. Basic services include preventive, emergency, restorative, oral surgery, and pediatric dentistry is emphasized, although a limited amount of endodontics, periodontics, and prosthetics is available. Great Plains Area oral health is complicated by the multiple comorbidities and a high rate of early childhood caries.

American Indian children are disproportionately affected by oral disease compared with the general population. Overall, American Indian children have significantly higher rates of dental caries and periodontal disease in all age groups.

According to the Federal Office of Minority Children (OMH), American Indian children aged 2 to 4 years have five times the rate of dental decay compared to all children, and 6- to 8-year old American Indian and Alaska Native children have nearly twice the rate of dental caries experience. Untreated rates for decay in these age groups are two to three times higher than in the same age groups within the general population. American Indian adults have two and half times higher rate of periodontal disease than the national population.

Factors such as poverty, geography, underserved areas, lack of oral health education, language and cultural barriers, fear of dental care and the belief that people who are not in pain do not need dental care, significantly impact these rates. In fact, within the Great Plains Area, American Indian preschool children have the highest rate of tooth decay than any population in the country. On the Oglala Sioux Indian reservation, the W.K. Kellogg Foundation found 40 percent of children and 60 percent of adults suffer from moderate to urgent dental needs, including infections and other problems that could become life-threatening. The Great Plains Area has long been challenged to meet the very high level need for health care services, including oral healthcare for younger children. The need for restorative services has far exceeded the capacity of the dental programs.

Many communities do not have on-site services for children with advanced caries, and thus there is a constant stream of transports of children to larger communities for specialty care, where many children require restorations and extractions under general anesthesia. Precise data are not available, but with about 25% of children requiring general anesthesia, this rate is at least 50 times (i.e., 5000%) higher than the US, other races rate.

## 7. 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.

## 8. COMMUNITY HEALTH REPRESENTATIVES

Within the reservation boundaries, many tribal members need assistance to navigate the IHS healthcare system and overcome the many barriers to accessing health care in a rural community. Community Health Workers (CHW) are trusted members of the community and help individuals' access health care services. Services typically provided by CHWs include health promotion and health education, arranging for transportation, disease-specific education, specific direct services care, assisting individuals to navigate the health care system, and connecting individuals to other community service supports.

CHWs integrate basic medical knowledge about health promotion and disease prevention with local community knowledge. They often play a key role in follow-up care and patient education in Native languages and assist health educators with preventive initiatives. CHWs are an integral part of the Indian community and an integral member of the health care team.

## 9. HEALTH EDUCATION

Health education focuses on keeping people and their communities healthy. Defined by the World Health Organization, health education is: “Health education is any combination of learning experiences designed to help individuals and communities improve their health, by increasing the knowledge or influencing their attitudes.”

In the Great Plains Area collaboration with Tribes to increase Colorectal Cancer screening rates was implemented. It was evidenced by the Turtle Mountain Band of Chippewa Indians Health Education and Turtle Mountain Service Unit-Quentin Burdick Health Care facility PHN program were recipients of the North Dakota Colorectal Cancer Screening Award. Collaborative efforts led to a 10 percent increase in colorectal screening and an 80 percent Tribal member screening rate.

In an area where mortality is most often due to heart disease and cancers, through accidents, diabetes, and chronic liver disease is also among the leader causes of death among American Indians, the Health Education become an integral piece of health care to the tribal members of the Great Plains area. Health Education will teach, inspire, and support families to adopt healthier lifestyles.

## 10. PUBLIC HEALTH NURSING

The Great Plains Area Public Health Nursing (PHN) is a community health nursing program that focuses on the goals of promoting health and quality of life, and preventing disease and disability. The PHN program provides quality, culturally sensitive health promotion and disease prevention nursing care services through primary, secondary, and tertiary prevention services to individuals, families, and community.

The benefit of having funding for PHN, in 2016, the Pine Ridge PHN Mental Health Case Management Program was established to focus on suicide prevention in the local community. The intervention was to improve health outcomes of high risk patients through a community case management model that utilized the PHN as a case manager.

The PHN program continues to review the delivery of service for safe and quality standards of various accrediting bodies. This activity includes coordinating with the Joint Commission to define the PHN services as an integrated IHS service for review and continued efforts to host webinars to share practices on safe and quality care.

## 11. 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.

## 12. URBAN HEALTH

The Great Plains Urban Health has 2 urban clinics in the Area—South Dakota Urban located in Sioux Falls, South Dakota and Nebraska Urban in Omaha, Nebraska. The clinics provide health care services to the urban Indians who do not have access to the resources offered through IHS or tribally operated health care facilities because they do not live on or near a reservation.

The base funding for Urban Health in the Great Plains Area provides improving Urban Indian access to health care centers to improve health outcomes, implementing and utilizing advanced health information technology, expanding access to quality, culturally competent care for Urban Indians through collaboration with other federal agencies.

In order to continue to provide integrated care or even maintain current services, a significant increase to the Urban Health funding will allow program stability and an opportunity to look at program growth.

## 13. 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.

#### 14. INDIAN HEALTH CARE IMPROVEMENT FUND

The American Indian and Alaska Natives has long experienced a disproportionately high level of health problems compared to other Americans. The Great Plains Area would like to see additional funding put toward the Indian Health Care Improvement Fund so based on the pricing model additional Tribes would be eligible for this fund. Currently, the Great Plains Area only has one Tribe that receives these funds based on the model developed by a workgroup of tribal and Indian Health leaders.

#### **Indian Health Service and Tribal Health Care Facilities' Needs Summary**

	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

**INDIAN HEALTH SERVICE**  
**FY 2023 Nashville Area Budget Formulation Session**  
**Narrative of Budget Priorities**

The Nashville Area offers the following budget recommendations for FY 2023:

**Fully fund the Indian Health Service at \$48 billion, +276.20% over the FY 2022 proposed budget levels, a recommended increase of \$35.2 billion.**

- **80% of funding increase will be spread across all budget lines, with 20% of funding increase, at \$7 billion, for the specific following Clinical Services programs as Nashville Area priorities:**
  - Hospitals and Clinics \$1,413.2 billion
  - Purchase Referred Care \$1,144.8 billion
  - Alcohol/Substance Abuse \$983.8 million
  - Mental Health \$948.1 million
  - Electronic Health Record System (New) \$751.3 million
  - Dental Health \$518.7 million
  - Community Health Reps \$375.6 million
  - Maintenance & Improvement \$375.6 million
  - Health Education \$304.1 million
  - Self-Governance \$232.5 million

## **TOP 10 BUDGET INCREASES**

### **1. Hospitals & Clinics +\$1,413.2B**

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

### **2. Purchased/Referred Care (PRC) +\$1,144.8B**

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.

### **3. Alcohol/Substance Abuse Program (ASAP) +\$983.8M**

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.

### **4. Mental Health +\$948.1M**

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, but with early intervention and proper support and treatment, outcomes can be improved. Lack of access to timely, high-quality treatment is the greatest barrier to healthy Native American individuals and communities. Hundreds of 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.

#### **5. Electronic Health Record System (New) +\$751.3M**

RPMS has been utilized by IHS for 34 years and through partnership and cost sharing with the U.S. Department of Veteran's Affairs (VA) IHS has been able to develop and design specific applications to meet the unique needs of the Indian healthcare delivery system. On June 5 2017, when the VA announced its plans to modernize their EHR and move from the current Veterans Information System and Technical Architecture (VistA) to a commercial off the shelf (COTS) system. This announcement forced IHS to evaluate the future of RPMS EHR to determine if the agency can maintain costs without the support of the VA or if the IHS too should consider a new option.

Over the years, IHS has been able to limit the costs associated with upgrades to the RPMS EHR by building upon the upgrades and advancements that the VA had made to VistA, which is similar in infrastructure to the RPMS. It has been cost-effective to maintain RPMS with the VA's partnership, especially when faced with limited increases to the health information technology budget line in IHS's annual appropriation.

Due to the growing needs of health information technology within the Indian healthcare system, IHS has faced a need for increases in operational and maintenance costs, however funding has remained stagnant. Before moving forward, IHS should strongly consider the costs of implementing a new EHR system that would replace RPMS. The Indian health care system suffers from chronic underfunding and shortages in resources. Nashville Area Tribal Nations have deep concerns on not only the costs to IHS associated with transitioning to a new EHR system but the subsequent costs for maintenance system updates as well. Since 2015, funding for the IHS Health Information Technology (HIT) Program that administers RPMS has remained stagnant at \$182,149,000. We have concerns that if a new system is implemented, IHS and Tribally operated facilities may not have enough funding for these updates and the burden of the costs may cause shifting of funding from other vital IHS services. Given the current underfunding of the IHS system, any changes to the Indian health system requiring additional resources without increased funding would be inconsistent with the federal government's trust responsibility to provide for the health of Indian people.

#### **6. Dental Health +\$518.7M**

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.

## **7. Community Health Reps \$375.6M**

Community health workers (CHWs) in Tribal communities, referred to as community health representatives (CHRs), are considered the oldest CHW workforce program. Congress established the program in 1968. The CHR program in AI/AN communities was designed specifically to meet the need for greater involvement of AI/ANs in their own health programs, and greater participation by Native Americans in identifying and solving health problems. CHRs are particularly suited to working in Tribal communities due to their shared history and culture with those they serve, an understanding of the challenges faced by community members, and deep connections with the community.

Funding for CHRs has been posed to elimination from previous administrations but congress has maintained the program with limited to no increase in funding. Tribal Nations rely on CHRs to provide community connection to existing health services. Continued funding to support the CHR program would increase community health outcomes, build trust and connection amongst the community and the Indian health care delivery system.

### **7. (tie) Maintenance and Improvement (M&I) 375.6M**

M&I funds are the primary source for maintenance, repair, and improvements for facilities which house IHS funded programs, whether provided directly or through P.L. 93-638 contracts/compacts. M&I Funding is also used for maintaining compliance with accreditation standards of the Joint Commission or other accreditation bodies.

There has been an increase in M&I funding for the past two fiscal years, but this has only begun to address the long running deficit causing a large Backlog of Essential Maintenance and Repair. In addition, due to low Health Care Facilities Construction funding, existing infrastructure continues to age. The average age of IHS healthcare facilities is ~40 years. Additional improvement funding is essential to ensure functional health care facilities that meet building/life safety codes, conform to laws and regulations and satisfy accreditation standards.

Additional M&I funding would allow IHS to increase the quality of care provided to Native Americans and Alaska Natives.

### **9. Health Education \$304.1M**

Health educators are a necessary part of a culturally appropriate approach to addressing health concerns by teaching people about behaviors that promote wellness in American Indian and Alaska Native communities. 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. The Health Education program supports the provision of community, school and worksite health promotion, patient and professional education, and the development of educational materials for staff, patients, families and communities.

### **10. Self-Governance \$232.5M**

The Indian Health Service Tribal Self-Governance Program (TSGP) is more than an IHS program; it is an expression of the nation-to-nation relationship between the United States and each Indian Tribe. Through the TSGP, Tribes have the option to assume IHS program funds and manage them to best fit the needs of their Tribal communities. The Nashville Area currently has nine Tribal Nations who operate programs through the TSGP.

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 Indian Health Care Improvement Act (IHCA) authorities; providing resources and technical assistance to Tribes and Tribal Organizations for the implementation of Tribal Self-Governance; administering grants by funding Planning and Negotiation Cooperative Agreements for Tribes entering Self-Governance or seeking to expand the programs, services, functions, or activities under and Indian Self Determination and Education Assistance Act (ISDEAA) Title V Compact and funding agreements; and supporting activities of the IHS

Director's Tribal Self-Governance Advisory Committee which advises the IHS Director on Self-Governance policy decisions. Increases to this program would support and expand Self-Governance training, technical support, and planning and negotiation cooperative agreements in FY2023.

## **Standing Area Priority Recommendations**

### **Health Care Facilities Construction**

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.

While the Nashville Area has supported increased funding for Health Care Facilities Construction in the past, 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.

### **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; to identify hazards and risks to Area Tribal members through the development and implementation of comprehensive environmental health programs; to assess environmental conditions; and to provide technical assistance as needed.

In recent years the Nashville Area has grown to include six 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.

In the last two years, there has been a significant increase in M&I funding 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.

### **Funding Obligation for 105(l) Leases**

ISDEAA authorizes the IHS to enter into a lease with Tribal Nations for a facility used to administer and deliver PFSAs. Historically, the appropriations for facilities has been underfunded, so these lease agreements allow Tribal Nations to collect additional funds to maintain their facilities and frees up other resources that could be utilized to deliver health care services. To the disadvantage of the IHS, IHS doesn't receive separate appropriation for 105(l) lease agreement, though, if entered into, IHS has a binding obligation to pay these agreements, in accordance with regulatory criteria.

As more Tribal Nations enter into 105(l) agreements, the burden of payment could increase exponentially over time and be detrimental to the IHS Budget. Nashville Area Tribal Nations believe that funding for 105(l) lease agreements should be funded similar to Contract Support Costs, as a separate appropriation account with an indefinite amount- "such sums as may be necessary." Funding similarly to CSC would alleviate the burden that IHS and Tribal Nations experienced in FY 2017 and 2018, where IHS had to make a decision to pay for the lease agreements with program funding from unallocated inflation increases, which ultimately denied Tribal Nations in need of program increase to keep pace with the costs of living and health care.

### **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 and all of the IHS behavioral health initiatives.

### **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.

INDIAN HEALTH SERVICE  
Navajo Area FY 2023 Budget Formulation Session  
Budget Recommendation Narrative  
Mental Health

1. Discuss how the recommended budget increases should be allocated, i.e., including any effects of the previous year's increases and include data that highlights those effects.

The Navajo Area recommends a funding increase to the Mental Health budget category. The implementation of Primary Care Behavioral Health (PCBH) increased the need for additional Behavioral Health providers for primary care and outpatient mental health departments. Evidence-based (EBP) mental health treatment availability is limited due to the challenges of recruiting qualified providers. Limited housing infrastructure and competitive salaries are additional barriers to recruitment strategies. The utilization of EBP screening tools and outcome measures for mental health conditions are minimal due to the lack of cultural sensitivity, which leads to ambivalence and distrust.

Inpatient mental health treatment facilities on the Navajo reservation are null. Therefore, patients are transferred off the reservation to access acute psychiatric care. Transitional or step-down mental health services are much needed to support independent living for the chronically mentally ill. There are limited specialized services available to address Postpartum depression, which is significantly higher among Indigenous populations. The high rates of suicidality among young adults and adolescent populations are critical areas that require advanced technical knowledge and skills in mental health interventions. Suicide surveillance of high-risk patients is challenging due to inconsistent methodology in suicide reporting across Navajo communities. The need for trauma-informed care to address the ongoing traumas related to early childhood exposure to family violence, sexual abuse, and substance use disorders is limited. The continuous breaks in mental health care lead to poor patient health outcomes for chronic medical conditions. Consistent, intensive treatment management services are needed to engage patients in mental health care 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 implementation of the Primary Care Behavioral Health (PCBH) model to support mental health access and care and achieving two GPRA measures for mental health screening.

2. The linkage to IHCIA provision, where applicable.  
25 USC § 1621 (h)-Mental Health Prevention and Treatment Services
3. The linkage to GPRA performance targets and outcomes.

There are two GPRA measures relevant to the mental health line item: 1). Depression screening and other mood disorders for ages 12-17 years old. In FY 2019, Navajo Area exceeded the depression screening target of 27.60% for this age group at 41.85%. The national performance was at 37.25%. 2). Depression screening and other mood disorders for ages 18 years and older. The target for this age group was 42.2%. Navajo Area performance was at 48.76%, with the national performance level was 42.56%.

4. The linkage to the IHS Strategic Plan.

Increased funding has allowed the Navajo Area to meet its GPRA performance targets for mental health screening for ages 12 and greater and this effort supports the IHS Strategic Plan Goals and mission. Significant innovative efforts have been made to integrate mental health screening and intervention with medical primary care, a collaborative model that supports population-based care and holistic approach to care. The Primary Care Behavioral Health model has increased patient access to mental health care for screening, counseling and intervention therapies/treatments. The collaborative model supports the Navajo philosophy of healing and well-being where the whole person is treated within a network of relationships.

INDIAN HEALTH SERVICE  
Navajo Area FY 2023 Budget Formulation Session  
Budget Recommendation Narrative  
Alcohol and Substance Abuse

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 Area recommends a funding increase to the Substance Abuse budget category. Alcohol use disorder is a critical public health concern on the Navajo reservation. According to the 2018 National Survey on Drugs Use and Health (NSDUH), 10% of American Indians (AI) have a substance use disorder, 4% report illicit drug use, 25% report binge drinking in the past 30 days. The alcohol and drug use statistics for AI is higher than other ethnic groups in the US. AI have the highest methamphetamine abuse rates, including past-month use at more than three times the rate of any other ethnic group. Opioid abuse intervention is a needed service on the Navajo reservation. The limited substance abuse education, outpatient and inpatient residential services is a significant barrier for access to services. The emergency department's challenge is the recurrent patient visits related to chronic substance abuse such as methamphetamine, opioids, and alcohol intoxication. 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. No evidence-based practice interventions are available for patients with methamphetamine and opioid use disorder. With the implementation of Primary Care Behavioral Health, there is an increased need for additional substance abuse providers and behavioral health technicians for primary care clinics across Navajo Area health care facilities. Recruitment for qualified substance abuse providers is a barrier to providing quality performance-based care. Recruitment faces challenges of competitive salaries and housing infrastructure limitations. 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.

Prior Year funding has allowed the Navajo Area to meet two 2019 GPRA performance targets for screening for alcohol and screening for intervention referrals for treatment.

2. The linkage to IHCIA provision, where applicable.

25 USC § 1655 (a) Behavioral health prevention and treatment services.

3. The linkage to GPRA performance targets and outcomes.

There are two GPRA measures relevant to the substance abuse line item: 1). Alcohol screening and other substance use disorders, for ages 9-95 years old. 2). Screening Brief

Intervention Referral for Treatment (SBIRT) for all ages. In 2019, the Navajo Area has met both performance targets: Universal Alcohol Screening: Target: 37.00%; Navajo Area: 49.69% and SBIRT: Target: 8.90%; Navajo Area: 16.73%.

4. The linkage to the IHS Strategic Plan.

Increased funding has allowed the Navajo Area to meet its GPRA performance targets for alcohol screening and intervention for treatment referrals, both measures support the IHS Strategic Plan Goals and mission. Significant innovative efforts have been made to integrate behavioral health screening and intervention with medical primary care, a collaborative model that supports population-based care and holistic approach to care. The Primary Care Behavioral Health model has increased patient access to behavioral health care for screening, counseling and intervention therapies/treatments. The collaborative model supports the Navajo philosophy of healing and well-being where the whole person is treated within a network of relationships.

INDIAN HEALTH SERVICE  
Navajo Area FY 2023 Budget Formulation Session  
Budget Recommendation Narrative  
Navajo Office of Environmental Health & Protection Program

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 Environmental Health & Protection Program (NOEHPP) ensures health and safety, protection and inspection and training for food handlers, retail food stores, cafes, restaurants, temporary food operations, food storage warehouses, bakeries, meat markets and public facilities, and regulates on the Navajo Nation to protect the health and safety of the Navajo People and communities.

The NOEHPP recommends an increase to the Navajo Office of Environmental Health & Protection Program budget line item. The current amount of funding is inadequate to fully provide monitoring, surveillance and regulation of all retail food stores, cafes, restaurants, itinerant food service operations, burrito sellers, flea market, food stands, fairs, celebrations, food storages warehouses, bakeries and meat markets, and provide consistent food handlers training courses. This past year, there were 7,828 food handler training cards issued to individuals. Increased funding will add much needed compliance officers for regulatory enforcement and fund increasing fixed and non-fixed costs for salaries and fringe benefits, supplies, training, travel, communication, utilities, and equipment. The NOEHPP Sanitarians collaborate and assist IHS Sanitarians (who periodically provide technical assistance) with, Institutional food Service inspections, Food handler's trainings, Institutional Health and Safety inspections such as: Head Starts, Child Care Centers, stand-alone Senior Centers, Detention Centers, Rehabilitation Centers, Schools, Cafeterias, Foster Homes, and BIE Schools. The NOEHPP enforces non-compliant facilities for the IHS-OEHE Program in complaints, follow-up and closure recommendations. Assistance is also given for communicable disease and vector surveillance, rabies vaccinations for dogs and cats, animal bites, enteric disease outbreak, Hantavirus outbreak, and public and health education outreach. The additional funds will support reviewing, updating, and drafting the "May 2, 1986 Navajo Nation Food Service Sanitation Code and Regulations", along with the "Navajo Retail Food Service Store and Regulations. The demand for NOEHPP services outweighs resources available to regulate, inspect, monitor and surveillance.

2. The linkage to IHCIA provision, where applicable.

The justification for the proposed budget increase outlined in this request is aligned with the authority of IHCIA, Title 25, Section §1621b, Health promotion and disease prevention

services. The NOEHPP works on implementation of environmental health services to reduce the transmission of communicable diseases related to food-borne illnesses.

3. The linkage to GPRA performance targets and outcomes.

The prevention and mitigation efforts of the NOEHPP support the IHS GPRA performance measures, resulting in the Navajo Area meeting its performance target for the service population.

4. The linkage to the IHS Strategic Plan.

The NOEHPP ensures quality protection of environment, health and safety of communities, workplaces, food services and drinking water, and prevention of potential lethal exposures, including outbreaks of communicable diseases that may cause harm to individuals. This mission is aligned with the IHS Strategic Plan and Goals.

INDIAN HEALTH SERVICE  
 Navajo Area FY 2023 Budget Formulation Session  
 Budget Recommendation Narrative  
 Health Facilities Construction

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 Area’s FY 2023 budget request for an additional \$7,406,164.00 million is to support Health Facilities Construction. Nationally, the Indian Health Service (IHS) has 10 new Inpatient and Outpatient and Small Ambulatory facilities, Staff Quarters Program, and Joint Venture Construction Program planned for construction, with only four facilities currently 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’s next major project, the Gallup Indian Medical Center, Gallup, New Mexico.

Further, Congress is urged to consider appropriation of funding in the estimated amount of \$620.5 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 and increase access to care. 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 four Navajo projects were approved by the IHS and are listed as follows with estimated funding needs:

PROJECT	ESTIMATED COSTS	ADDED COSTS
Pueblo Pintado Health Center	\$122,400,000	
Bodawav-Gap Health Center	\$ 151,200,000	
Gallup Indian Medical Center	\$ 552,000,000	\$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 \$822,600,000 million. The existing facilities are obsolete with

an average age of 49 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.

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 NAIHS 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 NAIHS makes every attempt to keep pace with changed and modernized technologies; however, due to limited equipment funds, the NAIHS 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. 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 Indian Health Care Improvement Act (IHICA) (25 U.S.C., SUBCHAPTER III---HEALTH FACILITIES) to improve quality and access to care by making available modern health facility square footage, facility infrastructure, and modern medical and information technologies. 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 the Navajo people in an efficient and equitable manner.

3. Linkage 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. The linkage to the IHS Strategic Plan.

The mission of the IHS is to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level. Our vision is healthy communities and quality health care systems through strong partnerships and culturally responsive practices. The Strategic Plan details how the IHS will achieve its mission through three strategic goals:

- (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.

INDIAN HEALTH SERVICE  
Navajo Area FY 2023 Budget Formulation Session  
Budget Recommendation Narrative  
Hospitals and Health Clinics

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 Area continues to recommend a funding increase to the Hospitals and Health Clinics (H&C) budget category 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 AI/ANs 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 P.L 93-638 Indian self-determination contracts and tribal self-governance compacts. Increased H&C appropriations support the Health Information Technology system and infrastructure, Navajo Epidemiology Center, and other community and public health initiatives of the Navajo Nation through self-determination contracts and self-governance compacts. Healthcare providers and workers are essential resources. The health system is challenged by increasing salaries/benefits expenses, coupled with rising costs for pharmaceuticals, medical supplies and biomedical and information technology (IT) equipment, including network communication systems, which continue to outpace existing resources.

The priority of the Navajo Area is to strengthen public health programs and update the 10 year plan to address uranium exposure and toxicity amongst the population served. This includes screening for uranium exposure at all healthcare facilities, increasing community awareness and education and community cancer screening, implementing childhood development surveillance with longitudinal studies, establishing a standardized and concurrent cancer registry, and heightening staff education. With the advent of the Covid-19 pandemic, strengthening the public health system, supported by a robust epidemiology program, is essential for prevention, mitigation, monitoring and surveillance.

Past budget increases have permitted mobile medical and pediatric dental programs, oncology and infusion services, Level II Perinatal care accreditation, and a Four-star quality rating award (Centers for Medicaid & Medicare Services (CMS)) to a self-determination contracted hospital. Funds allowed continued Baby Friendly certifications and Joint Commission and CMS accreditations for hospitals, ambulatory facilities and laboratory programs, and Primary Care Medical Home Model designations. State certifications for Levels III and IV trauma center designations for three hospitals were also supported. Funding supported immediate medical and public health responses to the Covid-19 pandemic in the Navajo Area. Numerous hospitals and ambulatory facilities repurposed their existing space to meet surges in Covid-19 cases and helped slow the spread of COVID and minimize infection to employees and patients. Funds were used for Covid treatments and implementation of a post-Covid patient management program for those patients with lingering symptoms who need continued medical, behavioral health, and rehabilitation services.

2. The linkage to the Indian Health Care Improvement Act (IHCIA) provisions, where applicable. 25 U.S.C. § 1601. Chapter 18-Indian Health Care.
  - 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. Linkage to GPRA performance targets and outcomes.

H&C funds allow the Navajo Area to meet and improve its annual GPRA performance measures, leading to improved population health. The Navajo Area has consistently strived to improve AI/AN health care outcomes using medical treatments, preventive care, and public health outreach. Below are GPRA performance measures results for 2019.

The Navajo Area has met 2 of the 3 Dental measures.

- Dental General Access: Target: 27.20%; Navajo Area Performance: 28.73%.
- Sealants: Target: 16.00%; Navajo Area Performance: 15.89%.
- Topical Fluoride: 30%; Navajo Area Performance: 30.19%.

Navajo Area has met the Diabetes care measures and established a baseline data point.

- Controlled blood pressure: Target: 52.30%; Navajo Area performance: 56.30%
- Nephropathy assessment: Target: 34.00%; Navajo Area performance: 47.73%.
- Poor glycemic control: Target: Baseline; Navajo Area performance: 23.05%. (*All Areas = 17.40%*)
- Retinopathy exams: Target: 49.70%; Navajo Area performance: 54.82%.
- Statin therapy: Target: 37.5%; Navajo Area performance: 51.86%.

The Navajo Area has met the Immunizations measures.

- Adult Immunizations – all age-appropriate immunizations: Target: 54.90%; Navajo Area performance: 64.76%.
- Childhood immunizations: Target: 45.60%; Navajo Area performance: 56.95
- Influenza vaccinations for ages 18 and over: Target: 18.8%; Navajo Area performance: 29.08%.
- Influenza vaccines for ages 6 month to 17 years: Target: 20.60%; Navajo Area performance: 37.11%.

The Navajo Area has met 3 of the 4 Prevention measures.

- Cervical PAP Screening: Target: 35.90%; Navajo Area performance: 41.34%.
- Childhood Weight Control: Target: 22.60%; Navajo Area performance: 23.50%.
- Colorectal Cancer Screening: Target: 32.60%; Nava Area performance: 35.14%.
- Controlling High Blood Pressure (MH): Target: 42.30%; Navajo Area performance: 41.04%.

The Navajo Area has met 8 of the 10 other health outcomes measures and established a baseline data point for Mammography Screening surpassing all of IHS Areas' baseline point.

- CVD Statin Therapy: Target 26.60; Navajo Area Performance: 38.04%.

- Depression Screening or Mood Disorder 12 – 17 years old: Target: 27.60%; Navajo Area: 41.85%.
- Depression Screening or Mood Disorder 18 years and older: Target: 42.20%; Navajo Area: 48.76%.
- Breastfeeding at Age 2 Months: Target: 39.00%; Navajo Area: 47.28%.
- HIV Screening Ever: Target: 17.30%; Navajo Area: 40.73%.
- IPV/DV Screening: Target: 41.60%; Navajo Area: 47.05%.
- Mammography Screening: Target: Baseline; Navajo Area: 47.22%. (*All Areas = 42.03%*).
- SBIRT: Target: 8.90%; Navajo Area: 16.73%.
- Tobacco Cessation Counseling, Aid, or Quit: Target: 27.50%; Navajo Area: 23.48%.
- Universal Alcohol Screening: Target: 37.00%; Navajo Area: 49.69%.

#### 4. The linkage to the IHS Strategic Plan.

The H&C funds supports the IHS Strategic Plan's 3 Goals.

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 (see GPRA results) is a commitment to increasing access to care for the population served. 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 H&C funds support and promote excellence and quality through innovation of the Indian health system into an optimally performing organization. Over the years, the Navajo Area has significantly met and improved its GPRA health measures outcomes using the principles of quality improvement and population health management. These principles foster innovations and interventions that improve not only individual medical and behavioral health but also realize healthy communities. See #1 heading for examples.

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 stems 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 FY 2023 Budget Formulation Session  
 Budget Recommendation Narrative  
 Information Technology & Infrastructure

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 Information Technology (IT) and its accessories (equipment and software programs), and network and bandwidth infrastructure requirements are located under the Hospitals & Health Clinics (H&C) major line item budget account. There is not a separate designated line item account, hence when there is competing needs and priorities the advancement, and often the sustainability, of an IT program becomes secondary until a failure or immediate threat occurs. Any previous H&C funds increases that was specifically earmarked for IT moderation and maintenance has been used accordingly. With the advancement of medicine, patient care procedures and treatments, the interfacing of medical equipment and electronic health records with the latest information technology and network systems are critical to the efficiency and effectiveness of hospitals and ambulatory field clinics in their delivery of safe patient care. Therefore, the H&C line item account needs to be increased with funds earmarked specifically for the continual advancement and maintenance of IT and IT security.

In 2018, the Navajo Area conducted an IT needs assessment and developed a 5-year plan reflecting IT needs and associated annual cost to keep current with changing technology and medicine. An IT modernization is an intentional investment to stay ahead and keep pace with the latest health care technology by terminating, stabilizing, upgrading and replacing equipment and systems.

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
<b>Total Area IT Spending</b>	<b>\$36,075,980.11</b>	<b>\$31,191,950.04</b>	<b>\$22,075,113.04</b>	<b>\$24,178,585.04</b>	<b>\$25,312,708.04</b>

2. The linkage to the Indian Health Care Improvement Act (IHCIA) provisions, where applicable. 25 U.S.C. § 1601. Chapter 18-Indian Health Care.

SUBCHAPTER I-INDIAN HEALTH PROFESSIONAL PERSONNEL

- a. 1616b Recruitment activities.
- b. 1616c Tribal recruitment and retention program
- c. Tribal health program administration.

#### SUBCHAPTER II-HEALTH SERVICES

- d. 1621c. Diabetes prevention, treatment, and control.
- e. 1621d. Other authority for provision of services.
- f. 1621h. Mental health prevention and treatment services.
- g. 1621k. Coverage of screening mammography.
- h. 1621m. Epidemiology centers.
- i. 1621n. Comprehensive school health education programs.
- j. 1621q. Prevention, control, and elimination of communicable and infectious diseases.

#### SUBCHAPTER III-HEALTH FACILITIES

- k. 1638c. Contracts for personal services in Indian Health Service facilities.
- l. 1638e. Other funding, equipment, and supplies for facilities.

#### SUBCHAPTER V-ORGANIZATIONAL IMPROVEMENTS

- 1662. Automated management information system.

- 3. Linkage to GPRA performance targets and outcomes.

The data entry, collection, and profiling of GPRA data is entirely depended on a modern IT and its electronic health records system.

- 4. The linkage to the IHS Strategic Plan.

The IT budget priority is in line with the modernization of federal IT and the IHS' mission to provide a reliable and efficient health information system to support the delivery of health care to American Indians and Alaska Natives.

INDIAN HEALTH SERVICE  
Navajo Area FY 2023 Budget Formulation Session  
Budget Recommendation Narrative  
Long-term Care Facility

1. Discuss how the recommended budget increases should be allocated, i.e., including any effects of the previous year's increases and include data that highlights those effects.

Legislative provisions for Long-term Care Facilities are an unfunded federal mandate under the "Indian Health Care Improvement Act (IHCIA), 25 U.S.C. § 1601. Chapter 18-Indian Health Care, § 1680l." Hence, there is no federal budget line item account under the IHS budget for this much needed service/care for a growing Navajo Nation elder population, 65 years and older, which now exceeds 66,000 individuals. The Navajo Nation requests the IHS to help 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 IHCIA.

The IHCIA, 25 U.S.C. § 1621d(b)(3), authorizes the Secretary to provide funding to Indian Tribes, in part, to (1) ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy; (2) ensure maximum Indian participation in the direction of health care services so as to render the persons administering such services and the services themselves more responsive to the needs and desires of Indian communities; (3) require that all actions under the IHCIA shall be carried out with active and meaningful consultation with Indian tribes and tribal organizations, and conference with urban Indian organizations, to implement this chapter and the national policy of Indian self-determination; (4) ensure that the United States and Indian tribes work in a government-to-government relationship to ensure quality health care for all tribal members; and (5) provide funding for programs and facilities operated by Indian tribes and tribal organizations in amounts that are not less than the amounts provided to programs and facilities operated directly by the Service.

In the spirit of the IHCIA and to achieve the established objectives, the Navajo Nation requests the IHS to help advocate and inform the U.S. Congress of the critical need for long-term care facilities and services throughout Indian Country, and submit a budget proposal to U.S. Congress to appropriate monies for long-term care services. 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-reservations to meet elder health care needs of a significant demographic in Indian Country.

Many Navajo elders are unable to live alone at home and have limited options or methods to remain in their home without supportive and assisted care. As the Navajo elder demographic ages and prolongs the amount of time they are able to live independently, tribal governments are having to figure out how to provide a comprehensive range of services that are culturally-sensitive and appropriate which also preserves the dignity and quality of life for this important and cherished group. The longevity of life among Navajos requires Navajo leaders,

communities and families to assess how best to provide comprehensive care and services for elders.

Unfortunately, it is no longer a viable option to consider families and extended family members to address the needs of the elders, as this practice has diminished considerably due to younger family members having to relocate from remote rural communities to distant urban communities in search of employment opportunities. Currently, the Dr. Guy Gorman, Sr. Care Home (aka Chinle Nursing Home), operated by the Navajoland Nursing Home, Inc., is the only long term care facility on the Navajo Nation to serve the entire Navajo elder population in need of comprehensive long-term care services. Unfortunately, it is impractical to expect the Chinle Nursing Home to meet the growing need for elder health care services. More nursing homes or long-term care facilities are needed in other regions of the Navajo Nation as Navajo families desire to keep their elderly family members as near as possible to provide all the necessary amenities to extend the life of their loved one(s).

There are two types of care needed; Intermediate Level Care which is assistive and does not include the use of skilled nursing care. The motivation for assistive care is to keep an elder in a safe environment; provide routine medication administration to those who are frail, disabled, or have forgetfulness or the mental inability to recall a medication regimen on their own. The second level of care is Skilled Nursing Care which is essential to care that requires nursing, rehabilitation or other professionally licensed care for a specified care plan prescribed by a physician. Without these resources, our elders will not receive the care that is needed for their health and safety.

2. The linkage to IHCIA provision, where applicable.

Long-term Care Facility/Service is an unfunded federal mandate under the “Indian Health Care Improvement Act (IHCIA), 25 U.S.C. § 1601. Chapter 18-Indian Health Care, § 1680/. Shared services for long-term care”. A formal budget request needs to be submitted to the U.S. Congress to fulfill this mandate as the elder population is growing across Indian Country.

3. The linkage to GPRA performance targets and outcomes.

The IHS annual appropriation budget’s Major Line Item Accounts such as Hospitals and Clinics (H&C), Dental, Public Health Nursing (PHN) and Mental Health funds allow the Navajo Area to meet and improve its annual GPRA performance measures, leading to improved population health which includes the elder individuals. These funds do not address the Intermediate Level Care and Skilled Nursing Care type of services that support the geriatric population. These services occur in a structured setting involving dedicated facilities and staff to provide around the clock care for elders who do not have acute health problems that require hospitalization. These facilities may be certified by the Centers for Medicaid and Medicare Services (CMS), or other accrediting agencies like The Joint Commission to ensure safe and efficient care.

#### 4. The linkage to the IHS Strategic Plan.

To strengthen the Indian health care delivery system involves the advancement of holistic approach to care, population health care, cultural competent care, quality and safe care, and comprehensive care. The systems of care must foster integration of services at all levels within a continuum of care, and the continuum of care is driven by the cycle of life and health needs of individuals. Elder care is a part of this continuum of care supported by structured nursing homes with dedicated staff.

INDIAN HEALTH SERVICE  
Navajo Area FY 2023 Budget Formulation Session  
Budget Recommendation Narrative  
Hospitals and Health Clinics  
Prevention Programs (CHR, PHN, & Health Education)

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.

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.<sup>1</sup> 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

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<sup>1</sup> Navajo Nation Epidemiology Center, 2019. Five Year American Community Survey.

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 frontline 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. 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 frontline 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 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.

2. 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
  - 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

3. 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, workplace, 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.

The Navajo Area has met 2 of the 3 Dental measures.

- Dental General Access: Target: 27.20%; Navajo Area Performance: 28.73%.
- Sealants: Target: 16.00%; Navajo Area Performance: 15.89%.
- Topical Fluoride: 30%; Navajo Area Performance: 30.19%.

Navajo Area has met the Diabetes care measures and established a baseline data point.

- Controlled blood pressure: Target: 52.30%; Navajo Area performance: 56.30%
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The Navajo Area has met the Immunizations measures.

- Adult Immunizations – all age-appropriate immunizations: Target: 54.90%; Navajo Area performance: 64.76%.

- Childhood immunizations: Target: 45.60%; Navajo Area performance: 56.95
- Influenza vaccinations for ages 18 and over: Target: 18.8%; Navajo Area performance: 29.08%.
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The Navajo Area has met 3 of the 4 Prevention measures.

- Cervical PAP Screening: Target: 35.90%; Navajo Area performance: 41.34%.
- Childhood Weight Control: Target: 22.60%; Navajo Area performance: 23.50%.
- Colorectal Cancer Screening: Target: 32.60%; Nava Area performance: 35.14%.
- Controlling High Blood Pressure (MH): Target: 42.30%; Navajo Area performance: 41.04%.

The Navajo Area has met 8 of the 10 other health outcomes measures and established a baseline data point for Mammography Screening surpassing all of IHS Areas' baseline point.

- CVD Statin Therapy: Target 26.60; Navajo Area Performance: 38.04%.
- Depression Screening or Mood Disorder 12 – 17 years old: Target: 27.60%; Navajo Area: 41.85%.
- Depression Screening or Mood Disorder 18 years and older: Target: 42.20%; Navajo Area: 48.76%.
- Breastfeeding at Age 2 Months: Target: 39.00%; Navajo Area: 47.28%.
- HIV Screening Ever: Target: 17.30%; Navajo Area: 40.73%.
- IPV/DV Screening: Target: 41.60%; Navajo Area: 47.05%.
- Mammography Screening: Target: Baseline; Navajo Area: 47.22%. (*All Areas = 42.03%*).
- SBIRT: Target: 8.90%; Navajo Area: 16.73%.
- Tobacco Cessation Counseling, Aid, or Quit: Target: 27.50%; Navajo Area: 23.48%.
- Universal Alcohol Screening: Target: 37.00%; Navajo Area: 49.69%.

#### 4. 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.

INDIAN HEALTH SERVICE  
Navajo Area FY 2023 Budget Formulation Session  
Budget Recommendation Narrative  
Urban Indian Health Facility Construction and Urban Facility Lease Improvement/Renovation

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 Native Americans for Community Action, Inc. (NACA) is located in Flagstaff, AZ and is one of 41 Urban Indian Health Programs (UIHP) serving the Urban Indian population. Urban Indians refer to 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, which now makes up more than 70 percent of the AI/AN population community throughout the United States. 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, and Workforce Investment. 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 produces revenue for both NACA and the artisans.

Currently, NACA rents facilities in two different locations. One location houses Administration and other programs. The other location, 3 miles away, houses the Family Health, Behavioral Health, and Health Promotion programs. The vision of NACA is to own its own building and be under one roof. Both of these facilities are covered through a lease which does not allow for owner-based tenant improvements. All improvements must be financed by NACA, including the recent renovations required to respond to the COVID-19 pandemic.

The Navajo Area identified health facility construction and leasehold improvement funding as the #10 budget priority in the IHS FY 2023 budget.

It is important to note that unlike the rest of the IHS system, UIHPs receive their funding through only one budget category, the urban Indian health program line item. It is crucial for UIHPs to receive a program increase that can expand services to Indian Country particularly to beneficiaries residing in urban areas.

Infrastructure is a problem faced by NACA and other UIHPs. UIHPs encounter issues related to ownership, liability and outdated facilities. Many UIHPs, including NACA, do not own their facilities but lease facilities to house their programs incurring hundreds of thousands of dollars in lease expenses annually. If NACA was allowed to utilize the IHS funding it receives to make leasehold improvements, it could better manage its limited resources and capital on other health care needs. NACA's financial position could improve if leasehold capital projects were completed utilizing IHS funds and this would allow the organization to build its financial reserves and work towards future property ownership.

Currently, there is no UIHP line item for facility construction or leasehold improvements in the IHS budget. The current budget structure does not allow for it, unless the program is accredited by The Joint Commission (TJC), which is difficult to accomplish with an older, out of compliance facility.

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 construction equaled \$574 per capita, compared with IHS health care facility (non-Urban Centers) construction appropriation of \$77 million, equating to \$35 per AI/AN per capita. The nation invests over 10 times the amount per capita than is appropriated for IHS facility construction.

A major recommendation is to establish a line item for health facility construction for urban Indian health programs and for Urban facility lease improvement and renovation.

Health facility construction is one of the IHS' top budget priorities and access is limited to Federal and Tribal projects. Urban Indian health programs do not have access to the IHS health facility construction funding and process. Having the availability of Federal funding to support the construction of health centers for urban Indian health constituents would enhance the quality of care, increase access to care, and help address health disparities. Leasehold improvement funds will assist UIHPs which lease buildings for health services in supporting and addressing critical maintenance needs, comply with building codes, and strengthen the infrastructure of existing UIHP facilities.

Equipment replacement is another infrastructure expense for NACA and places NACA in a position of balancing the available capital resources between needed leasehold improvements and necessary medical equipment.

2. The linkage to the Indian Health Care Improvement Act (IHCIA) provisions, where applicable. 25 U.S.C. § 1601. Chapter 18-Indian Health Care.

The IHCIA does not contain provisions for facility construction for urban Indian health programs. 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. New facility construction will enhance and ensure maintenance of accreditation or greatly improve the chances of accreditation for those seeking it.”* These legislative provisions apply to programs accredited by The Joint Commission (TJC) only. Many UIHPs are accredited or are pursuing accreditation by the Accreditation Association for Ambulatory Health Care, Inc. (AAAHC) or other certifications. NACA is not accredited by TJC or the AAAHC, hence it does not qualify to use current IHS funding for renovations. NACA is working towards the goal of being accredited by AAAHC.

In 2019, NACA modified its entrance/exit to the facility to become Americans with Disabilities Act of 1990A (ADA) compliant. With NACA having two locations for UIHP services, there are increased operating costs, along with additional electrical, HVAC and other system costs. It would be more cost efficient to have a new ADA and OSHA compliant building to reduce facility support and infrastructure costs.

Adequately sized and equipped facilities are critical for UIHPs to improve access to care for urban Indians. Some UIHPs have outgrown their space and lack the resources to expand to meet demand for services and some have facilities in need of major renovation and repair. For other UIHPs, gentrification has displaced Urban Indian communities to other neighborhoods, leading to transportation challenges for patients. To meet patient care goals, many UIHP's have largely self-financed the necessary relocation, modernization and facility expansion costs.

The IHCIA, 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 play an important role in the safety net and attract a disproportionate share of those without any other resources. The IHS Office of Urban Indian Health Programs (UIHPs) has a Strategic Plan for 2019-2023. The number one goal cited in the plan 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 consistent with the IHClA, as amended.

3. Linkage to GPRA performance targets and outcomes.

The allowance for Urban Indian Health Programs to utilize their IHS funding for leasehold improvement and renovations will have a significant impact towards elevating and achieving GPRA measures. Through improvements in clinical operational design, facility investment and expansion, reducing barriers for patients in urban communities and investing in the future of UIHPs will contribute towards the IHS mission of raising the physical, mental, social and spiritual health of American Indians and Alaska Natives to the highest degree.

4. The linkage to the IHS Strategic Plan.

In regards to the IHS priorities, investment into the necessary resources and infrastructure to sustain urban programs is one of the most essential priorities. Investments in capital improvements will impact the recruitment and retention of a dedicated workforce, allow for improved patient care and quality of care, and facilitate the development of local partnerships through contracted arrangements for health care delivery.

All of the proposed funding allocations have a tremendous impact on the ability of UIHPs to enhance and surpass current levels of healthcare by allowing funding they require to take care of 70% of the AI/AN population that resides in urban areas.

INDIAN HEALTH SERVICE  
Navajo Area FY 2023 Budget Formulation Session  
Budget Recommendation Narrative  
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 3,400 existing homes lacking funding for adequate water and sewer facilities. The total Navajo Nation water and sewer economically feasible unmet need is nearly \$166 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 waterborne communicable disease episodes, but by no means is their value limited to disease intervention. Safe drinking water supplies and adequate waste disposal facilities are essential preconditions for most health promotion and disease prevention efforts. Efforts by other public health workers are much more effective when safe water and adequate wastewater disposal systems are in place.

Patients admitted to the hospital have longer lengths of stay 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

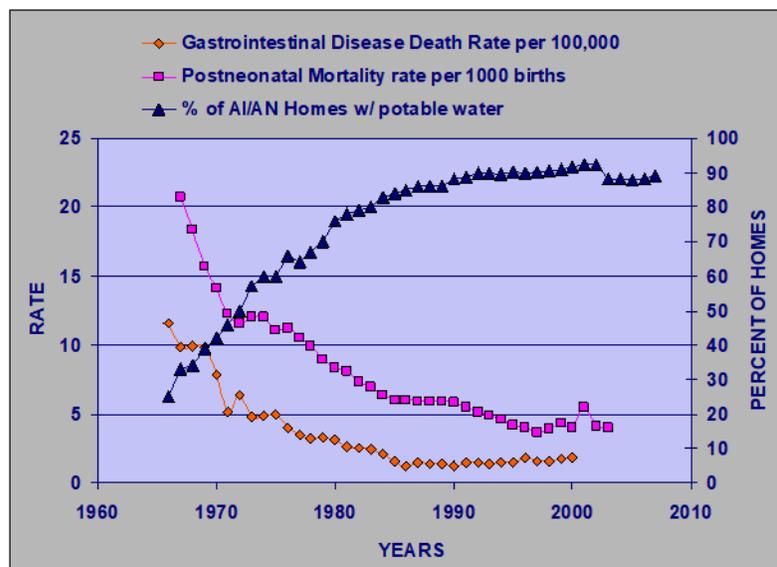
achieved. The IHS Sanitation Facilities Construction Program has been the primary provider of these services since 1960.

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 2020 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 2,347 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 2020, Navajo Area's project duration was 4.49 years, which exceeded the national goal of less than 4.0 years.

OKLAHOMA CITY AREA  
INDIAN HEALTH SERVICE  
FY 2023 Budget Formulation  
Narrative of Budget Priorities

On November 13, 2020, 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 2023 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 (Creek) Nation. Technical representatives are: Melissa Gower, Chickasaw Nation; Melanie Fourkiller, Choctaw Nation; Terra Branson-Thomas, Muscogee (Creek) Nation; Rhonda Beaver, Muscogee (Creek) Nation; Kasie Nichols, Citizen Potawatomi Nation; Nicholas Barton, Southern Plains Tribal Health Board; and Scott Miller, Sac and Fox 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 2020, the OCA user population was 391,776 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 8 hospitals, 59 health centers (which includes 5 health clinics in urban locations), 1 school health center, and 1 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 2019 American Community Survey 5-year report, there are 927,946 American Indians and Alaska Natives (AI/ANs) alone 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 service area.

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 five causes of death for the AI/ANs in Oklahoma with a comparison to All Races combined is shown below. The age-adjusted rate of Deaths due to Accidents (unintentional injuries) and Diabetes is higher for AI/ANs.

## Top 5 Rankable Causes of Death-ICD10 (State of Oklahoma)

American Indian/Alaska Natives	All Races Combined
1 Diseases of heart	1 Diseases of heart
2 Malignant neoplasms	2 Malignant neoplasms
3 Accidents (unintentional injuries)	3 Chronic lower respiratory diseases
4 Diabetes mellitus	4 Accidents (unintentional injuries)
5 Chronic lower respiratory diseases	5 Cerebrovascular disease

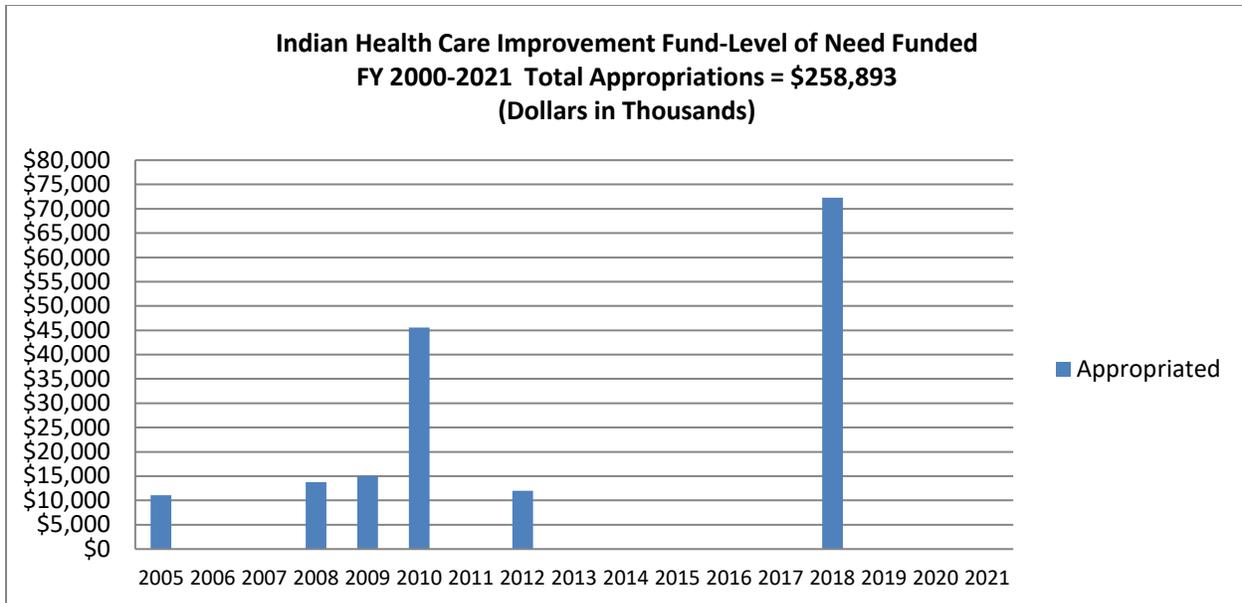
Source: Oklahoma State Department of Health (OSDH), Center for Health Statistics, Health Care Information, Vital Statistics 2014-2018, on Oklahoma Statistics on Health Available for Everyone (OK2SHARE).

## **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 is a priority, 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 citizens. The OCA has historically had the lowest funding per capita amongst the Areas in overall IHS funding, in FY 2020 the OCA per capita amount is \$2,297.

The Indian Health Care Improvement Act (IHCA) 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, or FY2021. 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 of the Indian Health System is underfunded, however the most underfunded units require immediate attention.



In FY 2023, 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.

Such an increase and equitable distribution of the IHCIF 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. 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 ~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/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 2023 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. 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.

### **3. 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 OCA IHS ranks last of the twelve IHS Areas in funding available for PRC services based on active patients. The level of funding in OCA was \$306.33 per person for FY 2020. 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 2019, the numbers of PRC denied cases were 20,118 and deferred cases totaled 27,512 for those facilities reporting. Of the deferred cases, over 90% were

for acute and chronic care. In FY 2019, OCA Catastrophic Health Emergency Fund (CHEF) reimbursed cases was \$10 million. The lack of state level Medicaid expansion in OCA has resulted in no relief of the financial pressure to provide even basic life-and-limb services. Furthermore, in the five years (2014-2018), the OCA averaged over 18% of funded CHEF cases nationally but was funded at only at 11% 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 orthopedic 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.

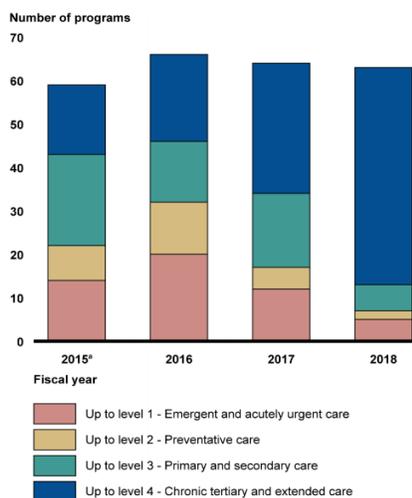
The lack of appropriations leaves many without access to primary health care services and even more to specialty and referred care. Other barriers also exist, such as, distance from an Indian Health care facility, overburdened health care facilities due to lack of resources, and services not provided 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.***

Finally, the OCA PRC programs have continued to be negatively impacted by the lack of Medicaid expansion. Other IHS Areas have experienced an expansion in their ability to provide a broader range of PRC, meeting more levels of medical priority. 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.

**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.*** Without Medicaid expansion, the OCA patients are often solely dependent upon PRC and the significant funding limitations of this program, and the disparity in PRC resources continues to grow.

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.<sup>1</sup>

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.

#### **4. Hospitals and Health Clinics, Including Health Information Technology**

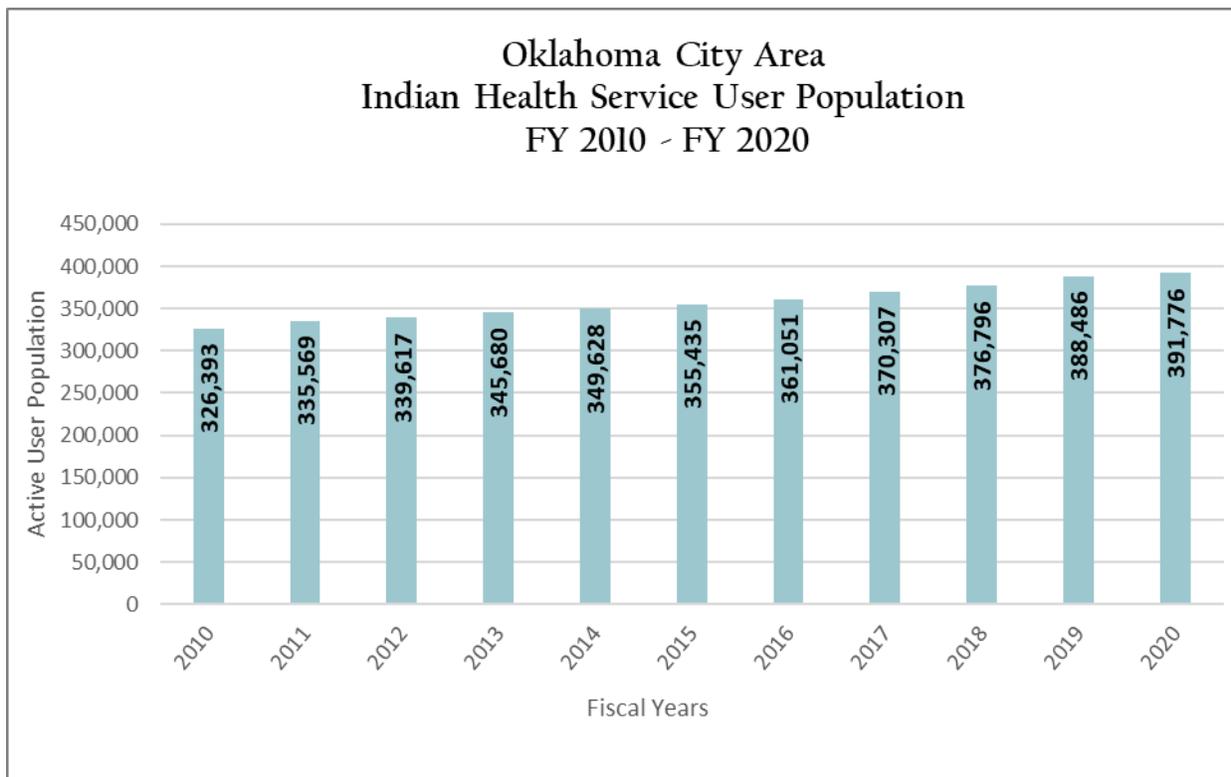
Hospitals and Health Clinics (H&HC) in the OCA funds essential personal health services for a user population of 391,776 AI/ANs including medical and surgical inpatient care, routine and emergency ambulatory care, and medical support services including laboratory, pharmacy, nutrition, diagnostic imaging, 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

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<sup>1</sup> 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](https://www.ihs.gov/sites/strategicplan/themes/responsive2017/display_objects/documents/IHS_Strategic_Plan_FY%202019-2023.pdf)

disparities, and communicable diseases including influenza, HIV/AIDS, and hepatitis. Collecting, analyzing, and interpreting health information is done through a network of tribally-operated epidemiology centers in collaboration with a national IHS coordinating center 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 continued to see a 20% increase in User Population from 2010-2020, as reflected in the table below.



This population growth is important to note because, during the last three fiscal year cycles, appropriated inflation increases to H&HC were reprogrammed to specific non-inflation line items, such as 105(I) leases. In FY2021, in order to create a separate indefinite account for 105(I) leases, Congress diverted \$86.5 million from the H&HC budget line to the new 105(I) lease account. This action caused the base funding for Hospitals & Health Clinics to be reduced permanently. All tribes benefit from H&HC, whereas only a few benefit from 105(I) lease awards. H&HC is already severely underfunded and serves a growing population; diversion of this important funding only creates a few “winners” and many “losers”.

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 life-saving 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**

The Roadmap Report developed by the Department of Health and Human Services (HHS) laid out a number of priorities and plans through FY2023, including establishment of a Project Management Office and governance structure, acquisition planning, HIT selection and procurement, implementation planning, and testing. While recent reports have not been driven by this report, Health Information Technology (HIT) improvement remains a top priority for Tribes. This is also a top priority for Legislators who supported HIT modernization and IHS leadership who allocated a portion of funds provided through pandemic relief funding to Electronic Health Records improvements.

Despite these investments, additional and recurring funds are necessary to achieve the plan as described in the Roadmap Report. Information technology that supports both personal health services (including the Electronic Health Record and telemedicine) and public health emergencies and initiatives has historically primarily been funded through the H&HC budget. Due to the complexity of HIT and the need to transition and improve legacy systems, OCA continues to recommend that a new separate line item is essential.

### **5. Urban Facilities**

Although approximately 78% of AI/ANs reside in urban areas, the IHS funding allocation for Urban Indian health reflects less than 1% of the total annual IHS budget. In addition, Urban Indian Health Programs (UIHP) do not receive funding from other line items which the other facets of the IHS system receive, such as the facilities line item budget. Moreover, in recent years, IHS has added 6 new programs to the Title V budget line item; yet there has not been a commensurate increase in the sole line item funding these programs – the Urban Indian budget. UIHPs are also ineligible for other payment options that reduce costs for the other facets of the IHS system – including Federal Tort Claims Act coverage, which results in UIHPs having to use a portion of their limited funding for costly malpractice insurance. Urban Indian programs await movement on the FTCA legislation from Congress and signature from the President. Services provided at UIHPs are not reimbursed at the 100% Federal Medical Assistance Percentage rate that similar services are at IHS and tribally operated facilities. Additionally, Urban Indian programs should be included on the Veterans Administration-Indian Health Service reimbursement program.

There are a total of 41 UIHPs spanning across 22 states, including 3 UIHPs in the Oklahoma City Area: Hunter Health in Wichita, KS; Kansas City Indian Center in Kansas City, MO; and Urban Inter-Tribal Center of Texas in Dallas, TX. These facilities are Urban Indian Organizations 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 – IHS/Tribal/UIHP – system. Because UIHPs 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 in addition to tribal health priorities to advocate that Congress increase the budget to appropriate funding levels for both.

# Phoenix Area IHS Tribal/Urban Budget Recommendations

Fiscal Year 2023

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Submitted on behalf of the Tribal Governments and the  
Urban Indian Health Programs served by the Phoenix Area  
Indian Health Service

By the Inter Tribal Council of Arizona (Contract #75H71220900002)

**INDIAN HEALTH SERVICE**  
**FISCAL YEAR (FY) 2023 PHOENIX AREA BUDGET FORMULATION SESSION**  
**BUDGET RECOMMENDATION NARRATIVE (DELIVERABLE #2)**

The Annual Phoenix Area Indian Health Service (PAIHS) Budget Formulation Meeting was held on December 2, 2020, via a virtual platform. Dr. Charles “Ty” Reidhead announced the meeting to Tribal Leaders, Tribal Health Directors and Urban Indian Organization officials at the monthly Phoenix Area IHS Partnership Call on November 17, 2020. At that session, PAIHS staff provided a COVID-19 Public Health Emergency (PHE) update and a presentation on the budget formulation process noting that the FY 2023 process would be conducted virtually this year due to the PHE which requires that all consultation meetings be held virtually. The staff provided a budget formulation “101” webinar at the meeting to highlight the new instructions and the process decided by the National IHS Tribal Budget Formulation Work Group.

Dr. Reidhead formally notified Tribes and Urban Indian Organizations (UIOs) programs regarding the consultation on November 23, 2020. The correspondence noted that PAIHS will seek to consult on the following topics:

- Formulation of the FY 2023 IHS budget totaling \$48 Billion, deemed full funding by the FY 2023 National Tribal Budget Formulation Work Group.
- Selection of Area Representatives – Nominations to represent the Phoenix Area region at the virtual National Budget Formulation Meeting on February 11-12, 2021.

The information transmitted to the Tribes and UIOs included the December 2<sup>nd</sup> tentative agenda and FY 2022 National and Phoenix Area budgetary recommendations. Tribes and UIO participants were requested to register for the upcoming formulation meeting so that additional meeting materials would be directly emailed to them. In addition, two “Office Hour” sessions were announced. They were held on November 24<sup>th</sup> and November 25<sup>th</sup> to assist participants to become familiar with the National Budget Spreadsheet Template and how their recommendation(s) for “full funding” would be tabulated. They were also requested to complete a brief survey to submit their recommendations prior to the December 2<sup>nd</sup> meeting including the identification of their top five budget priorities. Plus they were asked to nominate two PAIHS Tribal Representatives and one urban representative to attend the virtual IHS National Budget Formulation Meeting on February 11-12, 2021.

Several tasks were accomplished at the one-day budget formulation meeting. Area staff provided an overview of the IHS budget formulation process and the results from last year’s FY 2022 Tribal recommendations that served as a base for this year’s process. The participants heard presentations from Phoenix Area Consultants on health status, trends in the Phoenix Area budget over a three year period and information was provided on the Fiscal Year 2021 budget request which was not yet approved at the time of the meeting due to the FY 2020, Continuing Resolution that had been extended through December 18, 2020. After discussion on budgetary priorities, hot topics and emerging issues based on survey findings, the Tribal Leadership and UIO officials concurred on the National FY2023 budget by line item recommendations and the associated hot issues in the Phoenix Area noted in this report. (See Deliverable #3). A final work session held on December 7, 2020, completed the process.

The amounts for FY 2023 for the IHS national budget supported by the Tribes and urban Indian Health Programs in the Phoenix Area are summarized below.

**FY 2023 IHS BUDGET PHOENIX AREA TRIBAL/URBAN RECOMMENDATIONS AT \$48 BILLION\*  
+\$35.2 BILLION OVER THE FY 2022 NATIONAL TRIBAL BUDGET RECOMMENDATION\*\***  
(Dollars in Thousands)

Sub Sub Activity	FY 2020 IHS Enacted Budget	FY 2021 IHS President's Budget Request	FY 2022 National Tribal Recommend. (+30%)	FY 2023 Phoenix Area National Recommendation (Estimated Full Funding)	FY 2023 Phoenix Area Increase (Over FY22 Tribal Recommendation)
Clinical Services	3,934,831	3,996,964	8,739,599	20,738,365	11,998,846
Preventive Health	177,567	118,258	563,507	883,107	319,600
Other Services	202,807	171,320	371,116	534,916	163,800
Facilities	911,889	803,026	2,017,279	24,776,029	22,758,750
Contract Support Costs	820,000	855,000	1,067,583	1,067,583	0
<b>TOTAL</b>	<b>\$6,047,094</b>	<b>\$6,232,568</b>	<b>\$12,759,004</b>	<b>\$48,000,000</b>	<b>+\$35,240,996</b>

\*See Deliverable 1 - FY 2023 Phoenix Area National Budget Worksheet

\*\* Tribes were instructed that COVID-19 PHE response and treatment would not be addressed in the FY23 budget recommendations.

Fiscal Year 2023 IHS Budget Narrative

Tribes in the Phoenix Area recommend a total Indian Health Service (IHS) budget of **\$48 billion** for Fiscal Year (FY) 2023. This represents the estimated full funding for all line items above the FY 2022 National Tribal Budget Recommendation of \$12.75 billion, which served as the planning base for the FY 2023 budget formulation process. In addition to the recommended Program Increases totaling **\$35.2 billion**, the meeting participants concurred on estimated amounts for Current Services/Binding Obligations. The importance of funding current services and the Federal government's binding obligations (fixed costs) in the FY 2023 IHS Budget Request to maintain the Indian health care system is vital. The Phoenix Area Tribal and Urban leadership concur with estimates provided for the FY 2023 budget formulation process.

The estimate for Current Services (Pay Costs, Inflation and Population Growth) total \$197,058 million and the total for Binding Obligations total \$275,000 million.

### **Indian Health Care Improvement Act (IHCIA) (25 U.S.C. Chapter 18)**

Below is a description of the Phoenix Area's top 5 budget line item priorities under Services and the top 3 line items under Facilities that were agreed upon at the Phoenix Area budget formulation meeting. Several priority line items and hot issues connect to provisions of the Indian Health Care Improvement Act (IHCIA) (25 U.S.C. Chapter 18) adopted in 1976, that describes the legal authority and the authorized provision of services that may be made available through the Indian Health Service. The law was permanently reauthorized in 2010. It contains notable Congressional findings which guide American Indian health policy and the provision of health care services through the Indian Health Service, Tribal and Urban Indian Organizations:

#### **25 U.S.C. § 1601. Congressional findings.**

The Congress finds the following: (1) Federal health services to maintain and improve the health of the Indians are consonant with and required by the Federal Government's historical and unique legal relationship with, and resulting responsibility to, the American Indian people. (2) A major national goal of the United States is to provide the resources, processes, and structure that will enable Indian tribes and tribal members to obtain the quantity and quality of health care services and opportunities that will eradicate the health disparities between Indians and the general population of the United States.

#### **25 U.S.C. § 1602. Declaration of national Indian health policy.**

The Congress declares that it is the policy of this 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...

Tribes in the Phoenix Area specified IHCIA provisions associated with the priorities they identified. They have not been adequately funded in the history of appropriations made available to American Indian health care. These are noted in the following summary of priority line items and issues.

### **IHS Services - Top 5**

#### **1. Hospitals & Clinics (H&C) +\$9.38 billion (223.3% increase)**

Building on the FY 22 National Tribal Budget Recommendation of \$4.2 billion, the Phoenix Area seeks a \$9.38 billion program increase for the H&C line item. This amount includes **\$7.7 billion** to enhance inpatient and outpatient services, emergency services, medical support services and specialized programs. In addition, funding is sought to address several priority concerns (hot issues) in the Phoenix Area that are listed below:

**+\$1.5 billion** to fund IHCIA long term care, home and community based care and hospice authorities.

**+\$42 million** for Telehealth/IT upgrades

- +\$30 million** for Traditional Healing (Policy Support & Integrated/Complementary care)
- +\$15 million** for Extra Support for Smaller Tribes
- +\$12 million** for Maternal & Child Health/Obstetrics-Labor & Delivery (\$1 million request for the Phoenix Indian Medical Center to reopen and retain the services)
- +\$12 million** for Rocky Mountain Spotted Fever (RMSF)

The Snyder Act of 1921 (25 U.S.C 13) authorized the provision of services through the Bureau of Indian Affairs until the establishment of the Indian Health Service in 1955. The legal authority for the provision of health care authorized under the IHCA provisions (25 U.S.C 1601, et seq.) associated with Hospitals & Clinics and the specified hot issues addressed in this line item are listed here:

- § 1621d. Other authority for provision of services
  - § 1680l. Shared services for long-term care
  - § 1621. (a) (D) Indian Health Care Improvement Fund
  - § 1621q. Prevention, control, and elimination of communicable and infectious diseases
  - § 1660h. Health information technology
  - § 1621h. Mental health prevention and treatment services
  - SUBCHAPTER V—A—BEHAVIORAL HEALTH PROGRAMS (§ 1665 et. al.)
  - PART B—INDIAN YOUTH SUICIDE PREVENTION (§ 1667 et. al.)
  - § 1680u. Traditional health care practices
  -
2. Community Health Representatives **+\$233.4 million** (95% increase)

The role of CHR's as members of the local IHS or Tribal health care delivery team providing information on health risks, policies, procedures and a range of preventative services to Tribal members is highly valued. In Tribal communities, Public Health Nurses (PHNs) are working with CHR's to guide them conduct their scope of work. CHR's must comply with standards of practice and fulfill training requirements including full utilization of RPMS or the electronic data system instituted in the future to replace it. Tribal and UIO CHR programs envision continuing to work with Health Educators and alongside Community Health Aides as the National Community Health Aide Program (CHAP) is instituted in the lower 48 states. Tribes have struggled due to insufficient appropriations to make available suitable salaries as well as hire more CHR's to help with the workload. Of particular concern is the ability of CHR programs to continue their efforts to assist in Rocky Mountain Spotted Fever prevention and education efforts in several Tribal communities. RMSF, a bacterial disease, can rapidly progress to a serious illness that can lead to amputation due to damaged blood vessels, paralysis and mental disability. Untreated cases can result in death.

The IHCA provisions associated with this priority are:

- § 1616. Community Health Representative Program
- § 1616l (d). Nationalization of the Community Health Aide Program
- § 1621n. Comprehensive school health education program

- § 1621q. Prevention, control, and elimination of communicable and infectious diseases
- § 1660f. Title 1 – Subtitle E. Health Services for Urban Indians – CHR

3. Alcohol & Substance Abuse **+\$706 million** (90.6% increase)

Alcohol and substance abuse health risks continue to be a major concern and correlates to the top leading cause of death in the Phoenix Area, unintentional injuries, primarily motor vehicle fatalities, but also includes poisonings and overdose as well as the fourth leading cause of death, chronic liver disease and cirrhosis. The increase is needed to institute the Comprehensive Behavioral Health Prevention and Treatment Program authorized by the Indian Health Care Improvement Act (25 U.S.C. §1665c). According to the law, “the Secretary, acting through the Service shall provide a program of comprehensive behavioral health, prevention, treatment, and aftercare, which may include, if feasible and appropriate, systems of care.” It is also imperative that coordination of care involve addressing co-occurring mental health disorders that patients experience. Tribes in the Phoenix Area continue to advocate for the resources needed to implement numerous behavioral health programs authorized by the IHCA provisions identified below. These should remain at the forefront of agency planning.

The IHCA provisions associated with this priority are:

- § 1665c. Comprehensive behavioral health prevention and treatment program
- § 1665f. Indian women treatment programs
- § 1665g. Indian youth program )

4. Indian Health Professions **+\$71.2 million** (86.16% increase)

A major focus must continue to increase the recruitment and retention of professionals and comprehensive efforts to encourage American Indian and Alaska Natives to enter into health careers. IHS and Tribes continue to struggle to recruit and retain qualified medical professionals to work in Indian Country. In 2018, it was reported that the estimated vacancy rates at federal/IHS sites, are as follows: Physicians - 34%; pharmacists - 16%; nurses - 24%; dentists - 26%; physician’s assistants - 32% and advanced practice nurses - 35%. Comprehensive efforts encouraging American Indian and Alaska Natives to enter into health careers are needed including accessing federal and state scholarships and loan repayment programs. Tribes also recommend that a portion of these resources support the development or access to mid-level provider training and financial support for students needed for the long term sustainability of CHAP.

The following IHCA provisions address staffing shortage issues:

- § 1616a. Indian Health Service loan repayment program
- § 1616a–1. Scholarship and Loan Repayment Recovery Fund
- § 1616b. Recruitment activities.
- § 1616c Tribal recruitment and retention program

- § 1616h. Health training programs of community colleges
- § 1616l. Community health aide program.
- § 1616m. Matching grants to tribes for scholarship programs.
- § 1616p. Health professional chronic shortage demonstration programs.

5. Mental Health **+\$504 million (70.49% increase)**

The funding is needed in the Mental Health line item to increase the ability of patients to receive outpatient counseling, psychiatric evaluations, crises response, case management and care coordination by mental health professionals and paraprofessionals in the Indian health care system who are well versed in the factors within Tribal communities that contribute mental health issues. Current funding levels are inadequate to provide the level of needed screening and services to assist patients that contemplate or attempt suicide, engage in self-harm, that experience depression, violence and other emotional trauma. The increase is also needed so that behavioral health integration occurs within primary care and utilization of peer support measures. Additional concerns are growing our own behavioral health professionals, adapting Traditional Healing and Faith-Based counseling, as requested, and making available higher levels of psychiatric care as appropriate for AIAN patients within the IHS system or by connecting patients to state services, through the legal process or if the individual is Medicaid eligible. Comprehensive case management that results in the coordination of care that’s necessary for each patient’s stabilization and recovery, is key.

There are major provisions in the Indian Health Care Improvement Act (IHCA) that pertain to mental health. Tribes in the Phoenix Area seek new resources to enhance services and to fund implementation of the following two provisions pertaining to mental health care and co-occurring disorders. These are;

- § 1665, § 1665b, § 1665c) Behavioral Health Prevention and Treatment Services
- § 1665d. Mental Health Technician Program

**IHS Facilities - Top 3**

1. Health Care Facility Construction (HCFC) **+\$18.86 billion (2,585% increase)**

The needed exponential increase has already been identified and is known by the Indian Health Service. The HCFC backlog is also reported to the U.S. Congress. It includes funding to complete the projects on the current Health Care Facilities Construction Priority List at \$2.02 billion, funding for the new construction system and projects already identified by IHS Areas at \$14.5 billion in the 2016 IHS and Tribal Health Care Facilities’ Needs Assessment Report to Congress and needed allocations for the Small Ambulatory Program These needs are identified in the 2020 Facilities Appropriations Information Report (Package) completed by IHS on January 30, 2020. Tribes have waited for years for the funding to alleviate lack of space and old infrastructure in order to increase the quality of patient health care. The associated IHCA provisions that require implementation and resources to address these concerns are:

- § 1631(c) (1) (A). Health Care Facility Priority System
- § 1631(c)(1)(D), § 1631(c)(2)(B), § 1631(d)(1)(g)). Priority of Certain Projects Protected
- § 1637 Indian Health Care Delivery Demonstration Projects

Another major concern identified in the Phoenix Area pertains to Urban Indian Organizations. It is recognized that access to health care is hampered by poverty in urban areas, limited and unreliable transportation, the lack of the full range of medical services in lower income areas and lack of optimal space for serve delivery at urban Indian health programs. There is now a requirement in the IHClA that requires IHS to confer with Urban Health programs (25 U.S.C. §1659). Other priority provisions of the IHClA that are relevant to this priority encompass all of Title 1 – Subtitle E. Health Services for Urban Indians. Notably the following section of that title, has not been implemented and requires IHS attention to make available funds for minor renovations to facilities or construction or expansion of facilities, including leased facilities. A \$2 billion increase is sought in the HCFC line item for its implementation.

- § 1659. Facilities renovation (Urban Facilities)
2. Sanitation Facilities Construction (SFC) **+\$2.6 billion** (628% increase)

The second priority addresses essential sanitation facilities including water supply, sewage, and solid waste disposal facilities necessary for AIAN homes and communities. Projects are cooperatively developed with and transferred to Tribes which in turn assume responsibility for the operation of these systems and related support facilities. Phoenix Area Tribes/UIOs request the full amount noted in the SFC back-log for existing AI/AN Homes and/or Communities at the end of year 2019 of which there were over 110,000 AI/AN homes that needed some form of sanitation facility improvement.

§ 1632. Safe water and sanitary waste disposal facilities

3. Maintenance & Improvement **+\$1.14 billion** (239% increase)

This line item funds the on-going maintenance and improvement of IHS and Tribal health care facilities to maintain quality in older facilities. The program increase is based on priorities the Tribes in the Phoenix Area seek for the national budget which builds on the amount from the FY 2022 Tribal Recommendation of \$478.9 million for this line item. The following program increases are requested:

- +\$1.12 billion (\$767 million for the Backlog of Essential Maintenance Alteration and Repair (BEMAR) for deferred projects, plus an estimated \$300 million using a 4% Cost Replacement Value (CRV) formula to address maintenance and repair, plus \$75 million for the estimated funding needed for routine, non-routine and preventive maintenance.
- + \$12 million for Long Term Care facilities
- + \$10 million for Small Tribes

+ \$750,000 (PIMC OB Labor & Delivery Department)

The authorities provided by the Indian Health Facilities Act of 1957 (Public Law 85-151) pertain to this line item.

**Deliverable #3 – Hot Issues**

FY 2020 – FY 2023

(See Attachment)

**Deliverable #4 – Area Representatives**

(See Attachment)

**Deliverable #5 – Area Report Presentation**

(See Attachment)

# **Portland Area Indian Health Service**

## **FY 2023 Budget Formulation Narrative**

## Portland Area IHS Budget Formulation Representatives

### Tribal Representatives

Steve Kutz, Cowlitz Indian Tribe, Primary Representative, NPAIHB Delegate  
Andy Joseph, Jr., The Confederated Tribes of the Colville Reservation, Alternate Representative, NPAIHB Delegate

### Technical Representative: Northwest Portland Area Indian Health Board

Laura Platero, Executive Director

### IHS Representatives

CAPT Ann Arnett, Executive Officer  
Nichole Swanberg, Director, Division of Financial Management

## Consultation

Portland Area IHS held a virtual consultative meeting on November 5, 2020 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 2023 budget recommendations were established, as highlighted below:

## Summary of FY 2023 Budget Recommendations

The national budget mark for FY 2023 is a full funding request of \$48 billion, which includes the FY 2022 National Tribal Budget Workgroup recommendation of \$12.759 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 National Budget Recommendation Summary (Dollars in Thousands)	
Program	National FY 2023 Recommendation \$48 Billion
FY 2022 National Tribal Budget Recommendation	12,759,004
Purchased and Referred Care	21,690,786
Public Health	1,000
CHAP Expansion	659,938
Affordable Care Act, Indian Healthcare Improvement Act and Long Term Care	3,260,591
Workforce Development	1,000,000
Restoration of Pay Act	1,626,528
Facilities	1,759,268
Regional Referral Center	973,542
Information Technology & Electronic Health Records	493,804
Behavioral Health	3,313,068
EPI Center	462,471
<i>Total Program Increases</i>	<i>48,000,000</i>

## 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.

## **Program Increases**

### Purchased/Referred Care

Portland Area IHS recommends a \$21.69 billion increase to the Purchased/Referred Care (PRC) program. Portland Area IHS does not have hospitals or specialty care centers. 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 (IHCIA).

### Public Health

Portland Area recommends a \$1 million increase to the Environmental Health (EH) program. The EH Program addresses environmental determinants of health in AI/AN communities in order to protect and improve public health and quality of life. Healthy environments where we live, learn, work, and play are recognized as a vital factor in a person's overall health and well-being. The EH program includes community environmental and public health services, injury prevention support activities, and clinical and occupational environmental health services. More funding is needed to provide broader environmental public health services to tribal communities to address other environmental health needs (e.g., climate change, water issues, etc.) and to build the public health capacity of tribes.

### Community Health Aide Program Expansion

Portland Area IHS recommends a \$660 million increase to expand the Community Health Aide Program (CHAP), separate from the Community Health Representative (CHR) budget line. CHAP is authorized in the IHCIA under Section 111. Portland CHRs are part of the direct provision of health services and are authorized under IHCIA Section 165.

### Affordable Care Act, Indian Health Care Improvement Act and Long-Term Care

The Affordable Care Act (ACA) includes amendments and a permanent reauthorization of the IHCIA. Both the ACA and IHCIA include authorities that benefit IHS, Tribal, and Urban (I/T/U) Indian health programs. The IHCIA also provides authority to develop a grant program for technologically innovative approaches to assess, prevent and treat youth suicide. Included in the \$3.2 billion increase is funding to further implement the ACA and carry out new IHCIA authorities, \$1.2 billion is allocated to the Urban Indian Health budget line to allow Urban Indian Organizations to purchase insurance for their users. Portland Area IHS recommends a \$159 million increase in preventive health for education and grant programs directed towards prevention, per the IHCIA, Section 111.

IHCIA Section 124 provides authority for IHS to carry out hospice care, long-term care, assisted living, and home and community based services in tribal communities. There is additional need for facilities and infrastructure to comprehensively support these types of programs, which can be cost prohibitive. Portland Area recommends developing long-term care programs with staffing. Carrying out home and community based services, that are reimbursable under Medicaid and through qualified health plans on the insurance marketplace will allow these programs to become self-sustaining without major investments in facilities.

#### Workforce Development

IHCIA Sections 127, 165, 193, 705, 710, 712, 713, 714, authorize the IHS scholarship, loan repayment, and health professions training programs to recruit and retain health professionals to provide high-quality primary care and clinical preventive services to American Indians and Alaska Natives (AI/AN). Portland Area IHS recommends a \$1 billion increase to address chronic and pervasive health care provider shortages.

#### Restore Pay Act Increases

Portland Area IHS recommends an additional \$1.6 billion to restore past-years' unfunded pay costs resulting from a federal moratorium on Pay Act increases. Competitive compensation is required for IHS and tribes to retain employees. Reductions under sequestration in FY 2013 have not been fully restored, further eroding the purchasing power of the agency. Nationally, there is increased competition to recruit and retain qualified and competent providers, creating an increased need for recruitment and retention pay, as well as, additional market pay to attract applicants.

#### Facilities

Portland Area recognizes that past-years' budgets have not included increases necessary to address the ongoing backlog of facilities infrastructure. Recommended increases are \$1 billion in Maintenance & Improvements, \$484 million for the Sanitation and Facilities program and \$237 million for Equipment.

#### Regional Specialty Referral Center

Portland Area recommends a \$64 million increase in Health Care Facility Construction to fund a Regional Specialty Referral Center under IHCIA, Section 134, Indian Health Care Delivery Demonstration Projects. The Area is also requesting an additional \$128 million in Hospitals and Health Clinics for a staffing package, \$63 million in the Facility Support Account for operations and \$157 million in Medical Equipment. The current IHS Healthcare Facilities Construction Priority System does not provide a mechanism for funding regional specialty referral centers. The Portland Area Facilities Advisory Committee recommends that the first specialty referral center be constructed as a demonstration project for tribes to test alternative health care models and means.

#### Health Information Technology (HIT) Modernization

RPMS is now a legacy system and is inconsistent with emerging architectural standards and unable to meet evolving needs. Portland Area recognizes that the Veterans Administration's (VA) decision to move to a new HIT solution will create a gap for the parts of RPMS that are dependent on core coding from the VA. Substantial investment in IT infrastructure and software is needed to maintain RPMS or transition to another system. Portland Area recommends a \$494 million increase to the Electronic Health Records System fund to cover this initiative. Software replacement requires features to integrate behavioral health and interoperability to work with standardized Health Information Exchange (HIE) platforms to ensure seamless data sharing across health systems. Tribes also request inclusion and support for Tribes who have already transitioned to a commercial off-the-shelf system for upgrades and maintenance costs.

#### Behavioral Health

The provisions of IHClA allow for many expansions to the behavioral health programs which have not received substantial funding since enacted. The Portland Area recommends a \$1.6 billion increase in each of the Mental Health and Alcohol & Substance Abuse line items. Funding increases would be used to implement IHClA 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 IHClA 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 Indian youth suicide. In addition, funding must support youth inpatient and outpatient treatment services for both mental health and inpatient care.

### Tribal Epidemiology Centers

Portland Area IHS recommends an increase of \$462 million, in Hospitals & Health Clinics, for the twelve (12) nationwide Tribal Epidemiology Centers (TECs) to conduct the culturally attuned research, data, and evaluation services as defined in 25 USC § 1621m. TECs manage public health information systems, investigate diseases of concern, manage disease prevention and control programs, respond to public health emergencies, and coordinate activities with other public health authorities.

## **Portland Area IHS Health Statistics**

### Cancer

In the Portland Area, cancer is the leading cause of death for AI/AN aged 55-64 and the second leading cause of death for AI/ANs of all ages. AI/AN cancer mortality rates are approximately 1.3 times higher compared to non-AI/AN 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). In 2018, less than 30% of Portland Area IHS patients received age-appropriate breast, cervical and colorectal cancer screenings. One factor contributing to these disparities is limited access to cancer screening.

### Behavioral Health

#### a. Mental Health and Suicide Prevention

According to the 2014 trends in Indian Health, in comparison to other US races, AI/AN have a 60% greater chance of suicide. Suicide is the 7<sup>th</sup> leading cause of death among AI/AN in the Portland Area and accounts for 3.5% of all deaths among AI/AN. Suicide mortality rates for AI/AN are 60% higher compared to non-AI/AN in the region. AI/AN suicide mortality in the age group 10-29 is 2-3 times greater than that for non-AI/AN. AI/AN in the northwest are more likely to report depression or poor mental health than non-Hispanic whites. Over 30% of adult AI/AN in the Northwest report having been diagnosed with depression. AI/AN 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.

#### b. Alcohol and Substance Use Disorders

In the Portland Area, AI/ANs are more than 3.5 times more likely to die from alcohol-related causes than non-AI/AN, and almost 2.5 times likely to die from a drug overdose than non-AI/ANs. Opioids are involved in almost 70% of AI/AN overdose deaths, and methamphetamine is involved in over 30% of AI/AN overdose deaths in the Northwest.

#### c. 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. It's widely accepted that these statistics do not accurately portray the extent of the sexual violence against AI/AN women.

#### d. Trauma

Up to 74% of AI/AN youth have experienced at least one traumatic event during childhood. AI/ANs are 2-3 times more likely to meet Post Traumatic Stress Disorder (PTSD) criteria compared to the US adult population. AI/ANs 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.

#### Diabetes

In the Portland Area, approximately 13% of AI/AN adults report having been diagnosed with diabetes. AI/ANs have twice the rate of avoidable hospitalizations for diabetes compared to non-Hispanic whites. Diabetes mortality rates for AI/ANs are twice the rate of non-AI/ANs 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/ANs 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.

#### Injury Prevention

Unintentional injuries are the leading cause of death for AI/ANs from age 1 to 44, and the third leading cause of death overall for AI/ANs in the Portland Area. The age adjusted unintentional injury death rate for Northwest AI/ANs was 2.2 times the rate for non-AI/ANs during 2014-2016. In the Portland Area, during 2014-2016, the leading causes of AI/AN unintentional injury deaths were motor vehicles (38%), falls (29%), accidental poisoning/overdose (27%) and accidental drowning (3%).

#### Cardiovascular, Heart Disease and Stroke

The prevalence of risk factors for cardiovascular disease (CVD) among AI/ANs 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 in the Portland Area. AI/AN mortality rates from major cardiovascular diseases, including stroke, are 1.6 times higher compared to non-AI/ANs 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.

#### Health Promotion/Disease Prevention and Childhood Obesity

Two in five AI/AN children are overweight, and over 35% of AI/AN adults are obese.

Approximately 30% of AI/AN adults in the Northwest report being a current cigarette smoker. In 2018, 38% of AI/AN 12<sup>th</sup> graders in Washington reported using a vapor product in the past 30

days, the highest of all race/ethnicity groups in the state. Approximately 7% of AI/AN adults in Oregon report being a current e-cigarette user.

In the Northwest, childhood immunization rates have declined over the past decade and are currently among the lowest in IHS.

### Oral Health

Nationally, untreated tooth decay among AI/AN children is four times that of white children in the US. More than 1 out of 3 AI/AN children (37%) between 1-5 years of age have untreated decay. Almost 40% of AI/AN 2-year olds have experienced tooth decay, indicating the need for early prevention efforts.

Nationally, 66% of adolescent (ages 13-15) IHS patients have experienced tooth decay and 53% have untreated tooth decay. AI/AN dental patients are more than twice as likely to have untreated tooth decay compared to the general US population and are more likely to report poor oral health, mouth pain, and food avoidance due to mouth problems.

### Elder Health – Long Term Care

The treatment and medication management that is unique to the elder population requires development of specialized geriatric capabilities within the I/T/U health care system. The care of elders is a culturally inherent trait for AI/ANs that provides an important part of maintaining cultural knowledge and wisdom to strengthen families and communities. Portland Area Tribes agree that, with the expanded authority of Long Term Care under IHCA Section 124, Long Term Care needs to be fully funded.

### Maternal Child Health

Infant mortality rates among Northwest AI/AN are decreasing over time, but remain higher than regional averages. Causes of death and risk factors for infant mortality within the Northwest AI/AN population include birth defects, Sudden Infant Death Syndrome (SIDS) and unintentional injuries. Nationally, AI/AN women are 1.8 times more likely to die from pregnancy-related complications than white women. AI/ANs experience some of the highest disparities in infant mortality in light of current medical and public health interventions within the Portland Area and across the country. Chronic maternal stress and acute life events during pregnancy may contribute to the racial disparity in infant mortality. Analyses of the Washington and Oregon Pregnancy Risk Assessment Monitoring Survey (PRAMS) data show a greater proportion of AI/AN women reported each stressor in the PRAMS survey (partner, emotional, traumatic or financial-related) compared to white women, and were over two times more likely to experience five or more stressful life events during pregnancy than white women.

The rates of fetal and neonatal death, low birth weight, and babies born with developmental problems are also far higher among AI/AN women than the general US population. Another challenge facing AI/AN programs is the higher incidence of infants born to mothers abusing opioids with AI/AN children having up to 3 times the risk of developing neonatal abstinence syndrome resulting in higher costs for initial care and potential for negative health outcomes in the future.

### Liver Disease

Chronic liver disease is the 5<sup>th</sup> leading cause of death among AI/ANs in the Northwest. AI/ANs are 4 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 CLD than whites. In the Portland Area, AI/ANs have 2 to 4.5 times the risk of dying from hepatitis C compared to non-Hispanic whites.

### Other Communicable Diseases

In 2016, 8.7% of AI/AN hospitalizations were due to infectious causes, compared to 6.4% for non-AI/ANs. AI/ANs are 1.6 times more likely to die from influenza and pneumonia compared to non-AI/ANs in the region. In 2017, AI/ANs in the Northwest were 2.6 times more likely to be diagnosed with chlamydia than Whites in the region. AI/AN women are especially vulnerable for chlamydia infections, and are diagnosed at over 3 times the rate of their male counterparts. In 2017, Northwest AI/ANs were 3 times more likely to be diagnosed with gonorrhea than the general population.

In 2017, about 200 AI/ANs were living with HIV/AIDS in the Northwest. While the prevalence of HIV for AI/ANs was relatively lower, Northwest AI/ANs were 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. These disparities point to the need for expanded prevention and treatment services, particularly for vulnerable groups such as persons who identify as LGBTQ2S and persons who inject drugs.

The COVID-19 pandemic has disproportionately affected AI/AN communities in the Northwest and nationwide. AI/AN people are at higher risk for COVID-19 infection, illness, and death due to disparities in access to quality health care, underlying health conditions, and socio-economic factors such as housing, employment, and community infrastructure. Nationally, AI/AN people experience COVID-19 infection rates that are 2.5-3.5 times higher compared to non-Hispanic Whites. COVID-19 death rates are estimated to be up to 80% higher for AI/AN people compared to non-Hispanic Whites. In the Northwest, the ongoing pandemic appears to be exacerbating the burden of mental health and substance use disorders among AI/AN people. The pandemic has exposed the need for continued investment of core public health, primary care, and behavioral health infrastructure in tribal communities.

A 1991 study of AI/AN women in a Tribe in Washington State found the prevalence of rheumatoid arthritis to be 3.4% (compared to 1.5 % in women overall in the US population). Overall, AI/ANs experience not only higher rates of rheumatic diseases but tend to have more severe forms of disease and onset at younger ages.

### **Conclusion**

The budget request outlined in this document represents a consultative process that began many years ago between Portland Area Indian Health Service, 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 recommendations fund initiatives to address the health disparities that exists for AI/ANs.

Fully funding the budget will further the goal of the IHS and the Portland Area Tribes to elevate the health status of AI/ANs.

INDIAN HEALTH SERVICE  
FY 2023 TUCSON Area Budget Formulation Session

**Deliverable 2 - Budget Narrative / Justification**

The Tucson Area is submitting a National Budget Increase as requested by the Tribal Budget Formulation Work-group at the 276% level over the FY 2022 National Budget Recommendations to achieve National Needs Based Funding amount of \$35 Billion by 2031. The Tucson Area Office (TAO), Tohono O’odham Nation (TON), Pascua Yaqui Tribe (PYT) and the Tucson Indian Center (TIC) recommends program increase be distributed among the Tucson Area’s Top Budget Funding Priorities.

The Tucson Area is the second Area to become predominately Self Governance within Indian Health Service.

The Tucson Area budget priorities are Purchased/Referred Care, Hospital & Health Clinics, Health Care Facilities Construction, New/Replacement Equipment, Mental Health, Community Health Based Programs, Alcohol & Substance Abuse, Urban Program Services and Facilities, Long-Term Care/Assisted Services and Sanitation Facilities Construction.

The Tucson Area is submitting a National Budget at the 276% increase over the FY 2022 National Budget Recommendations and strongly recommends the Indian Health Service budget allocation be changed from discretionary appropriations to mandatory entitlements and to Advance Appropriations.

**TOP BUDGET PRIORITIES AND INCREASES**

**1. Purchased/Referred Care (PRC) +\$9.8 Billion**

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. Needs for the Tucson Area regarding intervention, treatment, and prevention of commonly occurring diseases, such as diabetes, cancer, arthritis, hepatitis C, and HIV have not decreased. Continued uncertainty regarding the constitutionality of the Affordable Care Act of 2010 has made forecasting medical care cost difficult to project based upon the fluctuation of health insurance rates. In addition, the designation of Arizona as a state-wide PRCDA would also have a large impact on PRC expenditures. In order to ensure that the health care services provided to American Indians living on the reservation are not curtailed, additional funding would be required. Increased funding would be necessary not only to pay for services provided to newly eligible PRC patients, but also for new staff to address the additional workload. It is extremely important for federal and state agencies to respect the government-to-government relationship through consultation with Tribes as a failure to do so has adverse effects on access to care and the overall ability to provide quality healthcare services.

**2. Hospitals & Health Clinics (H&HC) +\$4.9 Billion**

<u>Dental</u>	<u>+\$1.4 Billion</u>
<u>Equipment</u>	<u>+\$1.4 Billion</u>

The Tucson Area recommends an increase of \$7.7 Billion to maintain current and expand new services under the new provisions of the IHCA. Access to quality health care requires an increase in H&HC funding. Additional H&HC funding would support expanding services in the IHCA (Sections 112, 123, and 124), which were authorized without appropriations. The number one health priority continues to be the prevention and treatment of Type 2 Diabetes

and the promotion of healthy lifestyles. SDPI funding has not been sufficient and may not be available if not reauthorized to address all the health problems such as amputations, blindness, end stage kidney disease and cardiovascular disease caused by Type 2 Diabetes.

Equipment upgrades are needed throughout our facilities. Department areas of increased importance needing equipment are: Emergency Room, Podiatry Department, Dental, and Nursing to name but a few.

3. Health Care Facilities Construction +\$3.5 Billion

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 2022. 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 (version dated: March 5, 2020). We also recommend funding of \$450,000 for the Tohono O'odham Nation to develop a Program Justification Document (PJD) to determine cost for the replacement of San Xavier and Santa Rosa Health Centers that are greater than 65 years old and not on the I.H.S. Health Care Facilities Planned Construction Budget priority list. Outdated facilities prevent our members from receiving the care that they need and deserve.

4. New/Replacement Equipment +\$2.8 Billion

Tucson Area recommends increasing funds for new and replacement equipment in order to provide quality medical service to diagnose and treat certain medical illnesses. Bio-medical life expectancy of current equipment has been surpassed and does not meet current 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 licensure, LAN connectivity, and communication systems.

5. Mental Health (MH) +\$2.8 Billion

Additional funding of \$2.8 Billion is necessary to address the mental health needs for treating and expanding services. The additional increase would fund the new provisions in the IHCI (Sections. 707, 708, 710, and 712) such as: Comprehensive Behavioral Health and Treatment Programs, Fetal Alcohol Spectrum Disorders Programs, Long-Term Treatment Programs for Women and Youth. Current State Reimbursement Rates are inadequate for small programs to be self-sustaining and must be supplemented with tribal funds. Additional funds would enable the social-behavioral workforce to better serve the population, provide adequate behavioral health training and community educational programs.

The recent increases in behavioral health funding has only been allocated through limited time sensitive competitive grants. There are time constraints in the grant process to award funding which creates a barrier to address behavioral health crisis and interventions. Due to limited services available, many individuals are not able to receive timely services for mental illness or emotional disorders and may self-treat by using or abusing alcohol or drugs. American Indians and Alaska Natives fall victim to violence crime at more than double the rate of all

other U.S. citizens and at least 70% of violent victimization experienced by American Indians and Alaskan Natives is committed by non-Native and usually while they are 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 increases the risk for numerous public health and social issues: young age, low income, low academic achievement, unemployment as well as a numerous other factors. The State of Arizona Chapter 14 Title 13 Criminal Code recognizes that adolescents can be charged for an array of sexual misconduct, yet, do not have adequate services available. In the State of Arizona there are no facilities to specifically address the needs of high risk youth behavioral issues, which require costly out of state treatment.

We recommend direct funding to implement new specialized providers, therapists, clinicians and physicians to enhance services which include developing interventions for pre and post suicidal preventive programming. An increased budget allocation will establish an after-hour on-call crisis team, recruit case managers and develop a referral system for inpatient treatment, medical detox, and psychiatric hospitalization. Additional funds would be used to hire psychiatric providers and cover the cost of psychiatric medication for uninsured individuals and out of state treatment for youth.

6. Community Health Based Programs +\$2.1 Billion

Community Health Representatives (CHR) provide an array of community based services that target hard to reach medically underserved populations. The ultimate goal is to decrease the impact of future hospital/medical care costs and reduce readmissions. Current funds do not support our efforts. With the continuous shortage of PHNs, the CHRs fill the gaps that are critical to address the population's health needs in rural areas. The Association of State and Territorial Directors of Nursing (2008), recommends to establish a standard national Public Health Nurse to population of 1 Public Health Nurse to 5,000/population. This standard is not being met.

The Tucson Area recommends additional funds to support and expand CHR programs. CHRs are instrumental in providing preventative health screening services, wound care, community health education, delivery of medications, food handler training, home visits and the advocates for all health promotion and outreach. Without the fundamental services CHRs provide, Native Americans right to quality 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. CHR's are more likely to be trusted members of the community. The CHR model continues to work for Tohono O'odham Nation because it is rooted in the understanding that CHR's know their communities best and is a holistic approach to healing.

**The Tucson Area does not support the Administration's recent attempts to defund and eliminate the CHR Program for the past 3 years. These actions by the Administration are unacceptable.**

7. Alcohol & Substance Abuse (ASA) +\$2.1 Billion

Tucson Area recommends a budget increase of \$2.1 Billion to expand current services and fund new programs related to Behavioral Health under the IHCA (Section 127). The high prevalence of Alcohol & Substance Abuse such as the opioid epidemic, which contributes to

suicides and violence within the communities. Funding will expand the scope of treatment, establish group homes, inpatient treatment facilities and increase clinicians and case managers. Surgeon General's report on alcohol and substance abuse (November, 2016) stated that "90% of people with substance abuse disorder are not getting treatment". Drug overdose deaths from opioid misuse are of significant concern to tribal communities. According to SAMHSA's Treatment Episode Data Set (TEDS), in 2012 there were about 1.7 million individuals admitted to substance use treatment facilities. Of these, 43,572 (2.5%) were American Indians and Alaska Native individuals admitted reported alcohol misuse. Twenty-three percent of the American Indian and Alaska Native admissions were ages 15 to 24 ages, and among this group, 68.5% (6,885) reported alcohol misuse. Among this group, individuals who were admitted and misused alcohol only 80.5% (21,008) of them reported being first intoxicated at age 17 year or younger. 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 +\$1.0 Billion

According to the 2010 US Census ACS and Indian Health Service National Urban Indian Health Needs Assessment, the Tucson Urban American Indian Population has grown significantly to 44,000 citizens. The health disparities within this population continues to increase, with health priorities that include diabetes and pre-diabetes, behavioral health, arthritis, and asthma. Additional funding would be utilized to implement new health activities to include primary care, behavioral health and community health programs that are desperately needed to meet the needs of the population (IHCIA Section 164). It is also important for safety, accessibility, etc., to note that current funding does not support all necessary building improvements in order to maintain and expand services.

9. Long Term Care/Assisted Living Services +\$704 Million

The Tucson Area request new funding to implement Long Term Care and Assisted Living Services (IHCIA Section 124). The existing services on the Tohono O'odham Nation have limited capacity for assisted living and ancillary support services; the dire need for funding is required to cover and maintain services for the increasing elder population. The Pascua Yaqui Tribe is projected to have a limited long-term health care facility by February 2021. Most importantly, additional funding would allow an increase in case management and in-home support services, allowing elders and vulnerable adults to maintain their independence.

Since 2010, statistics from the National Data Base Warehouse show there has been a significant number of registrants 55 years and older with increases of 38% for Tohono O'odham Nation and 75% for Pascua Yaqui Tribe.

10. Sanitation Facilities Construction +\$2.4 Billion

The Tucson Area requests additional SFC funding to continue meeting the backlog of projects for Essential Water and Sewer needs in consultation with Indian Communities. The Tohono O'odham Nation is the second largest reservation in the United States in both population and geographical size, with a land base of 2.8 million acres and 4,460 square miles, approximately the size of the State of Connecticut. Most communities are in remote rural areas with challenges to providing access to clean water and sanitation facilities. Currently there are 39 homes that lack access to safe water or adequate sewer. In addition, there are five homes that obtain water from sources that exceed the maximum contaminate levels for primary contaminates set by EPA. Of the previously mentioned 39 homes, all 39 are identified on the FY 2020 Sanitation Deficiency System (SDS) list that have no indoor plumbing or adequate sewer; water must be hauled and pit privies used for wastewater disposal).

Indian Health Service  
FY 2023 National Tribal Budget Formulation Work Session  
**Hot Issues Summary Document**

*Most Common Hot Issues*

- Special Diabetes Program For Indians
- CHR/CHAP Expansion
- Hepatitis C
- 105 (I) Lease Funding
- Electronic Health Records/Information Technology
- Recruitment and Retention
- Long Term Care/Elder Care

### **Alaska**

- Investing in Infrastructure
  - Sanitation Facilities
  - Climate Change
  - Joint Venture Construction Program
  - Small Ambulatory Grants Program
  - Maintenance & Improvement
  - Staff Housing
  - Health IT
- Investing in People
  - Workforce Development
- Investing in Programs and Building parity
  - Behavioral Health
  - Special Diabetes Program for Indians
  - Dental Services
  - Hepatitis C Treatment Funding Parity
  - Best Treatment
- Supporting the Continuum of Care
  - Long-term Care/Eldercare
  - Purchased and Referred Care
  - IHS Advance Appropriations

### **Great Plains**

- Planning, Staffing, and Construction of Substance Use Disorder Centers
- Health Professional Manpower Shortages
- Non-Medical/Medical Transportation Services
- Health Care Facilities Modernization
- Medical Equipment
- Young Child Wellness Services/Preventive Strategies
- Health Care System Telehealth

### **Nashville**

- Funding for Telehealth Resources

### **Albuquerque**

- Hospital and Clinics (H&C)
- Purchase/Referred Care
- H&C- EMS Support
- H&C EMS Maintenance and repairs for Ambulances
- Public Health Nursing
- Electronic Health Record System/Health Information Technology
- IHS Funding Transparency
- Public Health
- Zero Suicide Initiative
- Special Diabetes Program For Indians
- Methamphetamine and Suicide Prevention Initiative (MSPI)
- Domestic Violence Prevention Program (DVPI)
- Health Promotion/Prevention
- Dental Services
- Equipment
- Tribal Management Grants
- Long Term Care/Elder Care
- Self-Governance
- Indian Health Professionals
- Facilities & Environmental Health Support
- Tribal Detention Health Care Resources

### **Bemidji**

- Advanced appropriation for IHS
- Under Funding of IHS
- Funding for Urban Healthcare Programs
- OMB Rate for Medicare Services
- Recruitment and Retention
- Access to Reliable Data
- Construction Funding
- Long Term Care
- Alcohol / Substance Abuse
- EHR Modernization

### **Billings**

Continued on Back

- Public Health Education Anticipated impacts of COVID on User Pop and Workload data
- Funding Obligation for 105 (I) Lease Agreements
- Funding for Aftercare and Housing Programs
- Funding to reduce the Hepatitis C Influx
- Continued Funding for CHR Programs
- Constitutionality Challenges
- Special Diabetes Program for Indians (SDPI)
- Modernizing Health Information Technology
- Expand Group Payor Authorities for I/T/Us when Sponsoring Health Care Plans

## **Navajo**

- Emergency Medical Service
- PPE Supplies & PPE Service Unit Warehouse Capacity
- Public Health Emergency Preparedness and Epidemiology

## **Oklahoma City**

- Electronic Health Records Modernization
- Workforce Development
- Establishment of Special Cancer Program for Indians
- Joint Venture Construction Program (JVCP)
- Indian Health Grant Funding and Contract Support Costs
- Line Item Funding Flexibility
- Necessity for a Youth Regional Treatment Center
- 105(I) Lease Funding and Estimates
- Community Health Aide Program/Health Representatives Program
- Sanitation Deficiency System Guidance and Implementation
- Special Diabetes Program for Indians
- IHS Headquarters Centrally-Managed Funds
- Purchased and Referred Care Formula – “Access to Care” Issue

- COVID-19
- Suicide
- Community Health Aide Program
- Medicaid Expansion

## **California**

- Full backup generators
- Recruitment and retention
- 105(I) Lease funding

## **Phoenix**

- Full Funding for HIS/Indian Health Facilities
- IHCIA Elder Long Term Care, Assisted Living & Hospice Authorities
- IHCIA Behavioral Health Authorities – Funding through appropriations, not grants
- CHR, Health Education/new appropriations for National Community Health Aide Program (CHAP)
- Indian Health Professions/Mid-Level Providers (recruitment & retention)
- Telehealth/IT Infrastructure
- Traditional Healing (policy support, integration and complementary services)
- Extra Support for Small Tribes (H&C, M&I, Equipment)
- Maternal & Child Health (+PIMC OB Labor & Delivery)
- Rocky Mountain Spotted Fever (RMSF)/Animal Control
- 100% FMAP Coverage for Urban Indian Health, FTCA Coverage for Urban Indian Health
- IHCIA Construction Authorities (priority list, unmet construction needs in all areas, & urban facilities)

## **Portland**

- IHS Funding
- Medicaid and Medicare
- IHS Health IT Modernization
- Special Diabetes Program for Indians (SDPI)
- Mental Health & Substance Use Disorder (SUD)
- Focus on Prevention
- Community Health Aide Program (CHAP) Expansion
- Access to Treatment for Hepatitis C
- Public Health
- Regional Specialty Referral Center
- Staffing, Recruitment and Retention
- Urban Program Funding
- Environment and Health Effects

- OB/GYN Services
- Missing and Murdered Indigenous People (MMIP)
- Veteran's Administration Memorandum of Understanding (MOU)
- COVID-19 3rd Party Reimbursement Losses
- Tucson
- Urban Health facility Funding
- IT/EHR
- 105(l) Lease Funding
- Budget Allocations
- Cancer Prevention
- HIV/AIDS HEP C

### **Tucson**

- Mental Health – Suicide increases and coping with COVID19
- PRC – Discussion of Possible Statewide CHSDA
- Aging Health Facilities and IT/Telephone Infrastructure
- Staffing Quarters – Lack of housing for personnel
- Cancer Prevention
- Electronic Health Record System – Full Implementation
- Urban Health Facility Funding Section 161 as amended



# FY 2023 Area Tribal Budget Consultation *Oklahoma City Area* Report

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PRESENTED BY: *PRESIDENT TERRI PARTON, WICHITA AND  
AFFILIATED TRIBES*

DELIVERABLE TO BE SUBMITTED: *JANUARY 8, 2021*

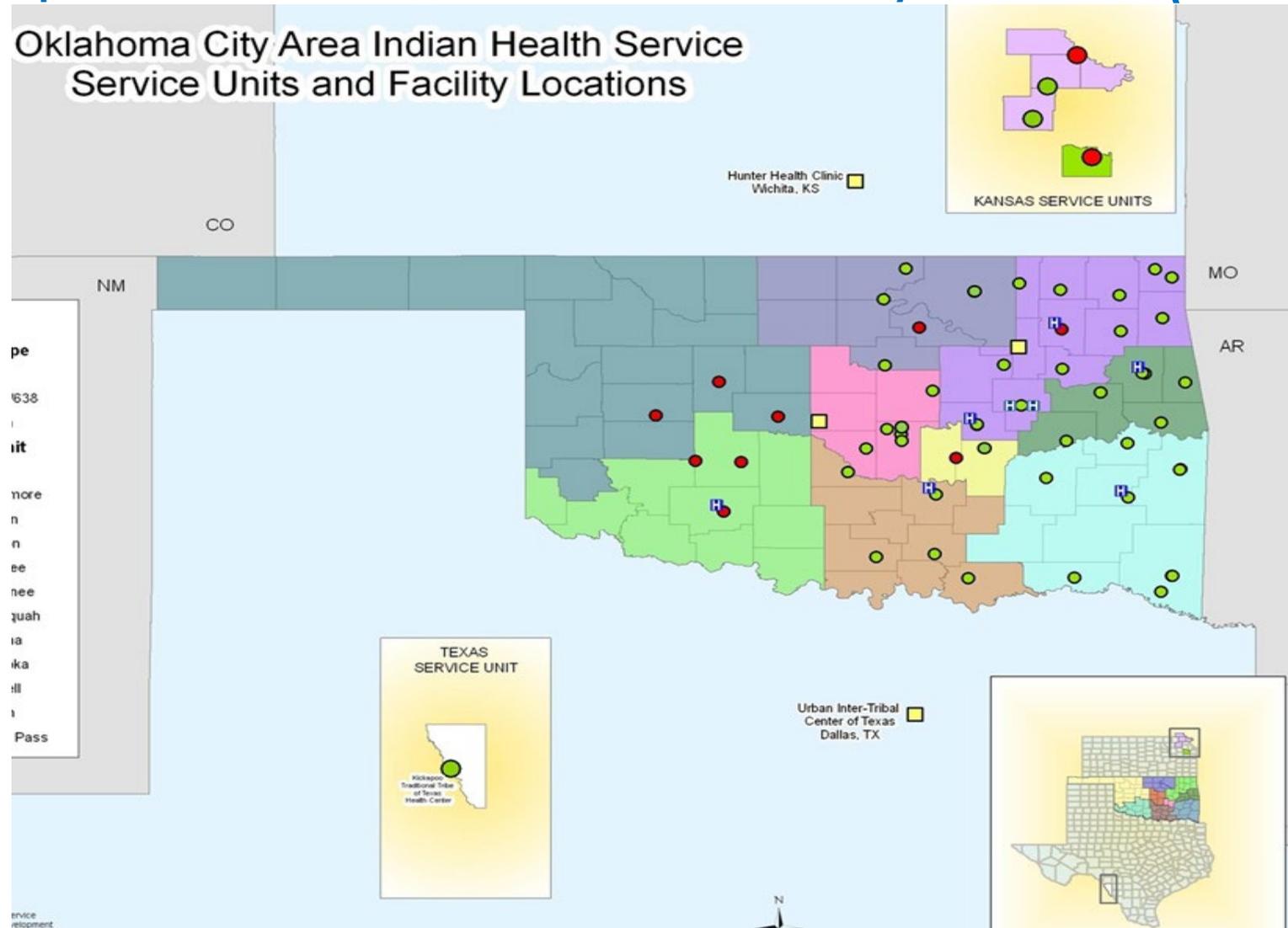
# Summary of Service Area and Demographic Information

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## **Oklahoma City Area**

- FY 2020 User Population is 391,776; the largest user population in IHS
- OCAIHS serves the states of Oklahoma, Kansas, parts of Texas and Richardson County, Nebraska
- Oklahoma City Area is home to 43 federally recognized Tribes
- There are 8 hospitals (2 are IHS operated and 6 Tribally Operated); 59 Health Centers with 5 located in urban cities.

# Map of the Oklahoma City Area (OCA)



# Summary of Funding Priorities

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## **Priority 1 - Indian Health Care Improvement Fund: \$21,144,598**

- ❖ To address the inadequate funding levels of Indian Health Service programs
- ❖ Lack of additional funding as user population and health disparities continue to rise

## **Priority 2 - Maintenance & Improvement: \$5,286,149**

- ❖ Average age of IHS facilities is 40 years
- ❖ Current funding level for M&I is dangerously low
- ❖ Failure to fully fund BEMAR impairs overall quality of and access to care

## **Priority 3 - Purchased Referred Care: \$5,286,149**

- ❖ Specifically to address disparity in PRC funding
- ❖ Decrease CHEF threshold per eligible case

## **Priority 4 - Hospitals and Health Clinics: \$3,171,690**

- ❖ To address critical staffing needs, rising Pharmaceutical costs, IT needs (EHR, Security Systems)
- ❖ No increases in funding to support growing user population (reprogramming)
- ❖ Health Information Technology

## **Priority 5 – Urban Health: \$352,410**

- ❖ Inadequate levels of funding
- ❖ To address rising Urban patient populations

# Hot Issues

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Hot Topic 1: EHR/HIT

Hot Topic 2: Workforce Development

Hot Topic 3: Cancer Program for Indians

Hot Topic 4: JVCP Update

Hot Topic 5: Indian Health Grant Funding and CSC

Hot Topic 6: IHS Operated Funding Flexibility

Hot Topic 7: YRTC for Oklahoma

Hot Topic 8: 105(I) Leases

# Hot Issues (cont.)

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Hot Topic 9: CHAP, not to replace CHR

Hot Topic 10: SDS Guidance and Implementation

Hot Topic 11: SDPI

Hot Topic 12: IHS Headquarters Centrally-Managed Funds

Hot Topic 13: Purchased and Referred Care Formula –  
“Access to Care” Issue

# FY 2023 Area Tribal Budget Consultation *Albuquerque Area*

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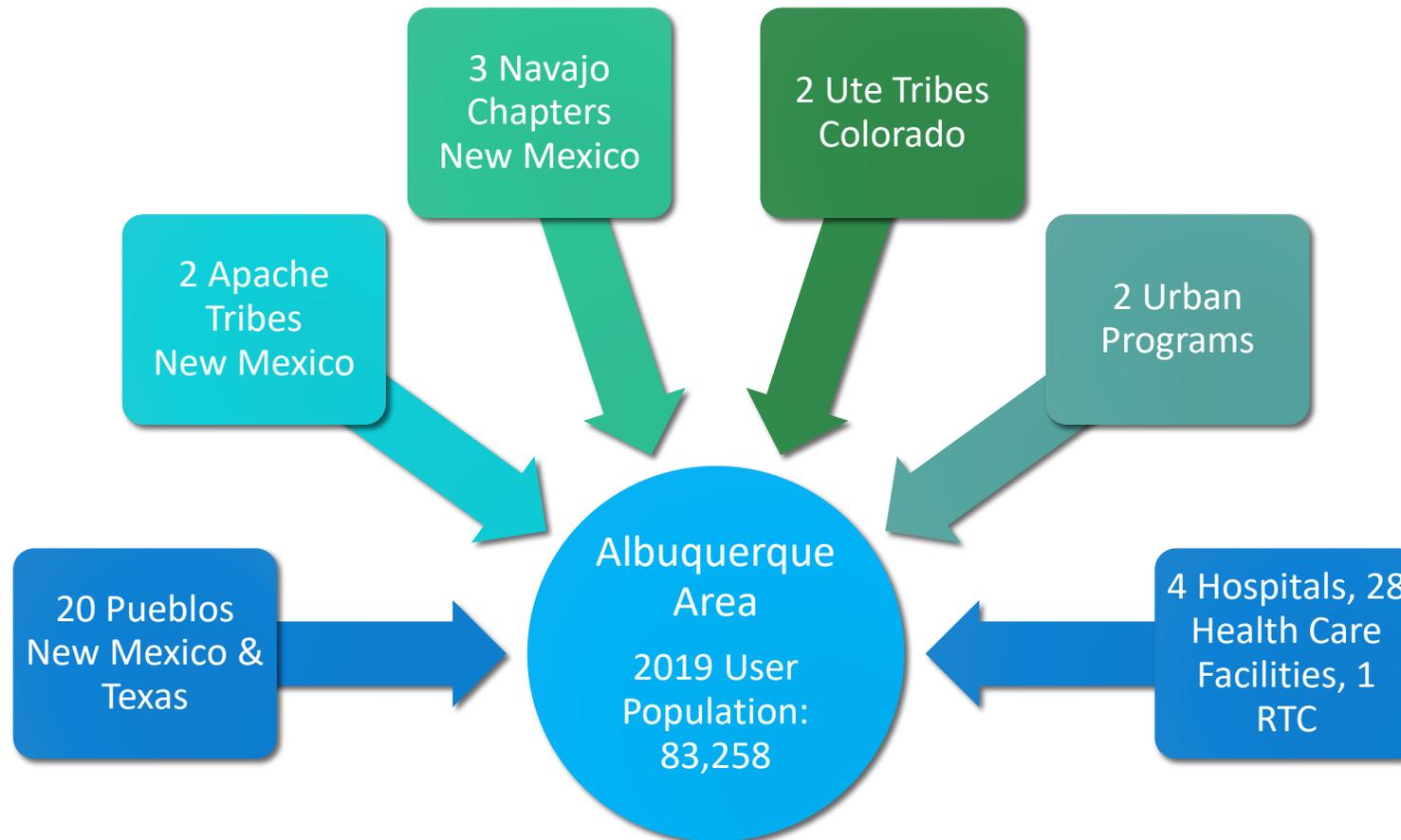
PRESENTED BY:

BEVERLY COHO, RAMAH NAVAJO CHAPTER RNSB,  
INC. PRESIDENT; AAIHB INC. VICE PRESIDENT  
RAY TAFOYA, BOARD TREASURER KEWA PUEBLO  
HEALTH CORPORATION

# Summary of Service Area and Demographic Information



# Summary of Service Area and Demographic Information



# Summary of Funding Priorities

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Priority 1- H&HC: \$7,286,820,000

Priority 2- Mental Health: \$5,775,794,000

Priority 3- Purchased/Referred Care: \$4,927,387,000

Priority 4- Alcohol & Substance Abuse: \$3,559,431,000

Priority 5- Dental Services: \$2,558,402,000

Priority 6- Health Facilities Construction: \$2,222,222,000

# Hot Issues

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Hot Topic 1: Adequate funding for H & C to bring the IHS hospital delivery system up to a safer standard of care. Priority area to improve the delivery and quality of health care, reduce the high occurrence of health care disparities, and most importantly to retain the services including emergency rooms and inpatient services

Hot Topic 2: Inadequate EMS Resources

Hot Topic 3: Inadequate Mental Health Resources

Hot Topic 4: Fully Fund IHS

Hot Topic 5: Preserve IHClA

Hot Topic 6: Funding to address Public Health Emergencies

Hot Topic 7: Permanently authorize SDPI, MSPI, and Zero Suicide Initiative

# Success Stories

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\* The Albuquerque Area's Incident Command System (ICS) Team continues COVID incident management, response and mitigation efforts to prevent COVID infections in the Area's tribes, pueblos and the healthcare facilities that serve these communities. Noteworthy efforts include: supporting healthcare facility and community based testing; personal protective equipment allocations; Health Resources and Services Administration (HRSA) funding distributions; Centers for Disease Control and Prevention (CDC) field support; environmental health, safety and infection prevention consultation and assessments; continuous surveillance and monitoring; contact tracing and case monitoring; public health education; liaison outreach with federal, state and tribal entities; and COVID vaccine planning efforts. Additionally, the Area's Tribal Consultations serve as a way to provide additional information to leaders of the Area's Tribes and Pueblos. The Area's ICS Team actively works to engage and support the Urban and Tribal healthcare facilities with these efforts, as well as the IHS federal healthcare facilities that the serve the tribes and pueblos in the Albuquerque Area.

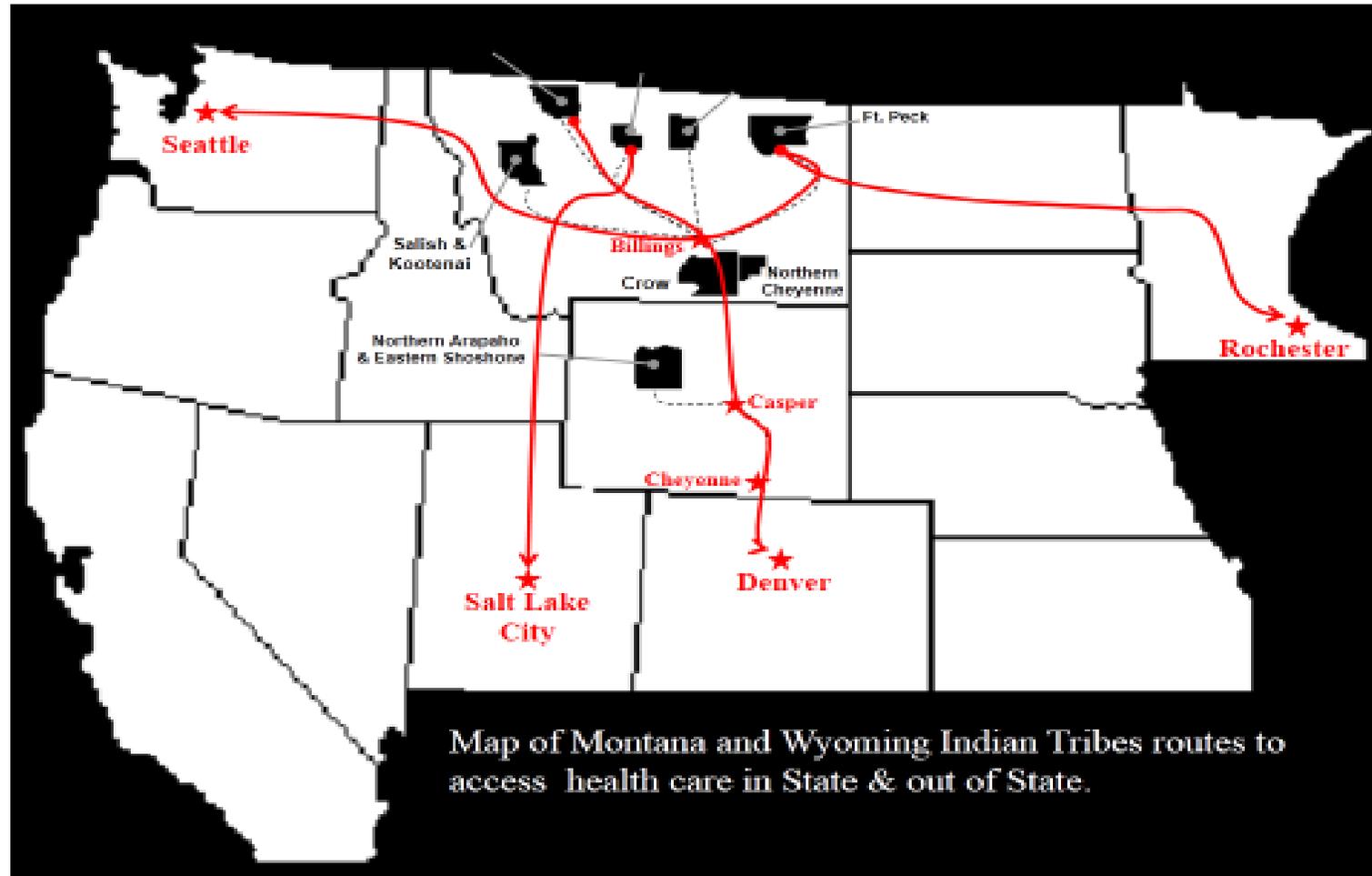
\* The Albuquerque Area's Cumulative Per Capita Testing significantly exceeds the All Races US Rate by 25 per hundred in the population.

# FY 2023 Area Tribal Budget Consultation *Billings Area* *Report*

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**PRESENTED BY: ANDREW WERK, JR., PRESIDENT,  
FORT BELKNAP INDIAN COMMUNITY**

# Billings Area Map



# Summary of Service Area and Demographic Information

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- ❖ FY 2019 **User Population** - Billings Area = **70, 219**
- ❖ The Billings Area consists of 8 Reservations – **Blackfeet, Crow, Fort Belknap, Fort Peck, Northern Cheyenne, Wind River (Eastern Shoshone/Northern Arapaho), Flathead and Rocky Boy**
- ❖ On December 20, 2019, the **Little Shell Tribe of Chippewa Indians** was federally recognized through Congressional Action. The Billings Area now has **10 Direct Service Tribes**.
- ❖ Seven (7) Title I ISDEAA Contracts (5 in Montana and 2 Wyoming)
- ❖ Two (2) Title V ISDEAA Self-Governance Tribes (Confederated Salish and Kootenai Tribes & Rocky Boy)
- ❖ There are five (5) Urban Health Centers in the Billings Area: **Helena, Great Falls, Billings, Missoula & Butte**
- ❖ There are three (3) Federally Operated Hospitals and several Satellite Clinics in the Billings Area

# Summary of Funding Priorities

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**Priority 1 - Mental Health: \$6,378,620**

- **Hot Topic: Suicide, COVID-19**

**Priority 2 - Alcohol & Substance Abuse: \$3,876,510**

**Priority 3 - Hospital & Clinics: \$6,836,753**

- **Hot Topic: Community Health Aide Program (CHAP), COVID-19**

**Priority 4 - Purchased/Referred Care: \$2,713,557**

**Priority 5 - Dental Services: \$3,629,823**

**Priority 6 - Public Health Nursing: \$2,713,557**

**Priority 7 - Community Health Representatives: \$2,819,280**

**Priority 8 - Urban Health: \$2,043,978**

**Priority 9 - Indian Health Care Improvement Fund: \$1,409,640**

**Priority 10 - Health Education: \$2,819,280**

# Hot Issues

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**Hot Topic 1: COVID-19**

**Hot Topic 2: Suicide**

**Hot Topic 3: Community Health Aide Program (CHAP)**

**Hot Topic 3: Wyoming Medicaid Expansion**

**Hot Topic 4: Veteran's Health**

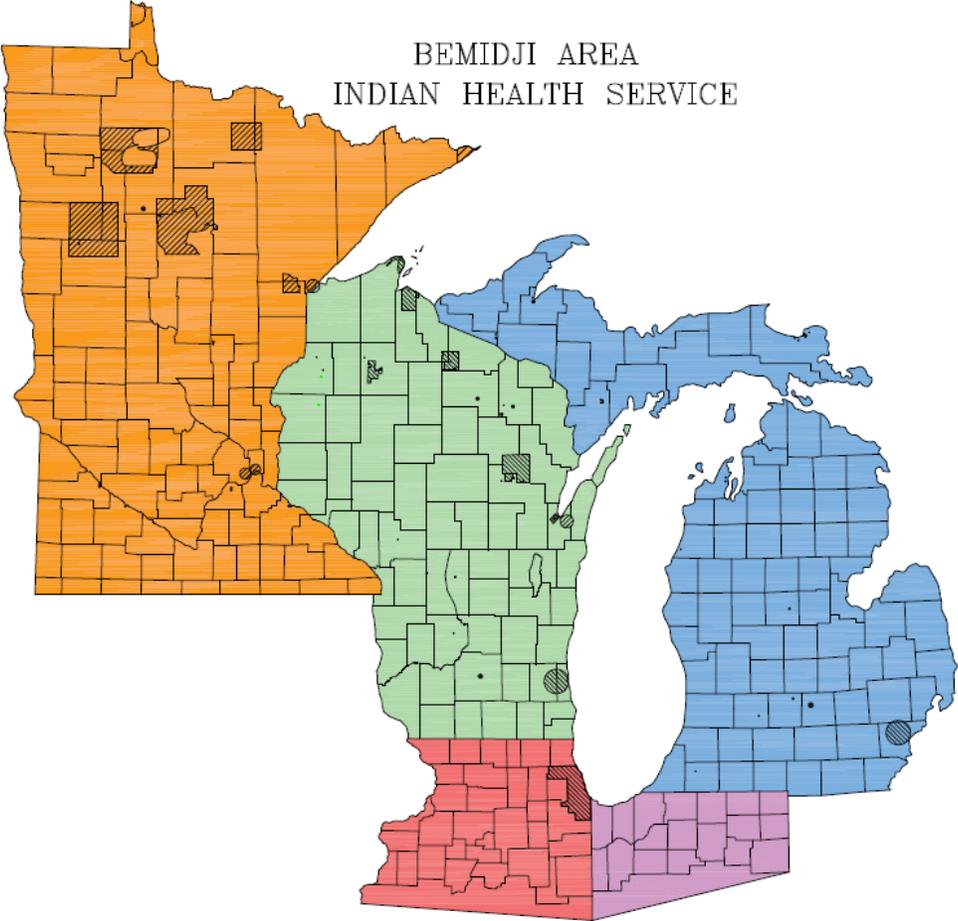
# FY 2023 Area Tribal Budget Consultation *Bemidji* *Report*

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PRESENTERS: *PHYLLIS DAVIS, MATCH-E-BE-NASH-SHE-WISH POTTAWATOMI*  
*AND*  
*CATHY CHAVERS, BOIS FORTE BAND OF CHIPPEWA INDIANS*

# Summary of Service Area and Demographic Information

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# Summary of Service Area and Demographic Information

## • **Bemidji Area**

Population: 104,932 (2020)

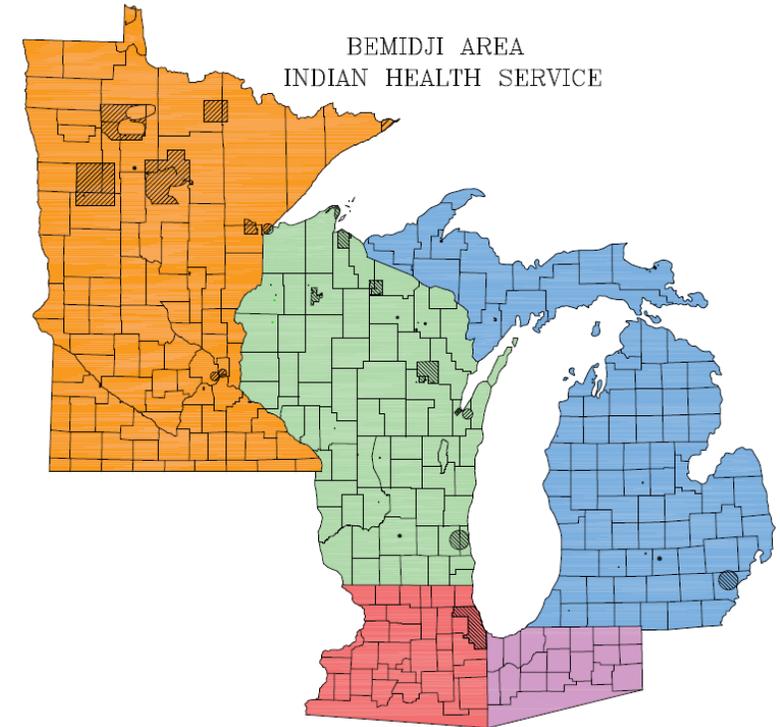
Tribes: 34 – 200-30,000 members

- 20 Title I
- 14 Title V
- 3 Federal Service Units: 2 Hospitals/1 Ambulatory Clinic

Urban facilities: 6

- Minneapolis, St Paul, Chicago, Detroit, Milwaukee (2)

Greater than 90% on average on GPRA Standards



# Summary of Funding Priorities

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## Priority 1- H H&C

\$4.484B

- Gives healthcare programs flexibility with unique treatments to reduce health disparities

## Priority 2- PRC

\$3.924B

- Access to advanced care is still needed and PRC funding increases will assist with this need

## Priority 3- Mental Health

\$2.432B

- Supports Section 127 of the IHClA as well as Sections 704 and 705 to address community issues

## Priority 4- Alcohol & Substance Abuse

\$2.008B

- Insufficient funding for psychiatry adolescent care & after-treatment care adds to increase opioids and drug relapses

## Priority 5- Dental

\$1.731B

- Current Bemidji Area funding level only allocates **\$20/individual** – typical costs \$50-350/visit

# Summary of Funding Priorities

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## Priority 6- Indian Health Care Fund

\$820M

- Assists with the unfunded need for disparities in cancer, diabetes, heart disease, suicide

## Priority 7- Electronic Health Record

\$750M

- Upgrade has been pending for many years, Tribes are purchasing system out of pocket to meet CMS guidelines.

## Priority 8- Urban Health

\$716M

- To align with authorized new programs and services of the ICHIA Title I-Subtitle E: Sec 164

## Priority 9- Community Health Representative

\$845M

- Greatly enhance the quality of life for the patients they service

## Priority 10 – Public Health Nursing

\$451M

- Early detection of disease and prevention will have enhanced outcomes for patients

# Summary of Funding Priorities

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Priority 11- Health Education	\$259M	0.7%
◦ Provides health information to providers and valuable wellness training to our communities		
Priority 12 - Direct Operations	\$ 2.8M	0.01%
◦ Assist with providing leadership due to dramatic increase of duties and obligations.		
Priority 13 - Self Governance	\$102,000	
◦ Critical to providing oversight of Tribal Self Governance Program and advocating tribes		
Priority 14 – Community Health	\$ 40M	
◦ Funding is instrumental with supporting Tribally-administered, culturally sensitivity programs		
Priority 15 – Tribal Grants Management	\$ 24,000	
◦ Funding is instrumental with supporting Tribally-administered, culturally sensitivity programs		

# Summary of Funding Priorities

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Priority 16 – Alaska Immunization Program \$ 16,000

- Need for immunizations in Alaska

Priority 17 – Maintenance & Improvement \$ 9.392B

- Assist in the start of eliminating the backlog of maintenance, repair, and improvements

Priority 18 – Sanitation Facilities Construction \$2.486B

- Increase in funds is greatly needed for water supply, sewage, and solid waste

Priority 19 – Hospitals and Clinics Facilities Construction \$3.53B

- Increase in funds is greatly needed

Priority 20 – Facilities Environment Health Support \$51.2M

- Supports personnel who provide facilities and environment health support

# Summary of Funding Priorities

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## Priority 21 – Equipment

\$401M

- Annual Replacement need per DOD transfers to IHS/Tribal Health Facilities exceed \$23M

## Priority 22 – Indian Health Care Improvement Act Scholarship \$ 917M

- Greatly enhance the ability to attract highly qualified providers. Current funding is less than private sector, which dramatically affects the number of qualified candidates received

# Hot Issues

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## Hot Topic 1: Advanced Appropriations for IHS

- Congressional Budget instability – Advanced Appropriations will minimize financial instability and enable long term planning

## Hot Topic 2: Under Funding of IHS

- Tribal programs are under funded and rely heavily on 3<sup>rd</sup> party funds/grants to establish stable budgets.

## Hot Topic 3: Funding for Urban Healthcare Programs

- Urban sites are under funded and rely heavily on grants which can be unstable.

# Hot Issues

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## Hot Topic 4: OMB Rate for Medicare Services

- Current discussion of Medicare-for-all could pave the way for the elimination of Medicaid program

## Hot Topic 5: Construction Funding

- Many tribal healthcare facilities are dated and in need of replacement. One Bemidji Area tribe is reporting the healthcare center was built on wet lands over 26 years ago and are experiencing unstable foundations and flooding. This is just one story albeit many more.

## Hot Topic 6: Recruitment and Retention

- I.H.S. loan repayment is not keeping pace with current standards.
- Data sharing among other federal agencies so HPSA scores are accurate
- Recruits are no-shows at regional and tribal events
- Additional funding to offer competitive wages for providers

# Hot Issues

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## Hot Topic 7: Access to Reliable Data

- Tribes are challenged with access to reliable data to improve quality healthcare in their facilities. Access to education, prevention, treatment and emergency funds are hindered by inadequate or undependable data.

## Hot Topic 8: Construction Funding

- Many tribal healthcare facilities are dated and in need of replacement. One Bemidji Area tribe is reporting the healthcare center was built on wet lands over 26 years ago and are experiencing unstable foundations and flooding. This is just one story albeit many more.

## Hot Topic 9: Long Term Care

- Tribal members are living longer. 51 yrs in 1940 to 76.9 yrs in 2001
- Tribal Elders are seen as keepers of tradition and instrumental in maintaining the tribe. Taking Elders out of the community due to lack of needed services is a major detriment to the soundness of the tribe.
- Dedicate funding for LTC would give tribes flexibility in designing programs meeting their population's unique needs

# Hot Issues

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## Hot Topic 10: Alcohol/Substance Abuse

- impact of alcohol and substance abuse within the Area is having a dramatic negative effect on lives, families and communities of the native people

## Hot Topic 11: EHR Modernization

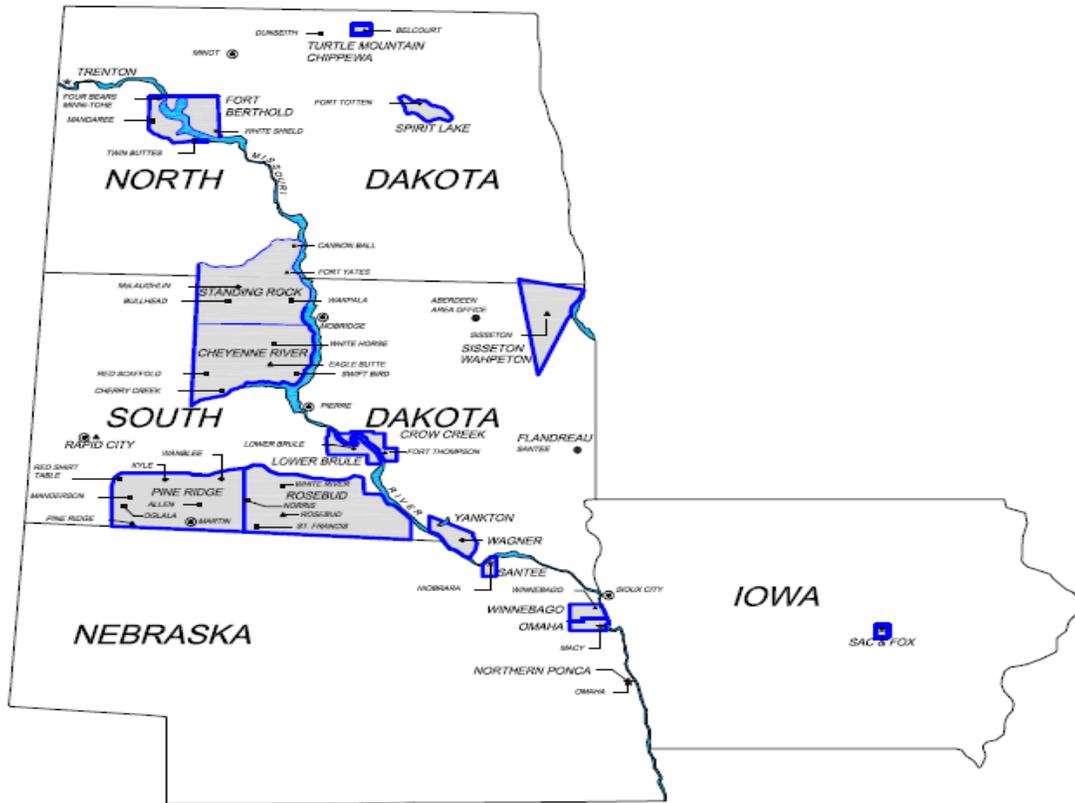
- Modernization of the RPMS HER package is needed to keep pace with EHR packages in the private sector.
- There is a big concern about where the funding will come from and how it will meld with tribes that have purchased private sector systems.

# FY 2023 Area Tribal Budget Consultation *GREAT PLAINS AREA Report*

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PRESENTED BY: MARK FOX, THREE AFFILIATED TRIBES  
RODNEY BORDEAUX, ROSEBUD SIOUX TRIBE

# Summary of Service Area and Demographic Information



- ❖ 17 federally recognized tribes in the Great Plains Area
- ❖ An estimated 179,366 residents within the four-state region identifying themselves as AI/AN
- ❖ An estimated 116,069 of these individuals live on or near a reservation
- ❖ The Great Plains IHS provides health services to approximately 122,000 Indian people who reside within nineteen service units.

# Summary of Funding Priorities

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Priority 1- Mental Health: \$6,130,717,000

Priority 2- Alcohol & Substance Abuse: \$5,797,035,000

Priority 3- Hospitals & Clinics: \$5,678,893,000

Priority 4- Health Care Facilities Construction: \$3,207,076,000

Priority 5- Equipment: \$3,207,076,000

Priority 6- Dental Services: \$2,275,778,000

Priority 7- Purchased/Referred Care: \$1,973,217,000

# Summary of Funding Priorities

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Priority 8- Community Health Representatives: \$1,971,755,000

Priority 9- Health Education: \$1,653,240,000

Priority 10- Public Health Nursing: \$1,337,650,000

Priority 11- Maintenance & Improvement: \$1,097,951,000

Priority 12- Urban Health: \$606,694,000

Priority 13- Sanitation Facilities Construction: \$534,512,000

Priority 14- Indian Health Care Improvement Fund: \$106,902,000

# Hot Issues

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Hot Topic 1: Health Professional Manpower Shortages

Hot Topic 2: Substance Use Disorder Centers

Hot Topic 3: Young Child Wellness Services/Preventive Strategies

Hot Topic 4: Health Care Construction Modernization-Infrastructure

Hot Topic 5: Health Care System Telehealth

Hot Topic 6: Medical Equipment

Hot Topic 7: Non/medical/medical Transportation Services

# Success Stories

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Tribe/Service Unit: Sisseton Wahpeton Oyate / Woodrow Wilson Keeble Memorial Health Care Center (Sisseton Service Unit)

The service unit's Pharmacy department completed a 1.5 day American Society of Health-System Pharmacist (ASHP) virtual accreditation survey encompassing the pharmacy residency program and overall pharmacy practice. The survey was very successful with only 21 findings out of 160 items reviewed. The majority of the findings were clerical. The staff are working on corrective actions and once submitted the ASHP accreditation board will review. The service unit is confident to receive accreditation in early 2021. The first resident candidate completed their one year residency rotation in August 2020 and they were selected for a permanent pharmacist position. The second residency candidate has completed their orientation and they are certified to give vaccines, counsel patients on smoking cessation and medications, and consult on patients with Hepatitis C. They have also started their research project utilizing a Veterans Affairs tool to complete medication reconciliations for patients.

# Success Stories

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The service unit's Radiology department held open house in October 2019 for the new mammography equipment and service. The Tribal Secretary was invited for the ribbon cutting ceremony. This project was a huge accomplishment for the service unit and the radiology department. The department also passed the American College of Radiology (ACR) accreditation for mammogram services. The service unit is now accredited for mammography for the next three 3 years.

The service unit's Nutrition department was recognized by the South Dakota Department of Health (SDDOH) for excellence in the Diabetes Self-Management Education program and has met the SD Diabetes Education Recognition Program criteria. This is a huge accomplishment and the recognition allows the service unit to bill SD Medicaid for diabetes self-management education.

# FY 2023 Area Tribal Budget Consultation *California Area Office*

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PRESENTED BY: *MICHAEL GARCIA*

# Service Area and Geographic Information



# FY 2023 Area National Budget Recommendation

## Summary of Funding Priorities

▶ Priority 1: Purchased/Referred care	\$5,286,149,000
▶ Priority 2: Behavioral Health	\$4,933,739,000
▶ Priority 3: Obesity/Diabetes	\$4,933,739,000
▶ Priority 4: Dental	\$3,876,510,000
▶ Priority 5: Methamphetamines / Suicide / Domestic Violence	\$3,524,100,000
▶ Priority 6: CHR	\$2,114,460,000
▶ Priority 7: Maintenance & Improvement	\$2,114,460,000
▶ Priority 8: Urban	\$1,762,050,000
▶ Priority 9: Health Information Technology	\$1,762,050,000
▶ Priority 10: Joint Venture	\$1,409,640,000
▶ Priority 11: Pharmacy	\$1,057,230,000
▶ Priority 12: Indian Healthcare Improvement Fund	\$1,057,230,000
▶ Priority 13: Small Ambulatory	\$1,057,230,000
▶ Priority 14: Sanitation Facilities Construction	\$352,409,000

Note: CA Tribal Leaders recommend 105(I) Leases be a separate appropriation and an additional budget line item going forward, similar to CSC.

# Hot Issues

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Hot Topic 1: Full backup generators

Hot Topic 2: Recruitment and retention

Hot Topic 3: 105(I) Lease funding

# FY 2023 Area Tribal Budget Consultation *National Council of Urban Indian Health (NCUIH) Report*

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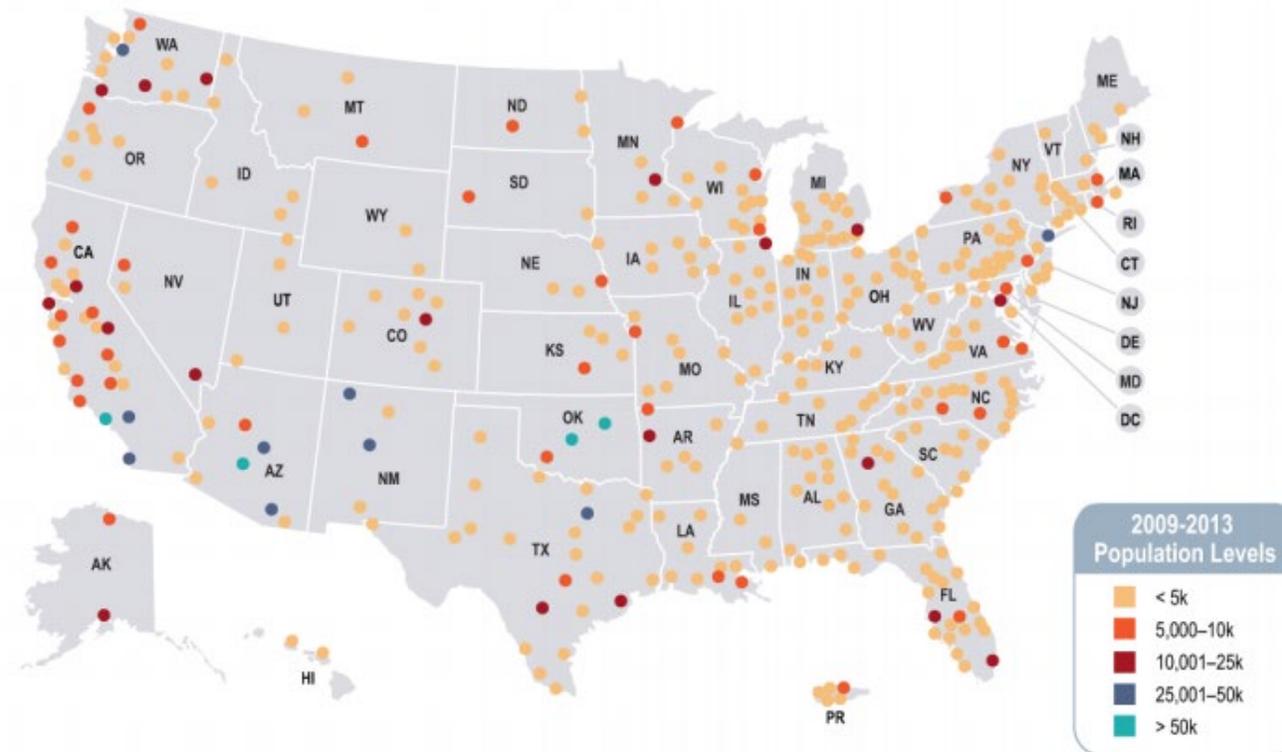
PRESENTED BY:

*JULIA DREYER, JD*

*NCUIH VICE PRESIDENT, PUBLIC POLICY*

# Summary of Service Area and Demographic Information

## 2009–2013 American Indian and Alaska Native Metro Populations



<sup>1</sup> US Census Bureau; American Community Survey, 2009–2013. [American Community Survey 5-Year Estimates, Table B02005 American Indian and Alaska Native alone for selected tribal groupings](#); generated by the Tribal Support Unit; using American FactFinder. Accessed Jun 8, 2015.

<sup>2</sup> Department of the Interior, Bureau of Indian Affairs. [Indian entities recognized and eligible to receive services from the United States Bureau of Indian Affairs](#). *Federal Register* 2015;80(9):1942–8.

# Summary of Service Area and Demographic Information

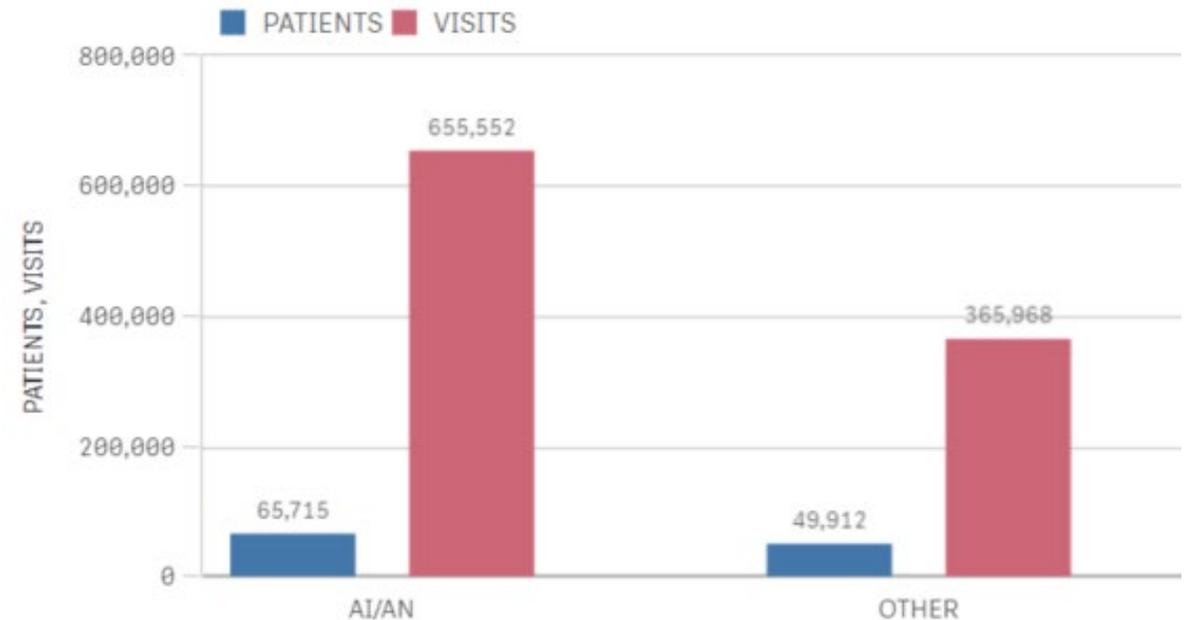
## Health and demographic statistics

### Population:

- More than 70% of the 5.2 million AI/ANs live in urban and suburban areas
  - Expected to increase with 2020 Census results

- Patients and Visits in Calendar Year 2019:

**PATIENTS AND VISITS**  
By Calendar Year



# Summary of Service Area and Demographic Information

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## Health and demographic statistics

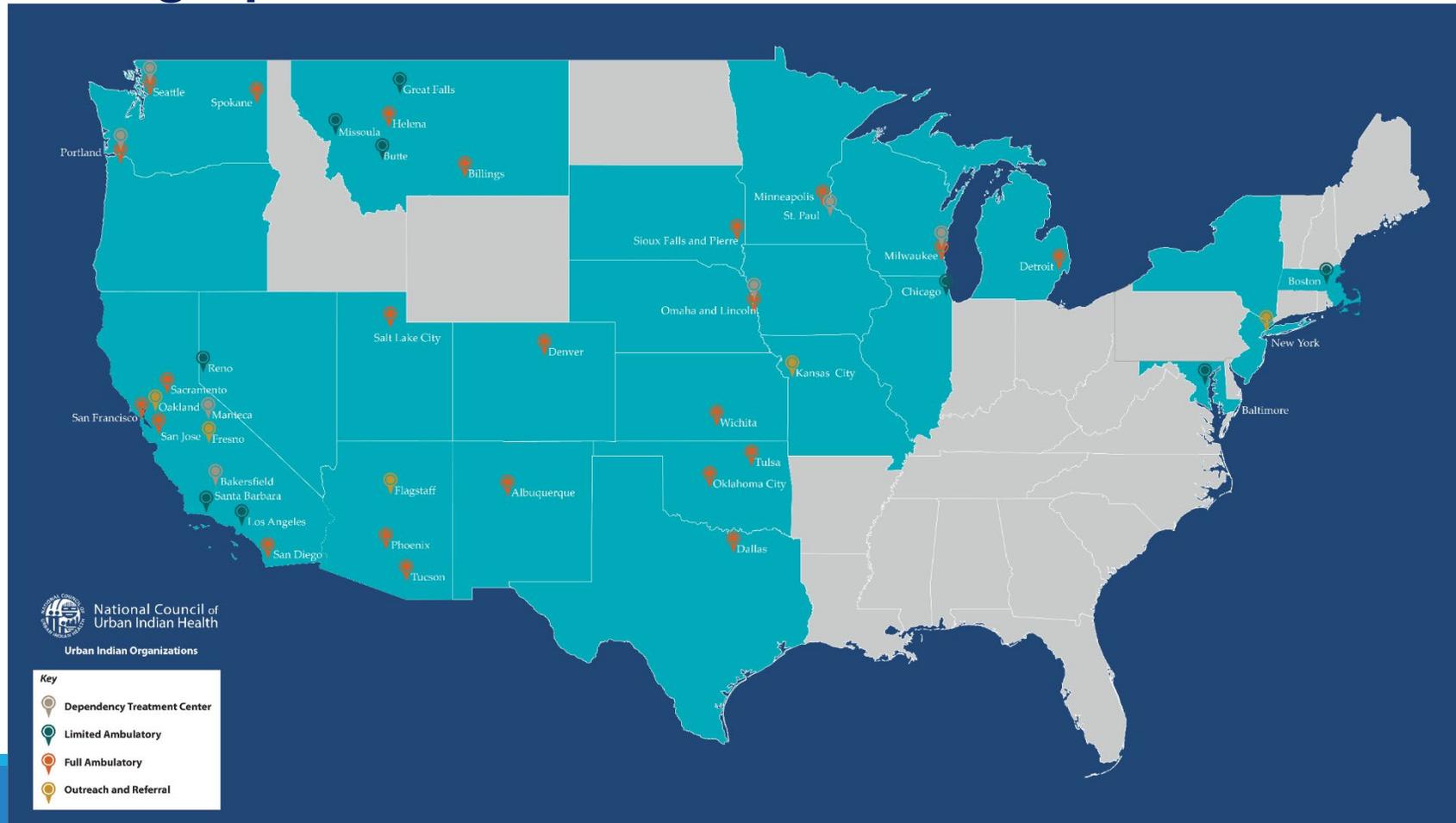
### UIO Patients

- Members of:
  - Tribes, bands, or other organized groups of Indians, including those terminated since 1940
  - Tribes, bands, or other organized group of Indians recognized by the state in which they reside
- Descendants of tribal members
- And individuals that are:
  - An Eskimo or Aleut or other Alaska Native
  - Considered by the Interior Secretary to be an Indian for any purpose; or
  - Determined to be an Indian under regulations promulgated by the Secretary

# Summary of Service Area and Demographic Information

## Health and demographic statistics

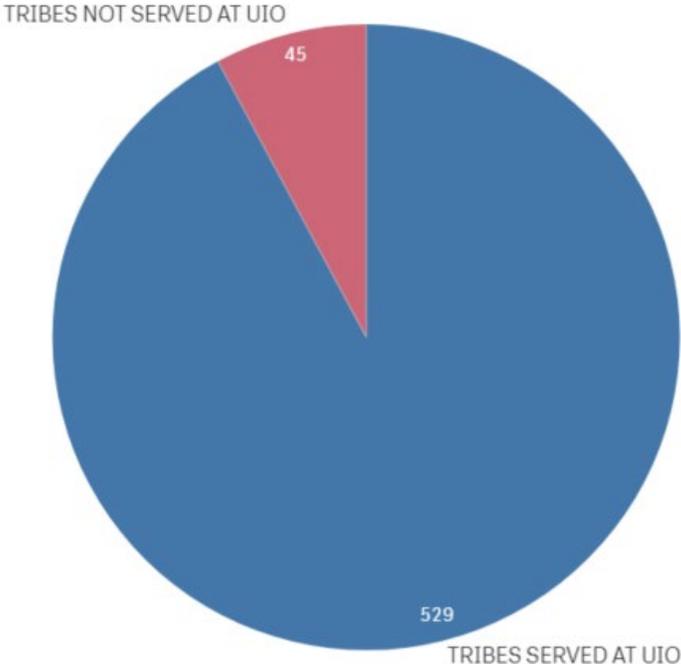
41 UIOs  
in 22 states



# Summary of Service Area and Demographic Information

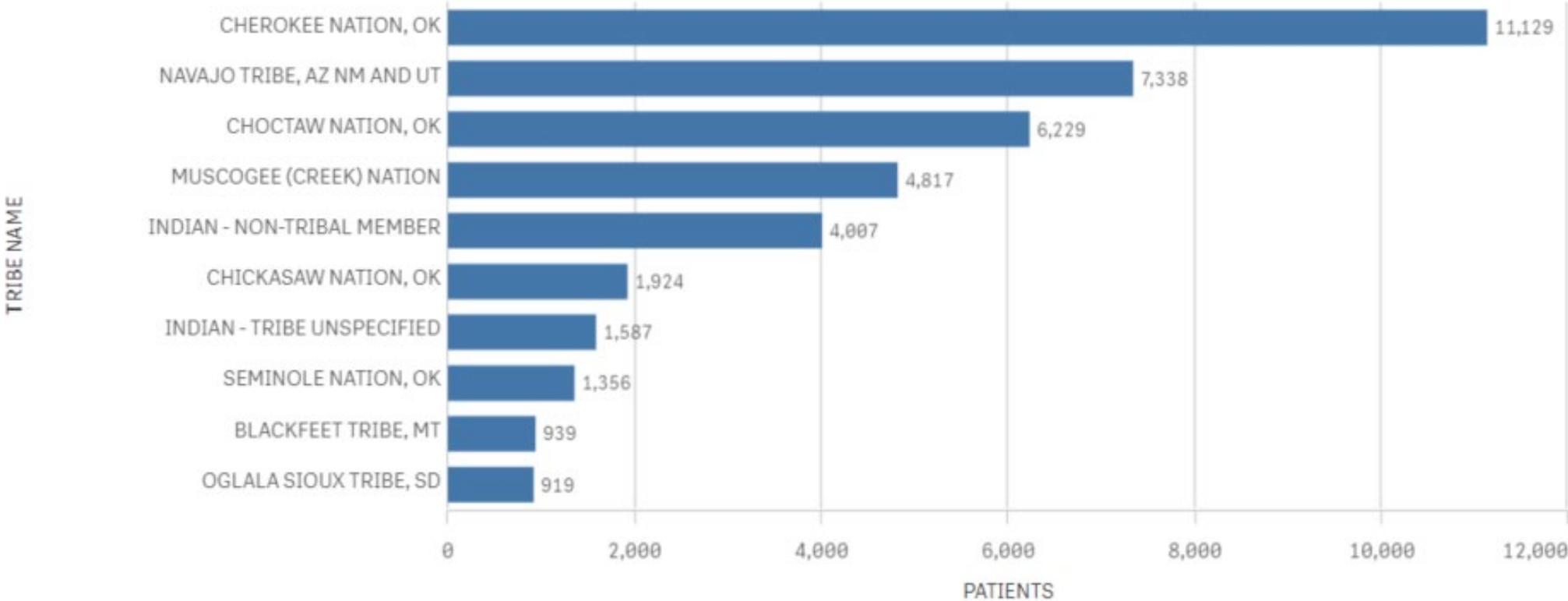
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TOTAL NUMBER OF TRIBES SERVED



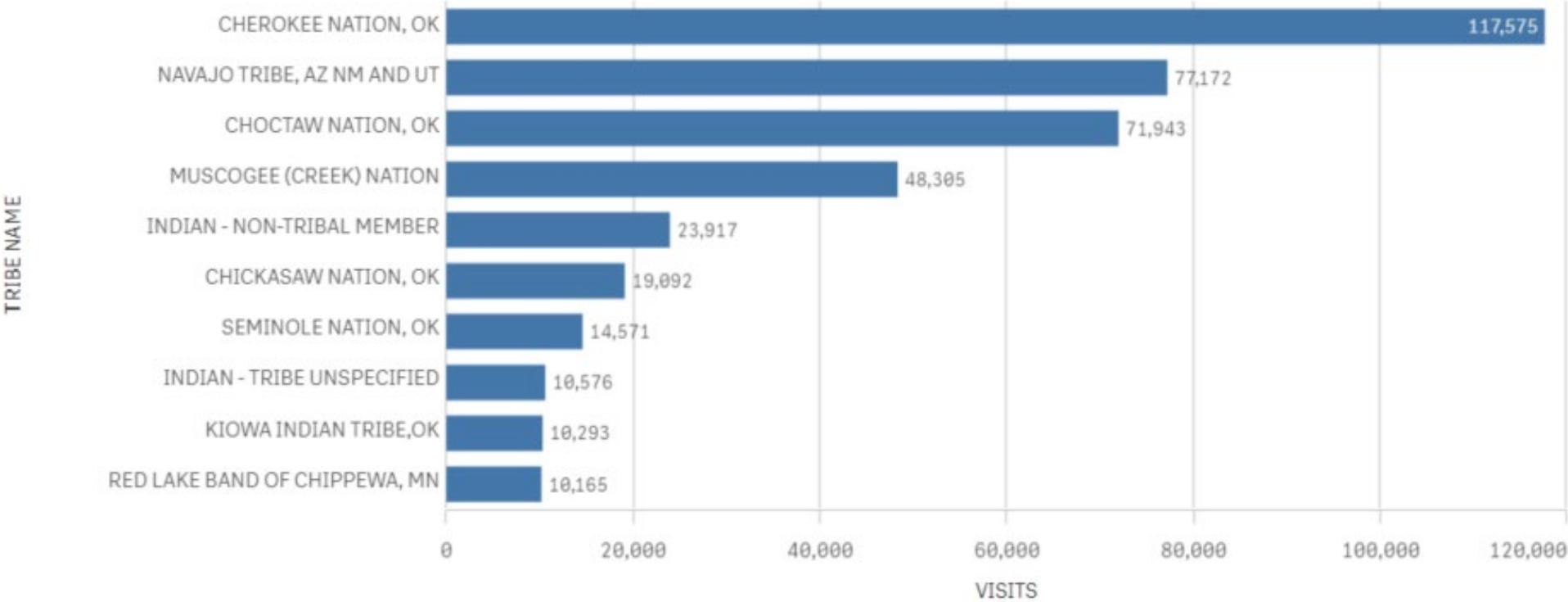
# Summary of Service Area and Demographic Information

TOP 10 TRIBES SERVED - PATIENTS



# Summary of Service Area and Demographic Information

TOP 10 TRIBES SERVED - VISITS



# Summary of Funding Priorities

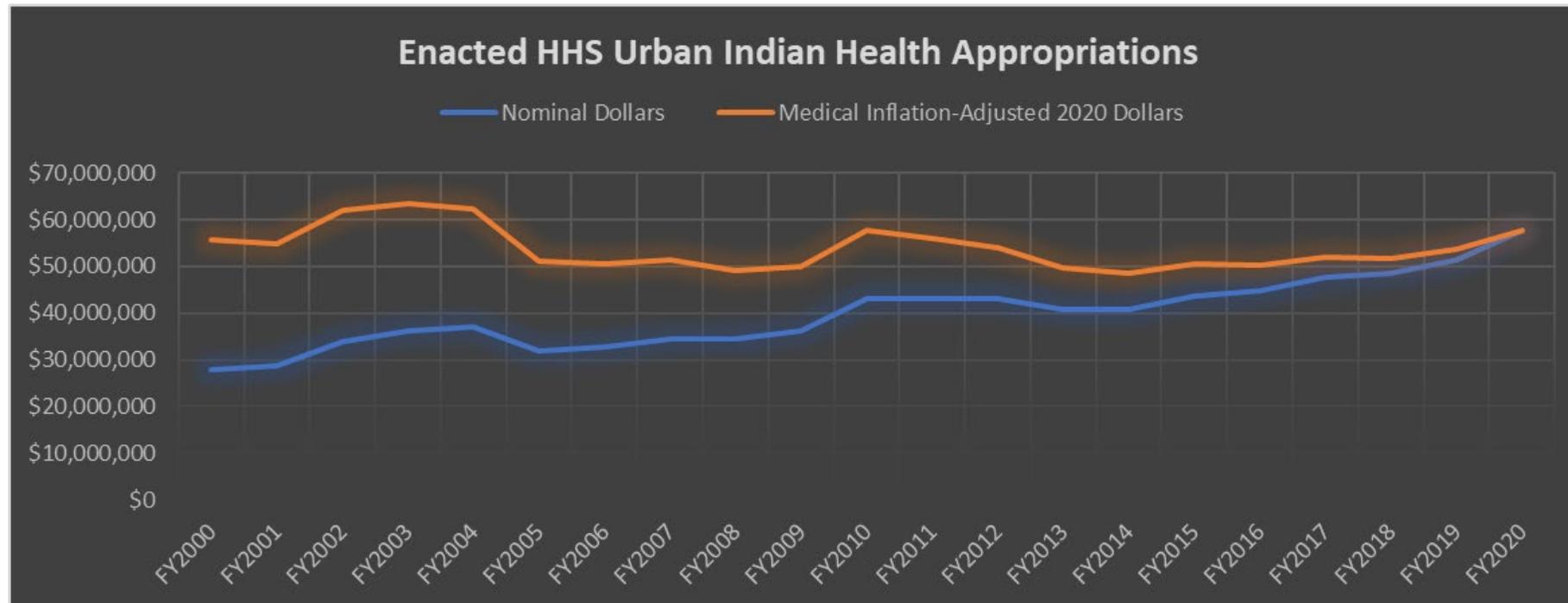
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## Urban Indian Health

- **Usually** would recommend an increase over the previous fiscal year's TBFWG recommendation for Urban Indian Health that represents an average of the increases recommended by Areas
  - Would not achieve level of need but would allow UIOs to expand services, provide services to more patients, hire additional practitioners, and more
- **Due to the pandemic**, our recommendation was going to be an increase over FY 2022 TBFWG recommendation in an amount that represented the total amount of coronavirus legislation funding from IHS to UIOs
  - Would allow for service and workforce expansion to continue an appropriate COVID-19 response and preparation for future epidemics

# Summary of Funding Priorities

Since 2000, most of the increases in funding for Urban Indian Health has been absorbed by medical inflation.



# Summary of Funding Priorities

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In 2020 dollars, Urban Indian Health was funded at \$55.6 million in FY 2000. In FY 2020, UIOs received \$57,684,000.

Last year's (FY 2022) TBFWG recommendation for Urban Indian Health funding was \$200,548,000.

# Summary of Funding Priorities

## Urban Indian Health

- However, the Tribal Budget Formulation Work Group recommended a request consistent with needs based funding, with full funding of IHS at \$48 billion. Consistent with this guidance, we recommend the amount for Urban Indian Health set at **either**:

	NHE Per Capita + Updated Urban user count	In proportion to TBFWG FY 2022 recommendations
<b>Methodology</b>	<p>NHE: \$11,582 per person                      #of Urban AI/AN Patients in CY 2019: 65,715</p> <p><math>\\$11,582 \times 65,715 = x</math></p>	$\frac{x}{\$48,000,000,000} = \frac{\$200,548,000 \text{ (Urban Indian Health)}}{\$12,759,004,000 \text{ (IHS total)}}$
<b>Resulting Amount</b>	<p><b>X= \$761,111,130*</b></p> <p><b>*NOTE: This uses data for CY 2019 and should be updated once more recent data is available</b></p>	<p><b>X= \$754,471,431</b></p>

# Hot Issues

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## Hot Topic 1: Ensure Urban Indian Health funding keeps pace with population growth

- Increased population will require UIOs to increase access to care by hiring additional and expanding services to help meet the need.

## Hot Topic 2: Funds for construction or expansion of urban facilities

- UIOs are currently limited in their ability to construct or improve upon their facilities in order to meet their communities' needs. UIO funding should include funds for these purposes and should be read to be as flexible as possible.

## Hot Topic 3: Dental Services

- Many Urban Indian patients are unable to access regular dental exams from an Indian health care provider. Regular dental visits are a standard of care for all adults, especially for pregnant women and those with diabetes or HIV.

## Hot Topic 4: Retain eligibility for UIOs to participate in grant programs

- UIOs are highly reliant on grants to maintain operations. Many times grants are restrictive, reduced, or eliminated, making maintaining a balanced level of facility operations difficult.
- Examples: SDPI, Behavioral Health

## Hot Topic 5: No funding from Urban Indian Health line item withheld or reprogrammed from UIOs

- In past years, funds were reprogrammed from UIO inflation increases.

# Contact Information

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For questions or further information, contact:

Sunny Stevenson, NCUIH Director of Federal Relations: [sstevenson@ncuih.org](mailto:sstevenson@ncuih.org)

Julia Dreyer, NCUIH Vice President of Public Policy: [jdreyer@ncuih.org](mailto:jdreyer@ncuih.org)

# **FY 2023 Indian Health Service Budget Recommendations from**

## ***Nashville Area***

**Presented by: Dee Sabattus, Passamaquoddy Indian Township**

**Edie Tullis Baker, Poarch Creek Indians**

**Kerry Lessard, Native American LifeLines**

# Summary of Nashville Area and Demographic Information



- 23 Tribally Operated Facilities
    - 9 Compacting
    - 14 Contracting
  - 3 Purchased Referred Cares Sites
  - 3 Direct Service Facilities
  - 2 Urban Indian Health Program
    - 1 serving Baltimore and Boston
    - 1 serving New York
  - 1 Youth Regional Treatment Center
  - 1 Tribally Operated Adult Treatment Center
- Servicing: 80,000 American Indian and Alaska Natives

## Area Statistics:

- Diabetes Prevalence Rate: 22%
- Leading Cause of Death: Major Heart Disease with Cancer, Injuries and Diabetes following close behind.
- Average Age of Death: 60 which is far below the U.S. all races age of 72.

# Nashville Area Budget Formulation Team

Kickoff Meeting held via teleconference on October 5, 2020; Wrap-Up Call held via teleconference on December 7, 2020

- ▶ 14 Tribal Nations participated and/or provided input throughout the process
- ▶ FY 2023 Team Members:
  - Edie Tullis Baker, Poarch Creek Indians (Title V)
  - Kerry Lessard, Native American LifeLines (Urban)
  - Dee Sabattus, Passamaquoddy Indian Township (Title I)
  - Catherine Willis, Indian Health Service Nashville Area Office
  - Conny York, Indian Health Service Nashville Area Office
  - Mark Skinner, Indian Health Service Nashville Area Office
  - Ashley Metcalf, Indian Health Service Nashville Area Office

# FY 2023 Nashville Area National Budget Recommendation

## Summary of Funding Priorities

- ▶ Fully fund the Indian Health Service at \$48 billion, +276.20% over the FY 2022 proposed budget levels, a recommended increase of \$35.2 billion.
- ▶ 80% of funding increase will be spread across all budget lines, with 20% of funding increase, at \$7 billion, for the specific following Clinical Services programs as Nashville Area priorities:
  - ▶ Hospitals and Clinics \$1,413.2 billion
  - ▶ Purchase Referred Care \$1,144.8 billion
  - ▶ Alcohol/Substance Abuse \$983.8 million
  - ▶ Mental Health \$948.1 million
  - ▶ Electronic Health Record System (New) \$751.3 million
  - ▶ Dental Health \$518.7 million
  - ▶ Community Health Reps \$375.6 million
  - ▶ Maintenance & Improvement \$375.6 million
  - ▶ Health Education \$304.1 million
  - ▶ Self-Governance \$232.5 million

# FY 2023 Nashville Area National Budget Recommendation

## Hot Topics

- ▶ **Hot Topic 1: Funding for Telehealth Resources** - *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.*
- ▶ **Hot Topic 2: Public Health Education** - *Provide increased recurring funding to support public health education professionals and programming.*
- ▶ **Hot Topic 3: Anticipated impacts of COVID on User Pop and Workload data** - *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 either the previous year's data or a 3 year average as to not significantly reduce funding need for ITUs.*
- ▶ **Hot Topic 4: Funding Obligation for 105 (l) Lease Agreements** - *Nashville Area Tribal Nations believe that funding for 105(l) lease agreements should be funded similar to Contract Support Costs, as a separate appropriation account with an indefinite amount- "such sums as may be necessary."*

# FY 2023 Nashville Area National Budget Recommendation

## Hot Topics cont.

- ▶ **Hot Topic 5: Funding for Aftercare and Housing Programs** - *Create additional recurring funding opportunities to support aftercare services.*
- ▶ **Hot Topic 6: Funding to reduce the Hepatitis C Influx** - *Tribal Nations are recommending that IHS advocate for additional funding to support Hepatitis C prevention programs, promote and provide access to testing, to facilitate access to care and comprehensive care management, and to support those Tribal citizens living with Hepatitis C.*
- ▶ **Hot Topic 7: Continued Funding for CHR Programs** - *CHR funding must be increased as CHRs improve access to health services through their training to provide information and create connections between providers and Native people. Work must be done to ensure data supporting the success and need of CHR programs is more accurately captured in the future.*
- ▶ **Hot Topic 8: Constitutionality Challenges** - *Indian Country must remain vigilant and continue to challenge and oppose any efforts within the federal government—executive, legislative, and judicial—that seek to undermine the constitutionality of our relationship. The federal government, including CMS, has ample legal authority to provide AI/ANs with accommodations in administering federal programs due to the unique federal trust responsibility to Indians. Even in the absence of statute, CMS has made regulatory accommodations for AI/ANs. For example, HHS regulations implementing Title VI of the Civil Rights Act recognize and implement this principle with respect to the Indian Health System (45 C.F.R. § 80.3(d)).*

# FY 2023 Nashville Area National Budget Recommendation

## Hot Topics cont.

- ▶ **Hot Topic 9: Special Diabetes Program for Indians** - *If additional funding is received for these Tribes, Nashville Area Tribes request a separate funding opportunity eligible only to Tribes with recent federal recognition that would allow them to plan for establishing an SDPI program. 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.*
- ▶ **Hot Topic 10: Modernizing Health Information Technology** - *The current electronic health record 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.*
- ▶ **Hot Topic 11: Expand Group Payor Authorities for ITUs when Sponsoring Health Care Plans:** *Nashville Area Tribal Nations request that IHS support initiatives that would give parity to ITUs for group payor authorities where needed.*

# FY 2023 Nashville Area Standing Area Priorities

- ▶ Health Care Facilities Construction
- ▶ Facilities and Environmental Health
- ▶ Advanced Appropriations
- ▶ Funding Obligation for 105(l) Leases
- ▶ Special Initiative funding for New Tribes
- ▶ Hepatitis C

# FY 2023 Area Tribal Budget Consultation *Navajo Area* *Report*

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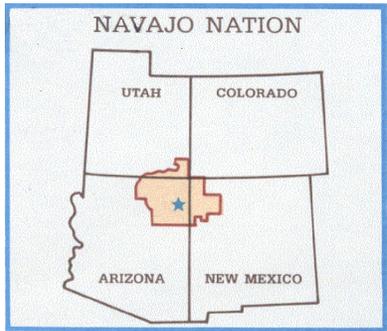
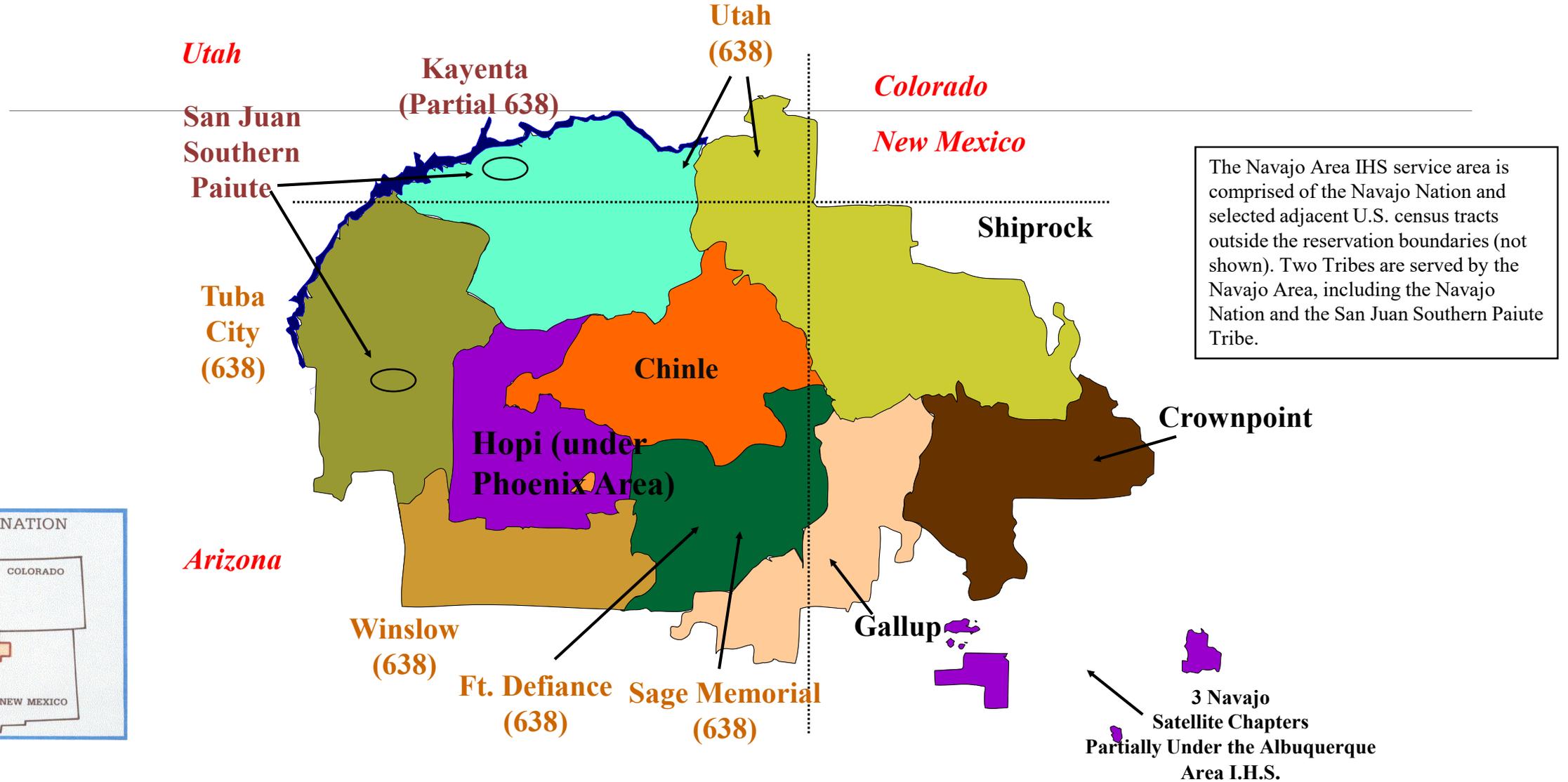
PRESENTED BY:

The Honorable Jonathan Nez, President of the Navajo Nation

The Honorable Carl Slater, 23<sup>rd</sup> Navajo Nation Council

*January 28, 2021*

# Navajo Area Federal Service Units and P.L. 93-638 Contracted/Compacted (Tribally Operated) Service Units



# Summary of Service Area and Demographic Information

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The Navajo Area Indian Health Service serves the Navajo Nation and the San Juan Southern Paiute Tribe. The Fiscal Year 2019 user population of the Navajo Area is 62% federal and 38% tribal.

## Navajo Health Care System Stakeholders:

### 5 Federal Service Unit

- (Gallup, Crownpoint, Shiprock, Chinle, and Kayenta)

### 6 Self-Determination Contractors

- NHF/SMH, FDIHB, HMS, EMS, NTCCTF, SJSPT

### 3 Self-Governance Compactors and

- WIHCC, TCRHCC, UNHS

### 1 Urban Indian Health Center

- Native Americans for Community Action

# Summary of Funding Priorities

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<b>Priority 1</b>	<b>Healthcare Facility Construction</b>	<b>\$7,406,164</b>
<b>Priority 2</b>	<b>Water Sanitation Construction</b>	<b>\$6,665,547</b>
<b>Priority 3</b>	<b>Mental Health</b>	<b>\$5,431,187</b>
<b>Priority 4</b>	<b>Information Technology (IT) Infrastructure</b>	<b>\$4,196,826</b>
<b>Priority 5</b>	<b>Hospital &amp; Health Clinics</b>	<b>\$3,826,518</b>
<b>Priority 6</b>	<b>Preventive Health (CHR, PHN, and Health Education)</b>	<b>\$3,641,364</b>
<b>Priority 7</b>	<b>Substance Abuse</b>	<b>\$1,481,233</b>
<b>Priority 8</b>	<b>Long Term Care/Elderly Care Facility</b>	<b>\$1,234,361</b>
<b>Priority 9</b>	<b>Facility &amp; Environmental Health Support</b>	<b>\$ 740,616</b>
<b>Priority 10</b>	<b>Urban Facility Lease Improvement/Renovation (under Urban)</b>	<b>\$ 617,180</b>

# Hot Issues

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- Hot Issue 1**      **Emergency Medical Services**
- Hot Issue 2**      **PPE Supplies & PPE Service Unit Warehouse Capacity**
- Hot Issue 3**      **Public Health Emergency Preparedness and Epidemiology**
- Hot Issue 4**      **Mental Health and Long Term Care/Elderly Care Facility**

# Success Stories

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- **FDIHB Repurposing of Fast Track/Observation Unit to a COVID Unit**
- **WIHCC PJD for New Facility Construction**
- **TCRHCC Cancer Care in Western Navajo**
- **Navajo Incident Command Center**
- **Water Access Coordination Group**
  - **[www.NavajoSafeWater.org](http://www.NavajoSafeWater.org)**



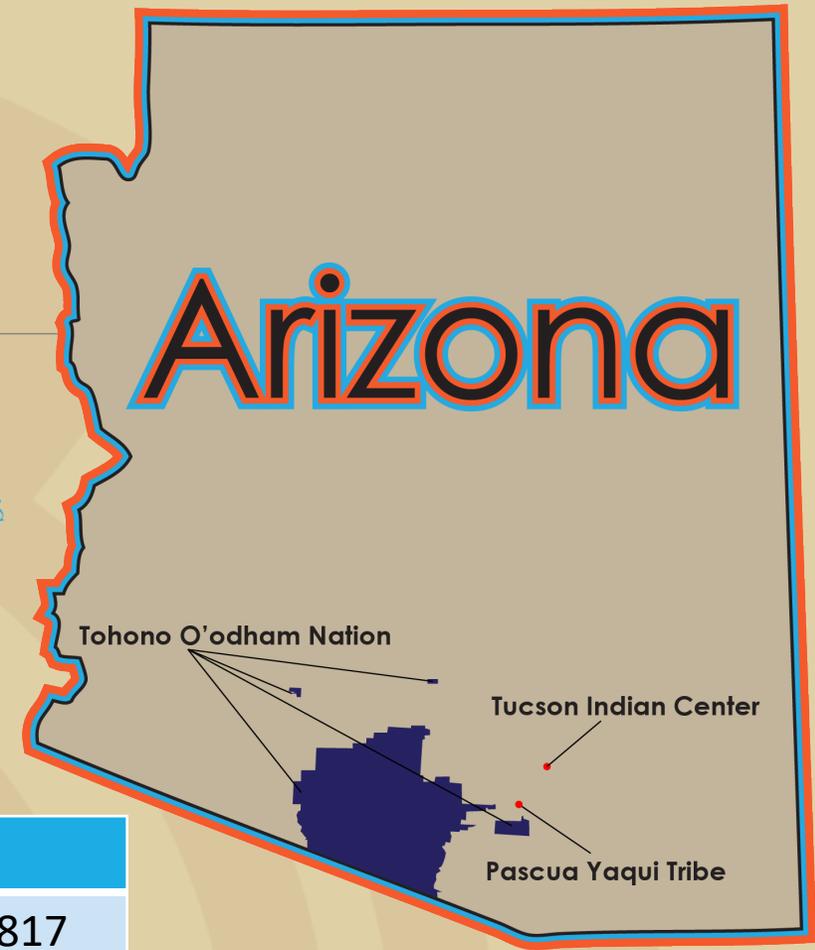
# FY 2023 INDIAN HEALTH SERVICE TUCSON AREA WEBINAR PRESENTATION

PRESENTED BY:

*PETER YUCUPICIO, CHAIRMAN,  
PASCUA YAQUI TRIBE*

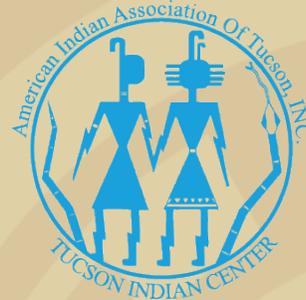
*WAVALENE SAUNDERS, VICE-CHAIRWOMAN  
TOHONO O'ODHAM NATION*

# Tucson Area Geographic and Demographic Information



Pascua Yaqui Tribe	Tohono O'odham Nation	Tucson Indian Center
Enrolled Members: 22,000	Enrolled Members: 35,469	Urban Population: 44,817
Land base: 2216 acres	Land base: 2.85 million acres	Metro Tucson
9 traditional communities	11 Districts/Sonora, Mexico/ 76 Communities	

# Summary of Funding Priorities



Funding Priorities	Amount ( In \$1,000)
Purchased Referred Care	\$9,867,475
IHCIA Diabetes Section 123	\$7,753,016
Facility Construction	\$3,524,098
Replacement Equipment	\$2,819,279
Mental Health	\$2,819,279
Community Based Program	\$2,114,459
Alcohol & Substance Abuse	\$2,114,459
IHCIA Urban Section 161	\$1,057,236
IHCIA Long Term Care	\$704,820
SFC Water Lines	\$2,466,875
<b>TOTAL</b>	<b>\$35,240,996</b>

# Services Budget Priorities

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- *Purchased/Referred Care*
  - Increased cost of contracted specialty services
- IHCIA Diabetes Section 112/123/124
  - Prevention and treatment of Type 2 Diabetes and promotion of healthy lifestyles
- Mental Health (MH)
  - Needs surpass available resources in Arizona
- Community Health Based Programs
  - Attempts to defund and eliminate CHR Program unacceptable
- Alcohol & Substance Abuse (ASA)
  - Expand types of treatment and services
- Long Term Care and Assisted Living Services
  - Meeting the needs of an increasing elder population



# Facilities Budget Priorities

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- Health Care Facilities Construction
  - Funding needed to replace old undersized health care facilities
- New/Replacement Equipment
  - Necessary to meet current and future standards of care
- Sanitation Facilities Construction
  - Backlog of projects on the Sanitation Deficiency System (SDS) needs list



# Hot Issues

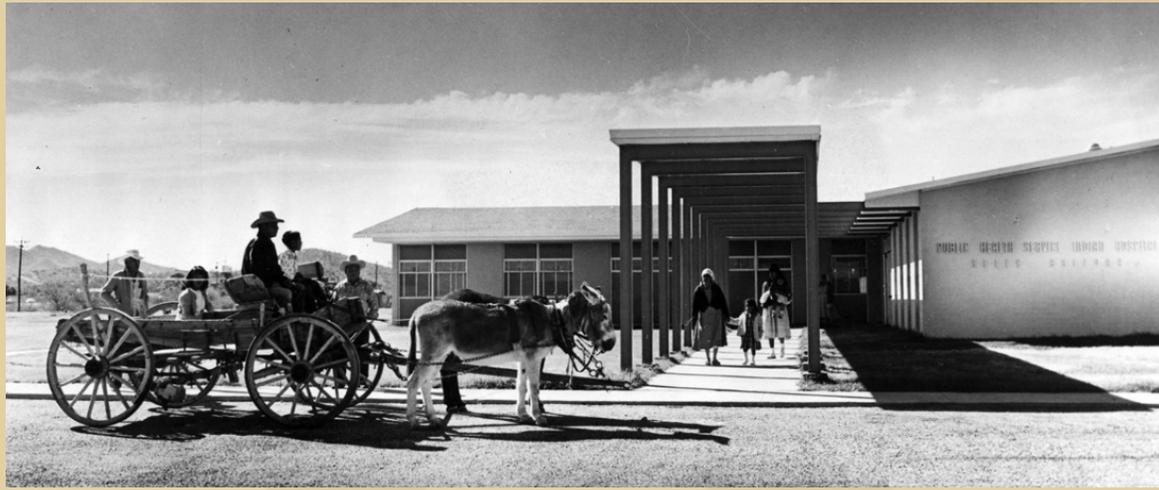
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- 1. Mental Health – Suicide increases and coping with COVID19**
- 2. PRC – Discussion of Possible Statewide CHSDA**
- 3. Aging Health Facilities and IT/Telephone Infrastructure**
- 4. Staffing Quarters – Lack of housing for personnel**
- 5. Cancer Prevention**
- 6. Electronic Health Record System – Full Implementation**
- 7. Urban Health Facility Funding Section 161 as amended**

# SUCCESS STORIES

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- Tohono O'odham Nation
- Pascua Yaqui Tribe
- Tucson Urban Indian Program



Historic photo of Sells Hospital entrance



San Xavier Health Center, TB Sanitarium, circa 1932



Current Sells Hospital entrance



2019 construction of Pascua Yaqui Tribe's new health care facility



Health and Social Services Building "Hiaki Hitevi Kari II" The Healing House II 100,000 sq. ft building. To be completed April 2021.

# COVID-19 Awareness and Precautions



Ak Chin Community



Florence Community

# COVID-19 Awareness and Precautions



# Housing Communities



Hanam Ke:k Housing Community



Black Mountain Housing Community

# Housing Communities



Pascua Yaqui Tribe construction of three separate housing facilities in support of its Health and Social Services Programs. These facilities, known as Men's Path Home (4500 sq. ft), Women's Path Home (4500 sq ft.) and the Assisted Living Home (6500 sq ft.) would be located on Tribal Trust Land. House 8 -10 individuals per facility and feature full living quarters, a dining room, kitchen, common areas/program activity areas, staff areas and outside use of areas.

# Community Renovations



Modular Bathroom Project in North Hikiwan



Completed install in Anegam

# Community Renovations



Pascua Yaqui Tribe Sewa U'usim Program showcase expansion of experiential services and activities to strengthen and balance our community. Kava'i Hitevi (Horse Healers) provides wellness services to over 60 children, youth and families. Green House for Hydroponic/ Aquaponic technology services for youth and elders. Microwave tower for high-speed internet – weather station

# Tribal Collaboration with Urban Indian Program



The Pascua Yaqui Tribe Diabetes Prevention Program collaborated with the Tucson Indian Center, Tohono O'odham Nation, Pima County, and the UA College of Public Health to hold the first virtual Native American Family Wellness Day on November 17 – 19, 2020, which was streamed live, connecting people to local community resources and promote healthy lifestyles.

Peter Acuna ( PYT Recreation Specialist was an MC for Day 1 & 2)

Day 1: Focused on Nutrition and included a Nutrition talk with the PYT Dietitian, Dominique Henry and cultural food videos by the Diabetes Outreach Specialists

Day 2: Focused on Physical Activity and guests' activities included a Tai Chi session done by Peter Acuna

Day 3: Focused on Tradition, Tobacco Free

There was a total of 313 participants who registered for this event; with 65 of these being Pascua Yaqui tribal members



# SPECIAL THANKS

## TOHONO O'ODHAM NATION

Ned Norris Jr., Chairman  
Wavalene Saunders, Vice-Chairwoman  
Jesse Navarro, Governmental Affairs  
Troy Klarkowski, CEO TONHC

## TUCSON INDIAN CENTER

Jacob Bernal, Executive Director  
Veronica Boone Wellness Director

## PASCUA YAQUI TRIBE

Peter Yucupicio, Chairman  
Robert Valencia, Vice-Chairman  
Reuben T. Howard, Executive Health Director  
Shanna Tautolo, Interim Associate Deputy Director  
Alva Obregon, Executive Assistant Health

## INDIAN HEALTH SERVICE, TUCSON AREA

Dixie Gaikowski, Area Director  
Mark Bigbey, Executive Officer  
Vivian Draper, Financial Management Officer  
Cathie Frazier, DEHE Director

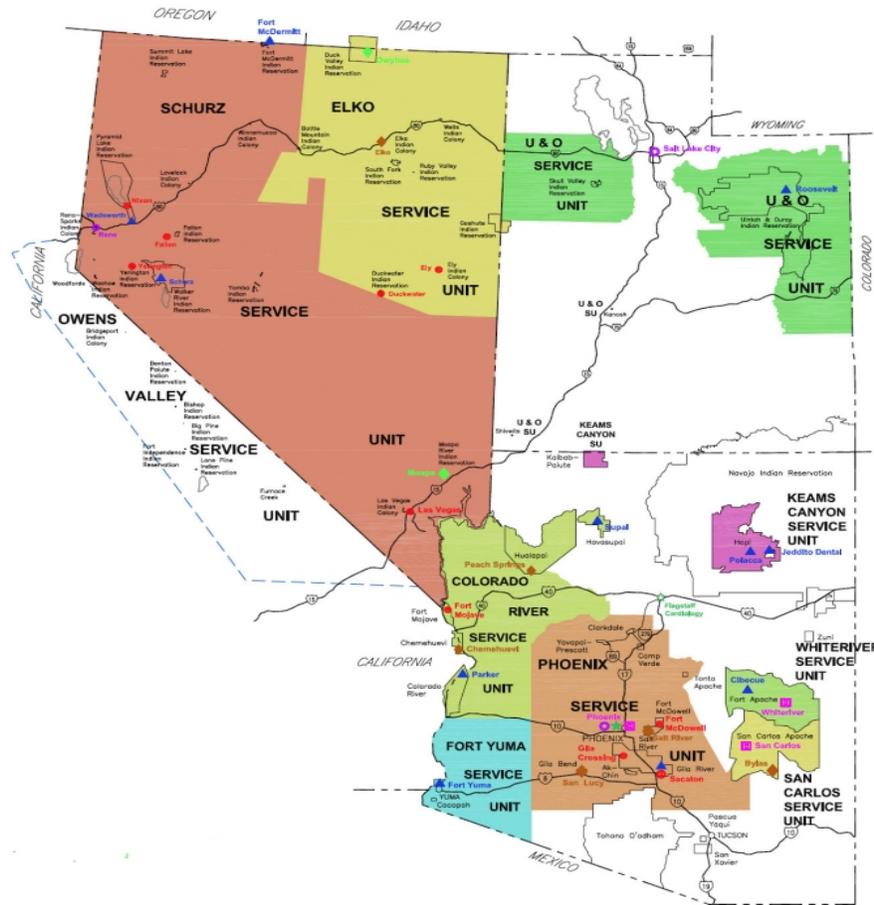
# FY 2023 Area Tribal Budget Consultation *PHOENIX AREA Report*

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PRESENTED BY: *CHAIRMAN AMBER TORRES OF THE WALKER RIVER PAIUTE TRIBE AND CHAIRPERSON TAMRA BORCHARDT-SLAYTON OF THE PAIUTE INDIAN TRIBE OF UTAH*

DELIVERABLE TO BE SUBMITTED: *JANUARY 8, 2021*

# Service Area and Demographic Information



Active User Population **178,854** (FY 2019)

Phoenix Area is the third largest Area, in terms of population. It covers the states of UT, NV, AZ and 1 Service Unit in CA.

**45** Tribes and Bands in UT, NV, AZ and **7** Tribes in the Owens Valley Service Unit in CA

**OTPT:** COLORADO RIVER-6 (Includes Ft. Mojave Clinic\*), ELKO-4, FORT MCDOWELL-1\*, FT. YUMA-1, GRHC-3\* (Includes Ak-Chin), HOPI-1, OWYHEE-1\*, PIMC-1, San Carlos HC-1\*, SCHURZ-5\*, UINTAH-OURAY-2\* (Includes PITU\*), WHITERIVER-2

**INPT:** GRHC-1\*, PIMC-1, WHITERIVER-1

**1** Adolescent Treatment Center (AZ) & **1** Satellite (NV)

**4** Urban Indian Organizations – Salt Lake City, UT., Carson City, NV., Phoenix, AZ (2)

*\*Title I Contracts/Title V Compacts*

# Leading Causes of Mortality: Phoenix Area (AZ, NV, and UT) AI/AN; 2013-2017; Ages 1-85+AI/AN; 2013-2017; Ages 1-85+

	Cause of Death	Number	Crude Rate
1	Unintentional Injury	1971	115.3
2	Heart Disease	1733	101.4
3	Malignant Neoplasms	1549	90.64
4	Liver Disease	1071	62.67
5	Diabetes Mellitus	958	56.06
6	Chronic Low. Respiratory Disease	257	15.04
7	Suicide	438	25.63
8	Influenza & Pneumonia	333	19.49
9	Cerebrovascular	361	21.12
10	Homicide	207	12.11

**Leading Unintentional Injuries:** 1) MV Traffic 797; 2) Poisoning 558; 3) Falls, 181 (NV, AZ)

## AZ, NV, & UT All Races

Cause of Death	No.
Malignant Neoplasms	58455
Heart Disease	57344
Unintentional Injury	18291
Chronic Low. Respiratory Disease	18023
Alzheimer's Disease	13951
Cerebrovascular	12147
Diabetes Mellitus	9881
Suicide	6280
Liver Disease	5617
Hypertension	4655

# Phoenix Area Summary of Increases for Priorities in Services & Facilities (Full Funding)

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## INDIAN HEALTH SERVICES:

Priority 1- **Hospitals & Clinics (H&C) +\$9.38 billion (223.3% increase)** Includes:

- +\$1.5 billion to fund IHCIA Long Term Care, Home and Community Based Care and Hospice Authorities
- +\$42 million for Telehealth/IT Upgrades
- +\$30 million for Traditional Healing (Policy Support & Integrated/Complementary Care)
- +\$15 million for Extra Support for Smaller Tribes
- +\$12 million for Maternal & Child Health/Obstetrics-Labor & Delivery (Includes \$1 million request for the Phoenix Indian Medical Center to reopen and retain the services)
- +\$12 million for Rocky Mountain Spotted Fever (RMSF) (Prevention Services by CHRs)

# Phoenix Area Summary of Increases for Priorities in Services & Facilities (Full Funding)

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## INDIAN HEALTH SERVICES:

### Priority 2- **Community Health Representatives +\$233.4 million (95% increase)**

Tribal/UIO CHR programs envision continuing their important work with Public Health Nurses, Health Educators and alongside Community Health Aides as the National Community Health Aide Program (CHAP) is rolled out in the lower 48 states.

### Priority 3 – **Alcohol & Substance Abuse +\$706 million (90.6% increase)**

The increase is needed to fully institute the Comprehensive Behavioral Health Prevention and Treatment Program authorized by the Indian Health Care Improvement Act (25 U.S.C. §1665c).

# Phoenix Area Summary of Increases for Priorities in Services & Facilities (Full Funding)

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## INDIAN HEALTH SERVICES:

### Priority 4 - **Indian Health Professions: +\$71.2 million (86.16% increase)**

The increase is necessary to recruit and retain qualified medical professionals to work in Indian Country to address vacancy rates at federal/IHS sites that include efforts to “grow our own” health professionals and mid-level providers.

### Priority 5 - **Mental Health: +\$504 million (70.49% increase)**

The funding is needed to increase the ability of patients to receive outpatient counseling, psychiatric evaluations, crises response, case management and care coordination by mental health professionals and paraprofessionals in the Indian health care system who are well versed in the factors within Tribal communities that contribute mental health issues.

# Phoenix Area Summary of Increases for Priorities in Services & Facilities (Full Funding)

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## INDIAN HEALTH FACILITIES:

Priority 1 - **Health Care Facility Construction: +\$18.86 billion** (2,585% increase)

Funds the HCFC Priority List at \$2.02 billion, the IHCI new construction system and projects identified by IHS Areas at \$14.5 billion and urban Indian facility renovation at \$2 billion.

Priority 2 - **Sanitation: +\$2.6 billion** (628% increase)

Addresses the backlog of sanitation facilities including water supply, sewage, and solid waste disposal facilities necessary for AI/AN homes and communities.

Priority 3 - **Maintenance & Improvement +\$1.14 million** (239% increase)

Funds the on-going maintenance and improvement of IHS and Tribal health care facilities to maintain quality in older facilities. Designated amounts for the following: + \$12 million for long term care facilities, + \$10 million for Small Tribes and + \$750,000 (PIMC OB Labor & Delivery Department)

# Phoenix Area Hot Issues

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## Hot Topic 1: **FULL FUNDING FOR THE INDIAN HEALTH SERVICE/INDIAN HEALTH FACILITIES**

- Advanced Appropriations
- Permanent Exemption from Sequestration
- Mandatory Appropriations
- Electronic Health Record

## Hot Topic 2: **IHCIA ELDER LONG TERM CARE, ASSISTED LIVING & HOSPICE AUTHORITIES**

## Hot Topic 3: **IHCIA BEHAVIORAL HEALTH AUTHORITIES – FUNDING THROUGH APPROPRIATIONS, NOT GRANTS**

# Phoenix Area Hot Issues

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Hot Topic 4: **CHR, HEALTH EDUCATION/NEW APPROPRIATIONS FOR NATIONAL COMMUNITY HEALTH AIDE PROGRAM (CHAP)**

Hot Topic 5: **INDIAN HEALTH PROFESSIONS/MID-LEVEL PROVIDERS (RECRUITMENT & RETENTION)**

Hot Topic 6: **TELEHEALTH/IT INFRASTRUCTURE**

Hot Topic 7: **TRADITIONAL HEALING (POLICY SUPPORT, INTEGRATION AND COMPLEMENTARY SERVICES)**

Hot Topic 8: **EXTRA SUPPORT FOR SMALL TRIBES (H&C, M&I, EQUIPMENT)**

Hot Topic 9: **MATERNAL & CHILD HEALTH (+PIMC OB LABOR & DELIVERY)**

# Phoenix Hot Issues

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Hot Topic 10: **ROCKY MOUNTAIN SPOTTED FEVER (RMSF)/ANIMAL CONTROL**

Hot Topic 11: **100% FMAP COVERAGE FOR URBAN INDIAN HEALTH, FTCA  
COVERAGE FOR URBAN INDIAN HEALTH**

Hot Topic 12: **IHCIA CONSTRUCTION AUTHORITIES (PRIORITY LIST, UNMET  
CONSTRUCTION NEEDS IN ALL AREAS, & URBAN FACILITIES)**

# Success Stories

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Funding & partnerships have made a difference!

- Fort Yuma Health Center – Staffing and operating dollars for the new facility were made available in FY 2019. The newly built ambulatory care facility that serves the Cocopah Tribe and the Quechan Tribe replaced the oldest IHS facility in the country in 2018.
- In FY 2019, Phoenix Area received a **8.6%** increase in the Dental Health line item, a **7.4%** increase in the Mental Health line item and a **5.8%** increase in the Urban Health line item.

# Success Stories

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Phoenix Area **8.6%** increase in the Dental Health line item in 2019:

- New dental positions were added:
  - 3 new dentists – 2 at Ft. Yuma, AZ & 1 at Whiteriver, AZ
  - 2 new dental assistants & 1 receptionist/admin. assistant at Ft. Yuma, AZ
  - 2 new dental hygiene positions; Ft. Duschesne, UT, & Ft. Yuma, AZ
- 2,307 additional patient visits in FY 2019 in the Phoenix Area
- 3D panoramic X-ray capability made available at Elko, NV and needed equipment, chairs and cabinetry bought for other locations.
- Phoenix Area sponsored infection control and dental program management training

# Success Stories

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Funding has made a difference! The Phoenix Area received a **7.4%** increase in the *Mental Health* line item in 2019.

- Funding now available for Behavioral Health (BH) clinical positions at four locations - Ft. Duschene, UT, Elko, NV, Yuma, AZ and PIMC (AZ).
- Area Behavioral Health team assisted IHS HQ roll out of the ASQ (Ask Suicide-screening Questions) pilot project at Whiteriver, AZ.
- 5 – 1 hour webinars on children's Mental Health issues and mental health assessments offered for I/T/U Behavioral Health staff. 60 free continuing education units (CEU's) were awarded.
- Phoenix Area sponsored or delivered over 3000 CEU's to Area I/T/U Behavioral Health staff in 2019, an increase of ~15% over 2018.

# Success Stories

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Funding has made a difference!

- The Phoenix Area received a **5.8%** increase in the Urban Health line item in 2019. These funds provided helped open a new clinic; add personnel; purchase equipment/medical supplies; increase professional development training and funding for dental services.
  - This has resulted in increased access to medical and dental care to meet the demand for services and improve the skills and knowledge of the staff.
-

# FY 2023 Phoenix Area Recommendations

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Thank you for your time and consideration!

- *Chairman Torres*
- *Chairperson Borchardt-Slayton*

# FY 2023 Area Tribal Budget Consultation *Portland Area* *Report*

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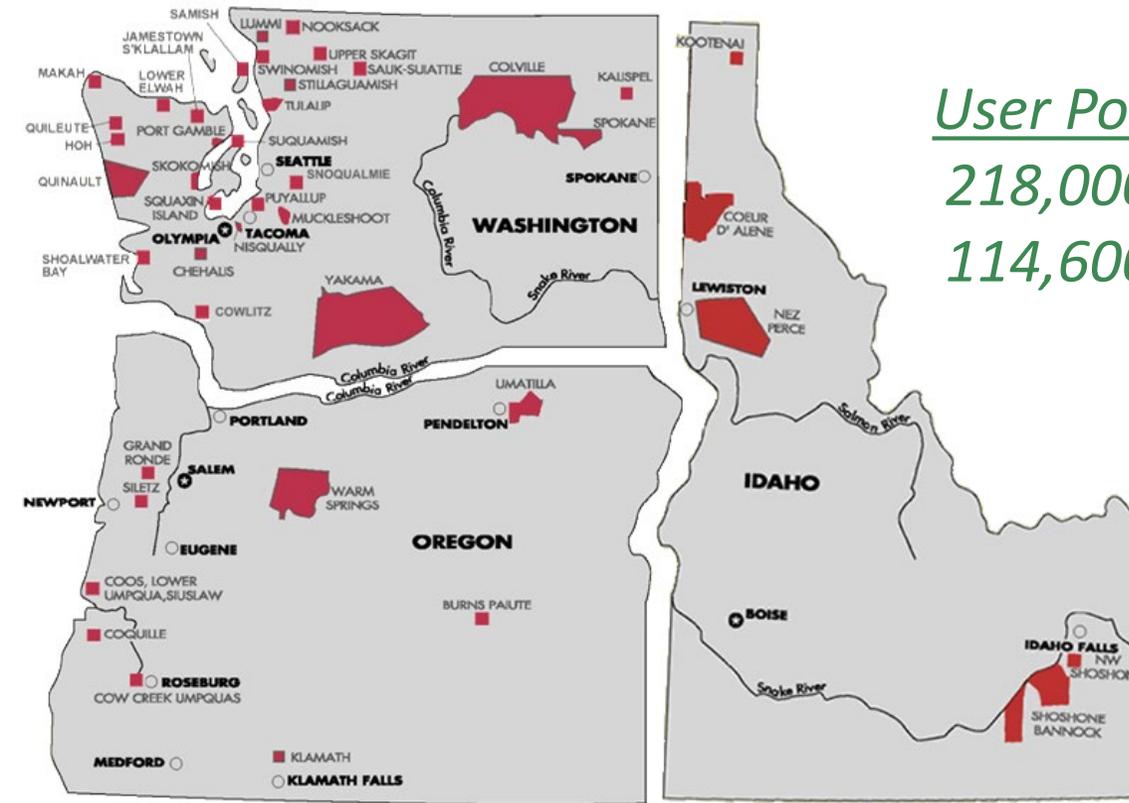
PRESENTED BY:

***STEVE KUTZ, TRIBAL COUNCIL MEMBER, COWLITZ INDIAN TRIBE***

# Summary of Service Area and Demographic Information

*Serving AI/AN residents of Oregon, Washington and Idaho.*

*Title 1 Tribes: 13  
Title 1 Orgs & YRTC: 3  
Title 1 DST: 5  
Title V Tribes: 25  
Urbans: 3*



*User Pop – (Approx.)*  
*218,000 registrants*  
*114,600 active*

Leading causes of death by race  
for decedents ages 1 and older, Portland Area  
2014-2016

*Prepared by NPAIHB Tribal Epidemiology Center*

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**Leading Causes of Death for non-Hispanic AI/AN  
people  
United States, 2018**

1. Heart Disease – 3,787 deaths

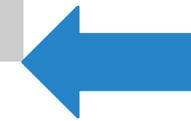
2. Cancer – 3,502 deaths

3. Accidents – 2,316

4. Chronic liver disease & cirrhosis – 1,148

5. Diabetes mellitus – 1,073

**COVID-19**  
February – October 2020  
**2,179 deaths**



# Summary of Funding Priorities

Budget Line Item	National Recommendation (\$ in Thousands)
Purchased/Referred Care	\$ 23,713,648
Hospitals and Health Clinics	\$ 8,067,747
Alcohol & Substance Abuse	\$ 2,551,657
Mental Health	\$ 2,418,547
Maintenance & Improvement	\$ 2,078,034
Urban Health	\$ 1,459,896
Indian Health Professions	\$ 1,243,613
Contract Support Costs	\$ 1,067,583
Sanitation Facilities Constr.	\$ 897,843
Health Care Fac. Constr.	\$ 793,729
Dental Services	\$ 752,364
Electronic Health Record System (New)	\$ 589,069

# Summary of Funding Priorities (Cont.)

Budget Line Item	National Recommendation (\$ in Thousands)
Equipment	\$ 493,397
Facil. & Envir. Hlth Supp.	\$ 489,306
Public Health Nursing	\$ 406,701
Comm. Health Reps	\$ 283,921
Health Education	\$ 282,028
Indian Health Care Improvement Fund	\$ 276,784
Direct Operations	\$ 121,586
Self-Governance	\$ 7,397
Tribal Management	\$ 2,694
Immunization AK	\$ 2,457
Community Health	\$ -

## Hot Issues Summary

IHS Funding

Medicaid Transformation – Value Based Payments (VBP)

IHS Health IT Modernization

Special Diabetes Program for Indians (SDPI)

Mental Health & Substance Use Disorder (SUD)

Focus on Prevention

Community Health Aide Program (CHAP) Expansion

Access to Treatment for Hepatitis C

Public Health

Regional Specialty Referral Center

Staffing, Recruitment and Retention

Urban Program Funding

Environment and Health Effects

OB/GYN Services

Missing and Murdered Indigenous People (MMIP)

Veteran's Administration Memorandum of Understanding (MOU)

COVID-19 3rd Party Revenue Losses

# FY 2023 Area Tribal Budget Consultation

*Alaska*

*Report*

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PRESENTED BY:

VICTOR JOSEPH, NATIVE VILLAGE OF TANANA

VERNÉ BOERNER, ALASKA NATIVE HEALTH BOARD

# Alaska Area Summary & Demographic Information

User Population:  
177,000

Federally  
Recognized  
Tribes: 229

Small community  
primary care centers: 171

Sub-regional mid-level  
care centers: 27

Multi-physician health centers: 4

Dedicated behavioral health  
centers: 4

Regional hospitals: 6

Alaska Native Medical Center  
tertiary care

Courtesy of ANTHC

# Summary of Funding Priorities

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Priority 1 - Hospitals & Health Clinics

Priority 2 - Dental Services

Priority 3 - Maintenance and Improvements

Priority 4 - Sanitation Facilities

# Alaska Hot Issues

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## **Supporting Sovereignty & Program Stability**

### **Investing in Infrastructure**

- Sanitation Facilities**
- Climate Change**
- Joint Venture Construction Program**
- Small Ambulatory Grants Program**
- Maintenance & Improvement**
- Staff Housing**
- Health IT**

### **Investing in People**

- Workforce**
- Development**

### **Investing in Programs and Building parity**

- Behavioral Health**
- Special Diabetes Program for Indians**
- Dental Services**
- Hepatitis C Treatment Funding Parity**
- Best Treatment**

### **Supporting the Continuum of Care**

- Long-term Care/Eldercare**
- Purchased and Referred Care**
- IHS Advance Appropriations**

# Success Stories

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- COVID-19 Testing Funding
- IHS Jurisdiction
- Self-Determination

# FY 2023 Area Tribal Budget Consultation *Tribal Self-Governance Advisory Report Report*

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PRESENTED BY: *CHIEF LYNN MALERBA, TSGAC TRIBAL CHAIR*

DELIVERABLE TO BE SUBMITTED: *JANUARY 29, 2021*

# Summary of Self-Governance

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- There are more than 375 Self-Governance Tribes from each IHS Area.
- Approximately \$2.6 billion of the IHS budget is administered by Tribes through Self-Governance or 45% of the total budget.
- The Office of Tribal Self-Governance provides key support to the negotiation, programmatic support, and transference of funding to Title V tribes. This includes in-person training and technical support.
- The Office also provides limited funding to support tribal self-governance planning and negotiation processes through cooperative agreements.

# Summary of Funding Priorities

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- Small request for the Office of Tribal Self-Governance to expand grant opportunities for Tribes who need support to transition to or strengthen their current health operations under Self-Governance.
- OTSG has limited funding each year to provide Planning and Negotiation Cooperative Agreements to Tribes interested in assuming tribal shares or improving their guiding documents. Additional funding would expand the number of tribes who can receive funding.

<i>(whole dollars)</i>	FY 2019 Final	FY 2020 Enacted
Planning Cooperative Agreements		
Number of Awards	6	5
Award Amount	\$113,100-120,000	\$120,000
Negotiation Cooperative Agreements		
Number of Awards	2	5
Award Amount	\$48,000	\$48,000

# Hot Issues

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- Mandate that Tribes and Tribal programs be permanently exempt from sequestration and rescissions
- Mandate Advance Appropriations for the Indian Health Service
- Authorize separate and indefinite appropriations for CSC and 105(I) lease agreements
- Specific funding Health Information Technology modernization efforts.

## FY 2023 Area Tribal Representatives and Technical Team

	Name	Title	Tribe/ Organization
<b>Alaska</b>	Verne Boerner	President/CEO	Alaska Native Health Board
	Victor Joseph	President/Chairman	Native Village of Tanana
	Jerry Moses-Proxy	Vice President	Intergovernmental Affairs, Alaska Native Tribal Health Consortium
	Jim Roberts- Proxy	Senior Executive Liason	Intergovernmental Affairs, Alaska Native Tribal Health Consortium
	<b>Technical Support Team</b>		
	Jacoline Bergstorm	Health Director	Tanana Chiefs Conference
	Jerry Moses	Vice President	Intergovernmental Affairs, Alaska Native Tribal Health Consortium
<b>Albuquerque</b>	Beverly Coho	AAIHB Vice Chair Member	Band of Ramah Navajos
	Ray Tafoya	Board Treasurer	Kewa Pueblo Health Corporation
	<b>Technical Support Team</b>		
	Sandra Winfrey	Executive Officer	IHS
<b>Bemidj</b>	Phyllis Davis	Council Member	Match-E-Be-Nash-She-Wish Pottawatomi
	Cathy Chavers	Chairwoman	Bois Forte Band of Chippewa Indians
	<b>Technical Support Team</b>		

	<b>Name</b>	<b>Title</b>	<b>Tribe/ Organization</b>
<b>ji</b>	Dr. Leo Chugunov	Health Director	Sault Saint Marie Health Center
	Jeff Bingham	Financial Management specialist	IHS
<b>Billings</b>	Andrew Werk Jr.	President	Fort Belknap Community Council
	Lee Spoonhunter	Vice-Chairman	Northern Arapaho Business Council
	<b>Technical Support Team</b>		
	Michelle Begay	Office of Tribal Programs	HIS
	Dylan Black Eagle	Budget Officer	IHS
	Tracy King	Board Member	Fort Belknap Community Council
<b>California</b>	Michael Garcia	Vice Chairman	Ewiiapaayp Band of Kumeyaay Indians
	Chris Devers	Tribal Representative	Pauma Band of Mission Indians
	<b>Technical Support Team</b>		
	Dan Redeagle	Financial Management Officer	IHS
	Nikolajs Berzins	Budget Analyst	IHS
<b>Great P</b>	Mark Fox	Chairman	Affiliated Tribe
	Rodney Bordeaux	President	Rosebud Sioux Tribe
	<b>Technical Support Team</b>		

	<b>Name</b>	<b>Title</b>	<b>Tribe/ Organization</b>
<b>Plains</b>	Jerome Lee Bearheels	Financial Manager	
	Sunny Colombe	Chief Operations Officer	Great Plains Tribal Chairmen's Health Board
<b>Nashville</b>	Edie Tullis Baker	Health and Elder Services Director	Poarch Band of Creek Indians
	Tihtiyas (Dee) Sabattus	Health Director	Passamaquoddy Indian Township
	<b>Technical Support Team</b>		
	Kerry Lassard	Executive Director	Micmac Service Unit IHS

	Name	Title	Tribe/ Organization
<b>Navajo</b>	Jonathan Nez	President	Navajo Nation
	Carl Slater	Delegate	Navajo Nation Council
	<b>Technical Support Team</b>		
	Jill Jim	Executive Director	Department of Health
<b>Oklahoma City</b>	Terri Parton	President	Wichita and Affiliated Tribes
	Del Beaver	Second Chief	Muscogee (Creek) Nation
	<b>Technical Support Team</b>		
	Melissa Gower	Senior Advisor, Policy Analyst	Chickasaw Nation
	Melanie Fourkiller	Policy Advisor	Choctaw Nation
	Kasie Nichols		Citizen Potawatomi Nation
Terra Branson-Thomas	Dir. of Plning,Grants & Self Governance	Muscogee (Creek) Nation	
<b>Phoenix</b>	Amber Torres	Chairman	Walker River Paiute Tribe
	Tamra Borchart-Slayton	Chairman	Paiute Indian Tribe of Utah
	<b>Technical Support Team</b>		
	Angela Lindsay	Financial Officer	IHS
	Arikah L. McClary	Budget Officer	IHS

	<b>Name</b>	<b>Title</b>	<b>Tribe/ Organization</b>
<b>Portland</b>	Andrew Joseph Jr.	Alternate	The Confederated Tribes of the Colville Reservation
	Steven Kutz	Council	Cowlitz Indian Tribe
	<b>Technical Support Team</b>		
	Laura Platero	Policy Director	NPAIHB
	CAPT Ann Arnett	Deputy Director	IHS
	Nichole Swanberg	Financial Mgmt. Director	Division of Financial Management,IHS
<b>Tucson</b>	Peter Yucupicio	Chariman	Pascua Yaqui Tribe
	Wavalene Saunders	Vice Chairwoman	Tohono O'odham Nation
	<b>Technical Support Team</b>		
	Mark Bigbey	Executive Officer	IHS
	Jesse Navarro	Government Affairs Assistant	Tohono O'odham Nation
	Reuben Howard	Executive Director	Pascua Yaqui Health Services Division

Indian Health Service  
FY 2023 National Tribal Budget Formulation Work Session  
**Survey**

Thank you for attending the FY 2022 IHS National Tribal Budget Formulation Work Session. In order to ensure the meeting met your needs and to determine how we might improve future meetings, we need your feedback and suggestions. Please complete this survey and return to the registration area or meeting organizers before you leave. Thank you.

Please check the box and provide any comments.

**1. The meeting was well organized.**

---

Agree                       Neutral                       Disagree

Comments:

**2. The meeting materials provided were informative and clear to understand.**

---

Agree                       Neutral                       Disagree

Comments:

**3. The speakers and presentations were informative.**

---

Agree                       Neutral                       Disagree

Comments:

**4. Adequate time was allotted to all the agenda items.**

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- Agree                       Neutral                       Disagree

Comments:

**5. What recommendations would you make to improve the National Tribal Budget Formulation Work Session?**

**6. Please provide any other feedback or comments that you would like to share about the overall meeting, presentations, length of day, topics, etc.**

# FY 2023 National Tribal Budget Formulation Work Session

## Virtual Meeting Tips & Procedures

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FEBRUARY 10<sup>TH</sup> – 12<sup>TH</sup>, 2021



# Getting Started

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There are two steps to log-in to the FY 2023 National Tribal Budget Formulation Work Session:

- ❖ Click the Zoom link provided on the Agenda for the corresponding day
- ❖ Dial in to the conference line with your phone:
  - Conference Line: 888-790-2011
  - Participant Code: 4639610
- ❖ Please note that you must dial in with your phone. Dial in using computer audio is disabled.

# Speaking & Raising Questions

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The Session will use an operator assisted line to facilitate communication and transcription. Please be sure to announce your name and the Area you represent before speaking.

- ❖ At the appointed times, the Operator will offer instructions for how to enter the speaker's queue.
- ❖ Tribal Representatives will have the opportunity to raise questions/make remarks.
- ❖ Technical Support Team members will have the opportunity to raise questions/make remarks after Tribal Leaders complete their questions/remarks.
- ❖ If the operator assisted line becomes cumbersome at any point, we can ask the operator to open all lines and discontinue the speaker's queue.

# Motions, Seconds, & Voting

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We will use the Zoom chat box to facilitate motions, seconds, and voting.

- ❖ To Make a Motion: Type “Motion” into the chat box, followed by the motion you wish to make.
- ❖ To Second a Motion: Type “Second” into the chat box.
- ❖ Voting Procedure: Moderator will perform a roll call vote by Area. Type “Yes,” “No,” or “Abstain” into the chat box.
- ❖ The IHS Federal team will display the motion using screen share. The IHS Federal team will also capture the votes by Area in a spreadsheet for future reference.

# Tribal Caucus, and Area Breakout Rooms

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NIHB will provide additional Zooms for Tribal Caucus and Area Breakout Rooms.

- ❖ Tribal Caucus: No federal staff will have access to this Zoom.
- ❖ Area Breakout Rooms: Each Area will have its own breakout room. Tribal Representatives and Technical Support Team members may invite Federal staff to use a given Area Breakout Room, if they so choose.

# Tips for Virtual Meetings

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Helpful hints for the best virtual meetings experience:

- ❖ Please keep your phone line muted while you are not speaking.
- ❖ Please don't put the line on "Hold." Hold music will play over the phone line, obstructing conversation.
- ❖ Use the chat box to raise technical issues. We will have IHS staff monitoring the chat box to resolve any issues that might occur.
- ❖ Use your full name on Zoom. Right click your zoom picture, and click "rename."
  - **Tribal Reps (2 per Area)** should put "TR" after their names, and their Area.
    - Example: First Last – TR/Area
  - **Tribal Support Team** members should put their Area after their name.
    - Example: First Last (Area)
  - **Federal staff** will put "IHS" after their name.
    - Example First Last - IHS