MAY 2022

Advancing Health Equity Through the Federal Trust Responsibility:

Full Mandatory Funding for the Indian Health Service and Strengthening Nation-to-Nation Relationships

The National Budget Formulation Workgroup's Recommendations on the Indian Health Service Fiscal Year 2024 Budget

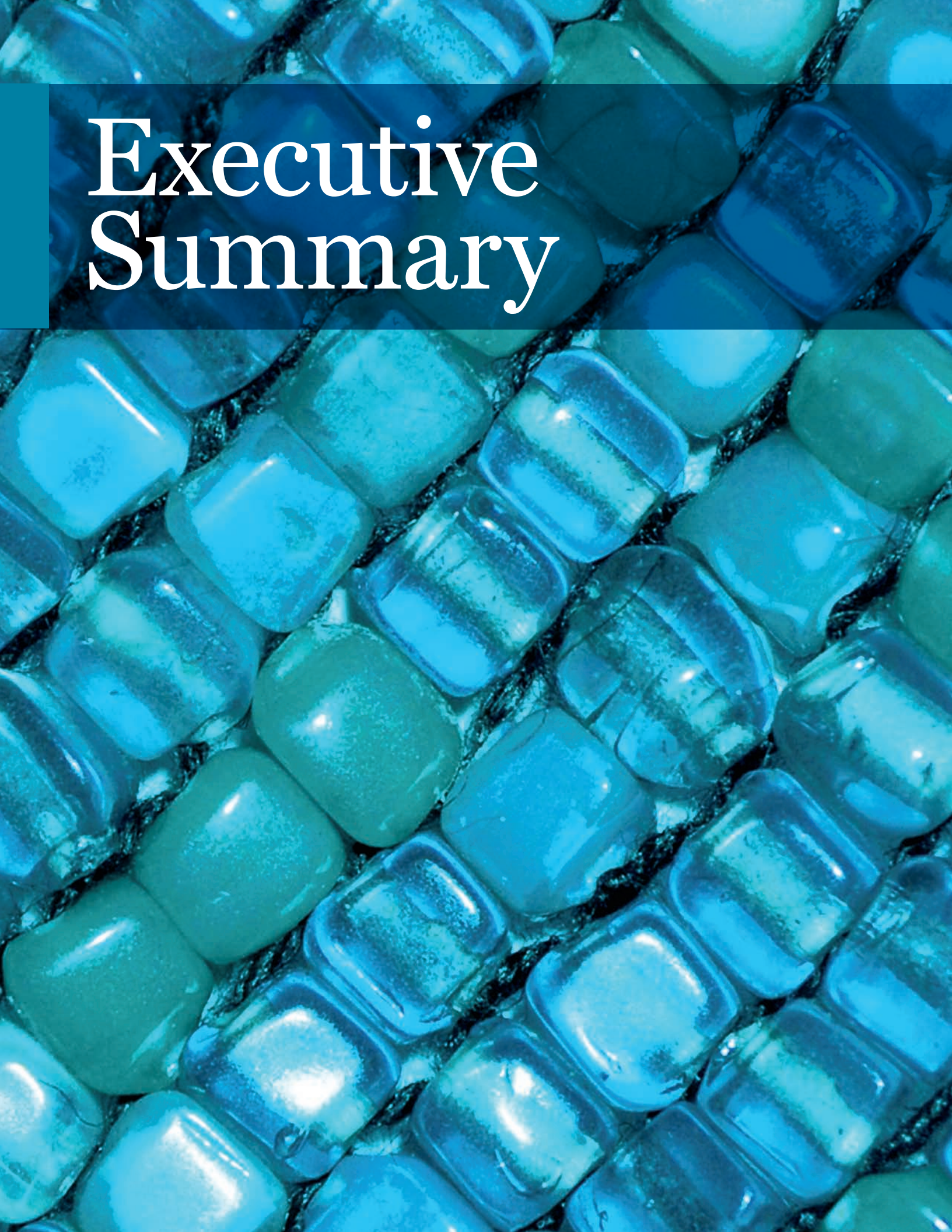
TRIBAL CO-CHAIRS

Amber Torres
Walker River Paiute

Victor Joseph
Tanana

Andrew Joseph, Jr.
Confederated Tribes of the Colville Reservation

Executive Summary



Tribal sovereign leaders on the national Tribal Budget Formulation Workgroup representing all 574 federally recognized sovereign Tribes within the twelve Indian Health Service Areas met on February 10-11, 2022, to exercise their right to provide meaningful input into the Indian Health Service budget request for the fiscal year 2024. Following thorough discussions of the Area Tribal health care needs, the national Tribal fiscal year 2024 budget priorities and recommendations were established, as highlighted below:

BUDGET RECOMMENDATION 1:
Urge the Administration to take immediate steps to address unfulfilled Trust and Treaty obligations with Tribal Nations by putting in place a strategy to finally end unacceptable health disparities and urgent life safety issues at the Indian Health Service and Tribal Health facilities by implementing a budget that fully funds the Indian Health Service at $51.42 billion.

At a full level of funding, the budget priorities include:

Rank	*Program Expansion*	*Funding Amount*
1.	Hospital and Clinics	$12.39 Billion
2.	Purchased/Referred Care	$8.30 Billion
3.	Indian Health Care Improvement Fund	$3.97 Billion
4.	Dental Services	$3.57 Billion
5.	Alcohol and Substance Abuse	$3.48 Billion
6.	Mental Health	$3.46 Billion
7.	Health Care Facilities Construction/ Other Authorities	$3.22 Billion
8.	Maintenance and Improvement	$3.14 Billion
9.	Sanitation Facilities Construction	$2.29 Billion
10.	Community Health Representatives	$1.25 Billion
11.	Urban Indian Health	$973.59 Million
12.	Public Health Nursing	$958.71 Million
13.	Health Education	$678.04 Million
14.	Equipment	$546.16 Million
15.	Electronic Health Record	$491.97 Million
16.	Facilities and Environmental Support	$441.56 Million
17.	Indian Health Professions	$335.27 Million
18.	Direct Operations	$101.87 Million
19.	Self-Governance	$55.89 Million
20.	Alaska Immunization	$42.54 Million
21.	Tribal Management Grants	$15.78 Million

The cumulative budget line amounts reflect the total Services and Facilities funding required of $49.65 billion. This amount reflects funds to maintain Continuing Services at the current level of service for pay costs, inflation, and population growth in the fiscal year 2024, plus the Service and Facilities Program budget line increases for the fiscal year 2024.

THE FISCAL YEAR 2024 CONTINUING SERVICES TOTALS $245.1 MILLION:

Federal pay costs	$35.95 Million
Tribal pay costs	$50.41 Million
Inflation (non-medical)	$5.36 Million
Inflation (medical)	$42.50 Million
Population Growth	$110.88 Million

BINDING OBLIGATIONS: $1.78 MILLION
The Tribal Budget Formulation Workgroup also proposes the following increase for Binding Obligations which the Indian Health Service expects to have to pay in the fiscal year 2024 as follows:

Binding Obligations	*Funding Amount*
New Staffing for Newly Constructed Facilities	$75 Million
Contract Support Costs - Need	$1.03 Billion
Health Care Facilities Construction (Planned)	$100 Million
105*(l)* Lease Cost Agreements	$572.47 Million
Total Binding Obligations Estimate	$1.78 Billion

In sum, the total of Continuing Services, Program Expansion, and Binding Obligations is $51.42 billion.

OTHER FISCAL YEAR 2024 BUDGET RECOMMENDATIONS:

BUDGET RECOMMENDATION 2:
Preserve Medicaid, Medicare, the State Children's Health Insurance Program, the Indian Health Care Improvement Act, and Indian-specific provisions in the Affordable Care Act and provide dedicated funding to begin implementing the new authorities and provisions of the Indian Health Care Improvement Act, which have not yet been implemented and funded.

BUDGET RECOMMENDATION 3:
Fully and Equitably Fund Critical Healthcare Facilities Construction Investments made by Tribes in the absence of the Indian Health Service fully and equitably; with respect to healthcare facilities construction and all available authorities of the Indian Health Care Improvement Act.

BUDGET RECOMMENDATION 4:
Make health IT funds available to both the Indian Health Service and Tribes under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 5301 et seq.) and request Congress to allow funds to be used by Tribes for corresponding needs from health IT modernization whether for a Tribal owned system or an Indian Health Service system.

BUDGET RECOMMENDATION 5:
Permanently Exempt Tribes, Tribal Programs, and Urban Indian Organizations from Sequestration and Recissions.

BUDGET RECOMMENDATION 6:
Enact Advance Appropriations for the Indian Health Service.

BUDGET RECOMMENDATION 7:
Authorize federally operated health facilities and the Indian Health Service headquarters to use federal dollars efficiently and adjust programmatic fund flexibility across accounts at the local level, in consultation with Tribes.

BUDGET RECOMMENDATION 8:
Require the Department and the Office of Management and Budget to work with Congress to create a mandatory appropriation account for the status and legal obligation to pay contract support costs and 105*(l)* lease agreements, to avoid competition with discretionary funding that could be directed to other program increases.

BUDGET RECOMMENDATION 9:
Permanently reauthorize the Special Diabetes Program for Indians and increase funding to $250 million per year, with built-in automatic annual medical inflationary increases, authorize Tribes and Tribal organizations to receive awards through P.L. 93-638 contracts and compacts. Restore previous reductions to the program resulting from sequestration.

BUDGET RECOMMENDATION 10:
Provide recurring funding and authority to build public health infrastructure to address current and future public health emergencies, which includes declaring the Indian Health Service as a jurisdiction for medical countermeasures, while maintaining the flexibility of Tribes to receive from both the states and the Indian Health Service. Provide Tribes with direct access to the National Strategic Stockpile while Tribal flexibility to access state and Indian Health Service resources. Ensure resources and flexibility are available to address staffing shortages and healthcare facility capacity issues.

BUDGET RECOMMENDATION 11:
Ensure the Office of Management and Budget is engaged in Tribal budget formulation for meaningful Engagement.

BUDGET RECOMMENDATION 12:
Expand the Community Health Aide Program nationally, which includes programs in the State of Alaska.

BUDGET RECOMMENDATION 13:
Expand the Community Health Representative Program.

BUDGET RECOMMENDATION 14:
Indian Health Service should end the practice of competitive grant-making was not required by statute; as appropriate, such funds should be distributed to Tribes through the Indian Self-Determination and Education Assistance

Act contracts and making such funds eligible for contract support costs and eliminating burdensome grants administration. Funding made available under these contracts and compacts should also be increased to meaningfully fund programs that meet patient needs.

BUDGET RECOMMENDATION 15:
Indian Health Service should remove remaining bureaucratic barriers to ensure all American Indian/Alaska Native communities and homes have adequate access to running water. The Indian Health Service should also make it a clear priority to provide sanitation services to all American Indian/Alaska Native communities, and to work on this by providing operations and maintenance assistance to ensure sanitation services are reliable and affordable.

BUDGET RECOMMENDATION 16:
Congress should address the dire need for long-term care, assisted living, home and community-based, and hospice services in American Indian/Alaska Native communities and appropriate recurring funding for this need.

While incremental increases are much needed to sustain the historical level of services, they do little to address the disparate health conditions of American Indian/Alaska Native communities. Unfortunately, the two to five percent incremental increases to the Indian Health Service budget over the past decade have not adequately kept pace with expenses related to population growth and medical and non-medical inflation.

Leaders of Tribal nations insist that a true and meaningful investment be made to eradicate the pervasive health disparities that have overwhelmed Indian Country for years. It takes a true nation-to-nation partnership between the United States trustees and Tribal nations' governance to put a strategy and budget in place to advance health equity through the federal trust responsibility. American Indian/Alaska Native Tribes have put their best strategy and budget together in this Fiscal Year 2024 Budget Request; it is time for the United States trustees to also put forward their best strategy and budget honor the trust responsibilities.

Decisive action by this Administration must occur to prioritize department resources to bring the health of American Indian/Alaska Native citizens closer to parity with the rest of the citizens of the United States. As prior years' testimonies pointed out, we must rise above just settling for maintenance and incremental funding. Doing so only continues what has proven to be an unacceptable level of health care being provided to Tribal citizens, far below what is acceptable to the general United States population.

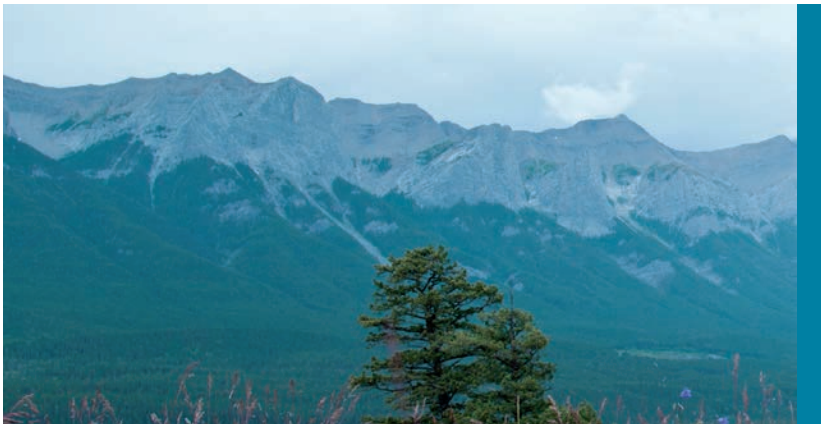
In the fiscal year 2021 and fiscal year 2022, Tribes strongly advocated for and welcomed the supplemental funds for Indian health through the various COVID-19 relief legislative packages; however, these funds only scratched the surface of addressing decades of neglect of basic public health infrastructure and services. There is so much work left to be done. Tribes stand with President Biden that these funds only serve as a down payment for the true funding needed to meet the treaty and trust responsibilities for all health services. The Tribes have repeatedly and thoughtfully stated true Tribal health funding needs, including public health and infrastructures, for decades through this budget formulation process.

The **Indian Health Care Service All-Purpose Table** illustrates the budget for the fiscal year 2024 compared to the enacted budget for the fiscal year 2022 and the President's fiscal year 2022. The fiscal year 2024 request is a departure from previous requests that asked for conservative percentage increases to be phased in over 10-12 years. It is more apparent than ever that our Tribal

nations will never achieve a full funding, needs-based budget unless we boldly stand up for the true need to address the ever-growing health disparities in Indian Country. Requesting a percentage increase based on a fiscal year budget inadequately funded from the outset allows the realization of only marginal gains for Tribes. This means we can never make health status, health systems, or public health systems. Note the large, significant changes in the chart that reflect this new way of advocating for the funds the Indian Health Service desperately needs.

Indian Health Service All Purpose Table (dollars in thousands)

Sub IHS Activity	FY 2022 Enacted	FY 2022 President's Budget	FY 2024 NTBFW Roll-Up Average	Difference in FY 2022 Enacted compared to FY 2024	Difference in FY 2022 President's compared to FY 2024
SERVICES					
Hospitals & Health Clinics	2,399,169	2,703,574	12,388,401	+9,989,232	+9,684,827
Electronic Health Record System	145,019	284,500	491,967	+346,948	+207,467
Dental Services	235,788	287,326	3,572,197	+3,336,409	+3,284,871
Mental Health	121,946	124,622	3,460,648	+3,338,702	+3,336,026
Alcohol & Substance Abuse	258,343	267,490	3,481,085	+3,222,742	+3,213,595
Purchased/Referred Care	984,887	1,191,824	8,303,663	+7,318,776	+7,111,839
Indian Health Care Improvement Fund	74,138	317,306	3,972,419	+3,898,281	+3,655,113
Total, Clinical Services	4,219,290	5,176,642	35,670,380	+31,451,090	+30,493,738
Public Health Nursing	102,466	102,693	958,713	+856,247	+856,020
Health Education	23,250	22,164	678,038	+654,788	+655,874
Community Health Representatives	63,679	65,557	1,247,277	+1,183,598	+1,181,720
Immunization AK	2,148	2,174	42,535	+40,387	+40,361
Total, Preventive Health	191,543	192,588	2,926,562	+2,735,019	+2,733,975
Urban Health	73,424	100,000	973,588	+900,164	+873,588
Indian Health Professions	73,039	92,843	335,272	+262,233	+242,429
Tribal Management	2,466	2,485	15,784	+13,318	+13,299
Direct Operations	95,046	107,788	101,874	+6,828	-5,914
Self-Governance	5,850	5,990	55,886	+50,036	+49,896
Total, Other Services	249,825	309,106	1,482,405	+1,232,580	+1,173,299
TOTAL SERVICES	**4,660,658**	**5,678,336**	**40,079,347**	**+35,418,689**	**+34,401,012**
FACILITIES					
Maintenance & Improvement	169,664	222,924	3,138,800	+2,969,136	+2,915,876
Sanitation Facilities Construction	197,783	351,445	2,287,386	+2,089,603	+1,935,941
Health Care Facility Construction	259,293	525,781	3,220,242	+2,960,949	+2,694,461
Facility & Environmental Health Suppo	283,124	300,153	441,564	+158,440	+141,411
Equipment	30,464	100,640	546,159	+515,695	+445,519
TOTAL Facilities	940,328	1,500,943	9,634,151	+8,693,823	+8,133,208
TOTAL Services & Facilities	**5,600,986**	**7,179,279**	**49,713,499**	**+44,112,513**	**+42,534,220**
Contract Support Costs	**880,000**	**1,142,000**	**1,130,408**	**+250,408**	**-11,592**
Section 105(l) Leases	**150,000**	**150,000**	**572,467**	**+422,467**	**+422,467**
TOTAL IHS BUDGET	**6,630,986**	**8,471,279**	**51,416,373**	**+44,785,387**	**+42,945,095**



Indian Health Service All Purpose Table (dollars in thousands)							
Sub IHS Activity	**FY2021 Enacted**	**FY 2022 Enacted**	**FY 2022 President's Budget**	**FY 2024 NTBFW Roll-Up Average**	**percentage change from FY 2021 Enacted to FY 2022 enacted**	**Percentage Change from FY 2022 President's to FY 2022 enacted**	**Proportion of the FY2024 budget**
SERVICES							
Total, Clinical Services	3,901,877	4,219,290	5,176,642	35,670,380	8.1	-18.5	69.4
Total, Preventive Health	178,789	191,543	192,588	2,926,562	7.1	-0.5	5.7
Total, Other Services	220,725	249,825	309,106	1,482,405	13.2	-19.2	2.9
TOTAL SERVICES	**4,301,391**	**4,660,658**	**5,678,336**	**40,079,347**	8.4	-17.9	78.0
FACILITIES							
TOTAL Facilities	917,888	940,328	1,500,943	9,634,151	2.4	-37.4	18.7
TOTAL Services & Facilities	**5,219,279**	**5,600,986**	**7,179,279**	**49,713,499**	7.3	-22.0	96.7
Contract Support Costs	916,000	880,000	1,142,000	1,130,408	-3.9	-22.9	2.2
Section 105(l) Leases	101,000	150,000	150,000	572,467	48.5	0.0	1.1
TOTAL IHS BUDGET	**6,236,279**	**6,630,986**	**8,471,279**	**51,416,373**	**6.3**	**-21.7**	**100**

The table provides an analysis at the significant levels to provide some context of the budget from the fiscal year 2021 to the fiscal year 2024 request.

Significant takeaways from the table include the following:

- While some areas of the budget increased substantially from the fiscal year 2012 to the fiscal year 2022, the overall increase in the Indian Health Service budget was only 6.3 percent, with contract support costs falling by almost 4 percent and facilities only increasing by 2.4 percent. The 6.3 percent increase was primarily driven by the increase in Section 105*(l)* leases (48.5 percent increase) and does not provide adequate funding for the Indian Health Service.
- Congress did not follow the President's fiscal year 2022 budget and funded the Indian Health Service at almost 22 percent lower than the President's recommendation.
- While the request for full funding in the fiscal year 2024 might seem significant, overall, it is less than eight times the fiscal year 2022 enacted budget.
- More than three-fourths of the funding request (78 percent) is for services (clinical, preventative health, and others). These services go directly to Tribal members for the care promised to them and are legally owed to them through the trust responsibility.

The following tables show the distribution of budget requests across the sub-activity for each Indian Health Service area. The fiscal year 2024 budget request is created by averaging the requests of the twelve Indian Health Service sub-activity areas.

INDIAN HEALTH SERVICE

FY 2024 National Tribal

FY 2024 National Tribal Budget Recommendation in Thousands: 12 Area Rollup Level over FY 2023 National Tribal Budget Recommendation

Planning Base (FY 2023 National Tribal Budget Recommendation): $50,138,679	Average	Alaska	Albuquerque	Bemidji	Billings	California	Great Plains
Current Services							
Federal Pay Costs	35,945	35,945	35,945	35,945	35,945	35,945	35,945
Tribal Pay Costs	50,412	50,412	50,412	50,412	50,412	50,412	50,412
Inflation (non-medical)	5,357	5,357	5,357	5,357	5,357	5,357	5,357
Inflation (medical)	42,504	42,504	42,504	42,504	42,504	42,504	42,504
Population Growth	110,879	110,879	110,879	110,879	110,879	110,879	110,879
Total Current Services	**$245,097**	**$245,097**	**$245,097**	**$245,097**	**$245,097**	**$245,097**	**$245,097**
New Staffing for Newly-Constructed Facilities	75,000	75,000	75,000	75,000	75,000	75,000	75,000
Contract Support Costs-Need	1,030,408	1,267,583	1,267,583	956,645	1,267,583	1,267,583	1,267,583
Health Care Facilities Construction (planned)	100,000	100,000	100,000	100,000	100,000	100,000	100,000
105(l) Lease cost Agreements	572,467	675,000	675,000	789,605	675,000	675,000	675,000
Total, Binding Obligations	**$1,777,875**	**$2,117,583**	**$2,117,583**	**$1,921,250**	**$2,117,583**	**$2,117,583**	**$2,117,583**
Services							
Hospitals & Health Clinics	12,189,240	26,979,531	13,229,327	13,578,476	5,591,444	13,229,327	13,229,327
Electronic Health Record	491,967	0	451,051	500,400	490,478	451,051	451,051
Dental Services	3,558,859	12,263,423	3,161,584	3,340,467	4,806,680	3,161,584	3,161,584
Mental Health	3,455,272	0	3,956,215	4,060,627	6,719,541	3,956,215	3,956,215
Alcohol and Substance Abuse	3,471,702	0	3,104,509	3,280,162	13,046,701	3,104,509	3,104,509
Purchased/Referred Care (formerly CHS)	8,261,917	0	7,314,979	7,563,242	5,640,491	7,314,979	7,314,979
Indian Health Care Improvement Fund	3,964,771	0	2,448,190	1,847,649	1,030,002	2,448,190	2,448,190
Total, Clinical Services	35,393,728	39,242,954	33,665,855	34,171,023	37,325,338	33,665,855	33,665,855
Public Health Nursing	953,491	0	841,003	825,117	4,414,298	841,003	841,003
Health Education	675,486	0	760,875	574,232	1,863,815	760,875	760,875
Community Health Representatives	1,245,424	0	1,493,536	1,281,548	3,040,961	1,493,536	1,493,536
Alaska Immunization	42,476	490,537	2,526	1,895	2,526	2,526	2,526
Total, Preventive Health	2,916,878	490,537	3,097,941	2,682,792	9,321,599	3,097,941	3,097,941
Urban Indian Health	970,781	0	955,300	1,081,448	931,908	955,300	955,300
Indian Health Professions	334,631	0	279,542	318,565	641	279,542	279,542
Tribal Management Grants	15,776	0	26,414	19,934	8	26,414	26,414
Direct Operations	99,226	0	103,168	77,861	2,649	103,168	103,168
Self-Governance	55,769	0	50,510	38,120	118	50,510	50,510
Total, Other Services	1,476,183	0	1,414,934	1,535,928	935,323	1,414,934	1,414,934
Services Total	**$39,786,789**	**$39,733,491**	**$38,178,729**	**$38,389,743**	**$47,582,260**	**$38,178,729**	**$38,178,729**
Facilities							
Maintenance & Improvement	3,133,816	4,905,369	2,762,552	3,544,327	245,239	2,762,552	2,762,552
Sanitation Facilities Construction	2,280,418	4,414,832	2,304,586	2,591,514	294,287	2,304,586	2,304,586
Health Care Facilities Constr./Other Authorities	3,220,064	0	4,516,998	3,750,256	392,382	4,516,998	4,516,998
Facilities & Environmental Health Support	428,345	0	462,015	348,682	441,429	462,015	462,015
Equipment	543,969	0	828,812	625,505	98,096	828,812	828,812
Facilities Total	**$9,606,612**	**$9,320,201**	**$10,874,963**	**$10,860,284**	**$1,471,433**	**$10,874,963**	**$10,874,963**
GRAND TOTAL	***$51,416,373***	***$51,416,372***	***$51,416,373***	***$51,416,373***	***$51,416,373***	***$51,416,373***	***$51,416,373***

** (dollars in thousands)*

Budget Recommendation

FY 2024 National Tribal Budget Recommendation in Thousands: 12 Area Rollup Level over FY 2023 National Tribal Budget Recommendation

Planning Base (FY 2023 National Tribal Budget Recommendation): $50,138,679	Average	Nashville	Navajo	Oklahoma	Phoenix	Portland	Tucson
Current Services							
Federal Pay Costs	35,945	35,945	35,945	35,945	35,945	35,945	35,945
Tribal Pay Costs	50,412	50,412	50,412	50,412	50,412	50,412	50,412
Inflation (non-medical)	5,357	5,357	5,357	5,357	5,357	5,357	5,357
Inflation (medical)	42,504	42,504	42,504	42,504	42,504	42,504	42,504
Population Growth	110,879	110,879	110,879	110,879	110,879	110,879	110,879
Total Current Services	**$245,097**	**$245,097**	**$245,097**	**$245,097**	**$245,097**	**$245,097**	**$245,097**
New Staffing for Newly-Constructed Facilities	75,000	75,000	75,000	75,000	75,000	75,000	75,000
Contract Support Costs-Need	1,030,408	1,267,583	1,267,583	0	1,267,583	0	1,267,583
Health Care Facilities Construction (planned)	100,000	100,000	100,000	100,000	100,000	100,000	100,000
105(l) Lease cost Agreements	572,467	675,000	675,000	0	680,000	0	675,000
Total, Binding Obligations	**$1,777,875**	**$2,117,583**	**$2,117,583**	**$175,000**	**$2,122,583**	**$175,000**	**$2,117,583**
Services							
Hospitals & Health Clinics	12,189,240	17,078,974	6,429,327	4,589,665	13,511,867	5,594,291	13,229,327
Electronic Health Record	491,967	1,244,273	451,051	0	699,249	713,948	451,051
Dental Services	3,558,859	2,709,872	3,161,584	0	3,013,005	764,944	3,161,584
Mental Health	3,455,272	3,170,533	4,956,215	0	3,758,404	2,973,083	3,956,215
Alcohol and Substance Abuse	3,471,702	3,684,132	3,207,035	0	2,949,283	3,075,075	3,104,509
Purchased/Referred Care (formerly CHS)	8,261,917	8,564,360	4,014,979	7,649,441	6,949,230	29,501,347	7,314,979
Indian Health Care Improvement Fund	3,964,771	835,105	1,148,190	30,597,765	2,325,780	0	2,448,190
Total, Clinical Services	35,393,728	37,287,248	23,368,381	42,836,872	33,206,818	42,622,688	33,665,855
Public Health Nursing	953,491	707,828	1,041,003	0	798,953	290,679	841,003
Health Education	675,486	695,801	960,875	0	722,831	244,782	760,875
Community Health Representatives	1,245,424	1,204,566	1,693,536	0	1,418,859	331,476	1,493,536
Alaska Immunization	42,476	2,127	0	0	2,526	0	2,526
Total, Preventive Health	2,916,878	2,610,322	3,695,415	0	2,943,170	866,937	3,097,941
Urban Indian Health	970,781	628,989	955,300	509,963	1,900,000	1,820,567	955,300
Indian Health Professions	334,631	355,321	279,542	0	265,565	1,677,777	279,542
Tribal Management Grants	15,776	12,211	26,414	0	25,093	0	26,414
Direct Operations	99,226	381,372	103,168	0	98,247	114,742	103,168
Self-Governance	55,769	318,049	50,510	0	52,735	7,649	50,510
Total, Other Services	1,476,183	1,695,941	1,414,934	509,963	2,341,639	3,620,735	1,414,934
Services Total	**$39,786,789**	**$41,593,511**	**$28,478,729**	**$43,346,834**	**$38,491,627**	**$47,110,360**	**$38,178,729**
Facilities							
Maintenance & Improvement	3,133,816	2,014,098	3,262,552	7,649,441	2,624,425	2,310,131	2,762,552
Sanitation Facilities Construction	2,280,418	1,453,449	6,504,586	0	2,189,357	698,649	2,304,586
Health Care Facilities Constr./Other Authorities	3,220,064	2,360,446	9,516,998	0	4,516,998	35,697	4,516,998
Facilities & Environmental Health Support	428,345	1,325,657	462,015	0	438,914	275,380	462,015
Equipment	543,969	306,532	828,812	0	787,372	566,059	828,812
Facilities Total	**$9,606,612**	**$7,460,182**	**$20,574,963**	**$7,649,441**	**$10,557,065**	**$3,885,916**	**$10,874,963**
GRAND TOTAL	***$51,416,373***	***$51,416,373***	***$51,416,373***	***$51,416,373***	***$51,416,372***	***$51,416,373***	***$51,416,373***
$ Change over Planning Base	1,277,694	1,277,694	1,277,694	1,277,694	1,277,693	1,277,694	1,277,694
% Change over Planning Base	2.55%	2.55%	2.55%	2.55%	2.55%	2.55%	2.55%

** (dollars in thousands)*

INDIAN HEALTH SERVICE

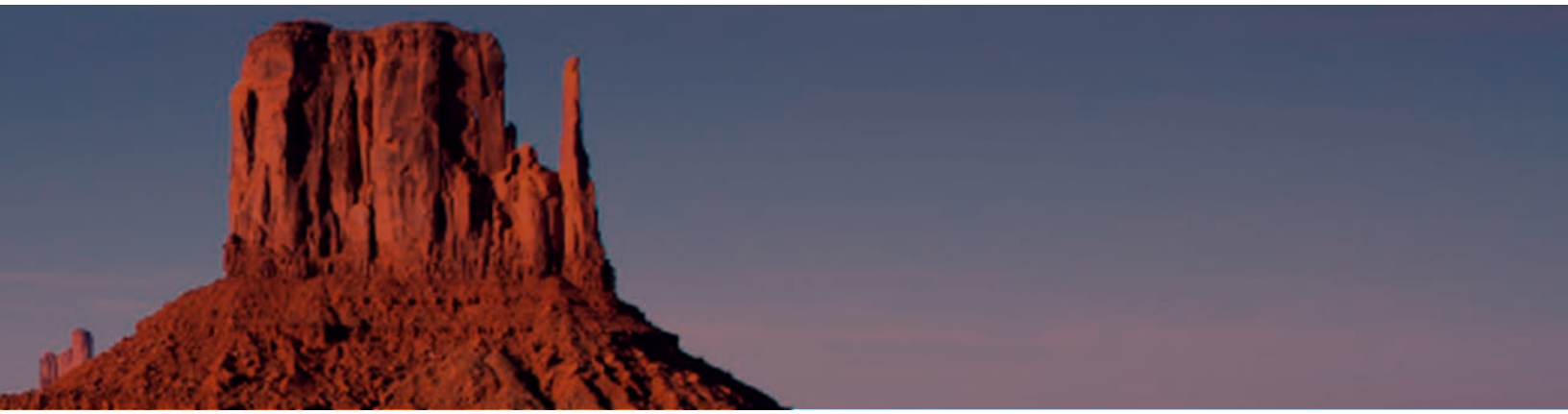
FY 2024 Summary of National Tribal Budget Recommendation*

Planning Base (FY 2023 National Tribal Budget Recommendation)	**$50,138,679**
Current Services - All 12 Areas recommended full funding	**$245,097**
Staffing Costs for Newly-Constructed Facilities Health Care Facilities	$75,000
Contract Support Costs Need (estimate)	$1,030,408
Health Care Facilities Construction Projects Priority List (estimate)	$100,000
105(l) Lease Cost Agreements	$572,467
Total Binding Obligations	**$1,777,875**
Total Binding Obligations & Current Services - All 12 Areas recommended full funding	**$2,022,972**

RANK	PROGRAM EXPANSION	TOTAL FUNDING REQUEST
1	Hospitals and Health Clinics	12,189,240
2	Purchased/Referred Care (formerly CHS)	8,261,917
3	Indian Health Care Improvement Fund	3,964,771
4	Dental Services	3,558,859
5	Alcohol and Substance Abuse	3,471,702
6	Mental Health	3,455,272
7	Health Care Facilities Constr./Other Authorities	3,220,064
8	Maintenance & Improvement	3,133,816
9	Sanitation Facilities Construction	2,280,418
10	Community Health Representatives	1,245,424
11	Urban Indian Health	970,781
12	Public Health Nursing	953,491
13	Health Education	675,486
14	Equipment	543,969
15	Electronic Health Record	491,967
16	Facilities & Environmental Health Support	428,345
17	Indian Health Professions	334,631
18	Direct Operations	99,226
19	Self-Governance	55,769
20	Alaska Immunization	42,476
21	Tribal Management Grants	15,776
Total (Base + Current Services + Program Expansion)		**$51,416,373**
Total (Planning Base)		**$50,138,679**
Total (Change Over Base + Program Expansion)		**$1,277,694**
Percent Over Planning Base		2.55%

** (dollars in thousands)*

Contents



Introduction

Building Health Equity with Tribal Nations

THE NEED FOR FULL AND MANDATORY FUNDING

Our Tribal nations continue to react and respond to the impacts of the COVID-19 pandemic. Two years in, they are beginning to assess its collateral damage and overall health system failures to determine a path forward for dealing with the next public health emergency. One truth that has become abundantly clear is that **allowing our health system to operate under the existing status quo is unacceptable**. Our people suffered disproportionate losses due to this pandemic; unless significant change happens, we have little reason to think the same would not happen again.

The tragic and devastating effects of the long-standing neglect of the Indian health system gained national attention during the pandemic. It was evident that our health delivery systems were ill-equipped to respond. The lack of public health infrastructure created new challenges. Tribes deserve better. Access to health care is a core element of the federal treaty and trust responsibility. The only way to ensure that the resources are available to guarantee that promise is to provide complete, mandatory funding to the Indian Health Service (IHS) in the fiscal year (FY) 2024 of $51.4 billion.

The theme chosen for this book, "Advancing Health Equity Through the Federal Trust Responsibility: Full Mandatory Funding for the Indian Health Service and Strengthening Nation to Nation Relationships," speaks acutely to what needs to be done to address the myriad of health issues plaguing Indian health in this country. Honoring the federal trust responsibility by requesting mandatory full funding for IHS will reverse substandard health outcomes and advance health equity for all American Indians/Alaska Natives (AI/ANs). Strengthening the nation-to-nation relationship requires *meaningful consultation* and *working with* Tribal leadership to ensure that policy and budget decisions reflect our true needs and solutions. We call for full and mandatory funding because, at its core, the federal trust responsibility is a sovereign and sacred promise. The United States should set the bar for any nation-state to aspire to have its word be golden, and its reputation for justice be unimpeachable. When our ancestors ceded land and all its rich resources to the United States, we were promised certain things sacred holdings. These promises will not be fulfilled until it is backed by the necessary full funding to achieve health parity for Tribal citizens comparable with the rest of our nation's citizens.

The failure to honor the promises made to our ancestors was detailed in the United States Commission on Civil Rights' 2018 report titled, *Broken Promises Report: Continuing Federal Funding Shortfall for Native Americans.* In the report's Executive Summary, the Commission wrote, "Since our nation's founding, the United States and Native Americans have committed to and sustained a special trust relationship, which obligates the federal government to promote Tribal self-government, support the general wellbeing of Native American Tribes and villages, and to protect their lands and resources. In exchange for the surrender and reduction of Tribal lands and removal and resettlement of approximately one-fifth of Native American Tribes from their original lands, the United States signed 375 treaties, passed laws, and instituted policies that shaped and defined the special government-to-government relationship between federal and Tribal governments. Yet the United States government forced many Native Americans to give up their culture. It did not provide adequate assistance to support their interconnected infrastructure, self-governance, housing, education, health, and economic development needs." The time to right this wrong and bring health equity for all AI/ANs is now. The time to honor and live up to sovereign nation-to-nation treaty and trust obligations is now.

The provision of health care is a fundamental element of the federal trust responsibility, Upheld again by the Eighth Circuit Court of Appeals in Rosebud Sioux Tribe v. United States. In that case, the Court discussed the duty of the government to provide "competent physician-led health care." The Court found that this duty did exist and that it had been strengthened by the Snyder Act and the Indian Health Care Improvement Act (IHCIA). Funds must be appropriated to honor this promise and ensure that "competent physician-led health care" can be provided throughout Indian Country.

TRIBAL RECOMMENDATIONS TO BUILD HEALTH EQUITY

The following 16 budget recommendations are put forward by the Tribal Budget Formulation Workgroup (TBFWG) as the national Tribal request for FY 2024. First and foremost is to recommend full mandatory funding to build health equity by investing in IHS and Tribal health delivery systems. As proposed, this and the remaining recommendations will provide the resources and policies needed to achieve improved health outcomes for our people. Throughout the next section of the document, we have listed each Tribal health priority with more detailed descriptions of their importance within each IHS program.

BUDGET RECOMMENDATION 1:
Increase the Tribal Budget Formulation Workgroup Recommendations to $51.4 billion for IHS in FY 2024. The $51.4 billion includes at a *minimum*:

- $245.90 million for full funding of current services (This amount is included within the total fully funded budget priorities as listed below).
- $1.78 billion for binding fiscal obligations.

Top budget priorities for programs and services at full funding (including continuing services):

Rank	*Program Expansion*	*Funding Amount*
1.	Hospital and Clinics	$12.39 Billion
2.	Purchased/Referred Care	$8.30 Billion
3.	Indian Health Care Improvement Fund	$3.97 Billion
4.	Dental Services	$3.57 Billion
5.	Alcohol and Substance Abuse	$3.48 Billion
6.	Mental Health	$3.46 Billion
7.	Health Care Facilities Construction/ Other Authorities	$3.22 Billion
8.	Maintenance and Improvement	$3.14 Billion
9.	Sanitation Facilities Construction	$2.29 Billion
10.	Community Health Representatives	$1.25 Billion
11.	Urban Indian Health	$973.59 Million
12.	Public Health Nursing	$958.71 Million
13.	Health Education	$678.04 Million
14.	Equipment	$546.16 Million
15.	Electronic Health Record	$491.97 Million
16.	Facilities and Environmental Support	$441.56 Million
17.	Indian Health Professions	$335.27 Million
18.	Direct Operations	$101.87 Million
19.	Self-Governance	$55.89 Million
20.	Alaska Immunization	$42.54 Million
21.	Tribal Management Grants	$15.78 Million

OTHER TRIBAL RECOMMENDATIONS FOR FY 2024

BUDGET RECOMMENDATION 2:
Preserve Medicaid, Medicare, the State Children's Health Insurance Program (CHIP), the Indian Health Care Improvement Act (IHCIA), and Indian-specific provisions in the Affordable Care Act (ACA) and provide dedicated funding to begin implementing the new authorities

and provisions of the IHCIA, which have not yet been implemented and funded.

BUDGET RECOMMENDATION 3:
Fully and Equitably Fund Critical Healthcare Facilities Construction Investments made by Tribes in the absence of IHS; concerning healthcare facilities construction and all available authorities of the IHCIA.

BUDGET RECOMMENDATION 4:
Make health IT (HIT) funds available to both IHS and Tribes under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 5301 et seq.) (ISDEAA) and request Congress to allow funds to be used by Tribes for corresponding needs from HIT modernization whether for a Tribal owned system or an IHS system.

BUDGET RECOMMENDATION 5:
Permanently exempt Tribes, Tribal Programs, and Urban Indian Organizations from Sequestration and Recissions.

BUDGET RECOMMENDATION 6:
Enact Advance Appropriations for IHS.

BUDGET RECOMMENDATION 7:
Authorize federally operated health facilities and IHS headquarters to use federal dollars efficiently and adjust programmatic fund flexibility across accounts at the local level, in consultation with Tribes.

BUDGET RECOMMENDATION 8:
Require the Department and the Office of Management and Budget (OMB) to work with Congress to create a mandatory appropriation account for the status and legal obligation to pay Contract Service Costs (CSC) and 105*(l)* lease agreements, to avoid competition with discretionary funding that could be directed to other program increases.

BUDGET RECOMMENDATION 9:
Permanently reauthorize the Special Diabetes Program for Indians (SDPI) and increase funding to $250 million per year, with built-in automatic annual medical inflationary increases, authorize Tribes and Tribal organizations to receive SDPI awards through P.L. 93-638 contracts and compacts. Restore previous reductions to the program resulting from sequestration.

BUDGET RECOMMENDATION 10:
Provide recurring funding and authority to build public health infrastructure to address current and future public health emergencies, which includes declaring IHS as a jurisdiction for medical countermeasures while maintaining the flexibility of Tribes to receive from both the states and IHS. Provide Tribes with direct access to the National Strategic Stockpile while preserving Tribal flexibility to access state and IHS resources. Ensure resources and flexibility are available to address staffing shortages and healthcare facility capacity issues.

BUDGET RECOMMENDATION 11:
Ensure the Office of Management and Budget (OMB) is engaged in Tribal Budget Formulation for Meaningful Engagement.

BUDGET RECOMMENDATION 12:
Expand the Community Health Aide Program (CHAP) Nationally, which includes programs in the State of Alaska.

BUDGET RECOMMENDATION 13:
Expand the Community Health Representative (CHR) Program.

BUDGET RECOMMENDATION 14:
IHS should end the practice of competitive grant-making that was not required by statute, and as appropriate, such funds should be distributed to Tribes through ISDEAA contracts and compacts, making such funds eligible for CSC and eliminating burdensome grants administration. Funding made available under these contracts and compacts should be increased to meaningful fund programs that meet patient needs.

BUDGET RECOMMENDATION 15:
IHS should remove remaining bureaucratic barriers to ensure that all Native American communities and homes have adequate access to running water. IHS should also make it a clear priority to provide sanitation services to all Native communities and to work to achieve this by providing Operations and Maintenance assistance to ensure sanitation services are reliable and affordable.

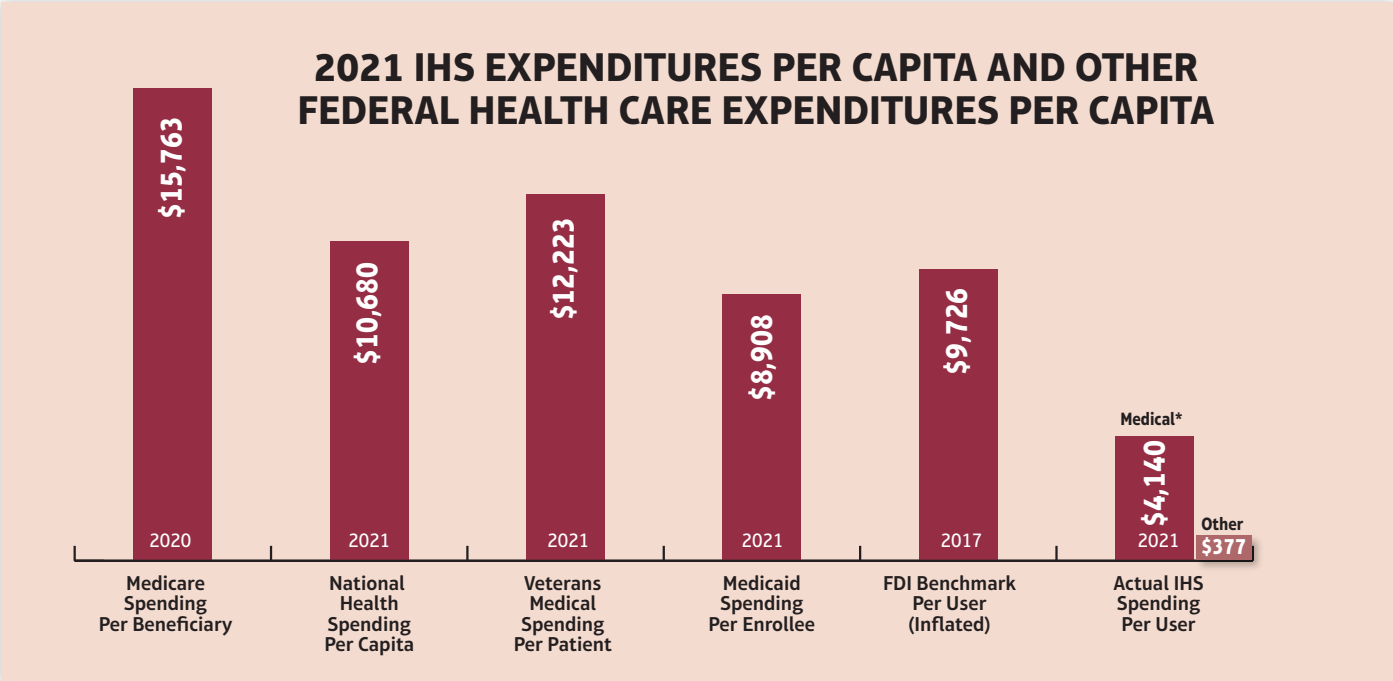
BUDGET RECOMMENDATION 16:
Congress should address the dire need for long-term care, assisted living, home and community-based, and hospice services in AI/AN communities and appropriate recurring funding for this need.

Tribal leaders continue to advocate for these key priorities because they are essential to honoring the nation-to-nation relationship and building health equity through honoring the trust responsibility. Tribal leaders strongly promote the need for full and mandatory funding because they have seen the failures resulting from only

incremental increases in the IHS budget. The COVID-19 pandemic showed that incrementalism is not how healthcare should be satisfied. Anything less than full funding is a broken promise.

ENDING THE HEALTH CRISIS: WHY HAVE NOT PRIOR-YEAR INCREMENTAL INCREASES WORKED?

While incremental increases are much needed to sustain the historical level of services, they do little to address the disparate health conditions of AI/AN communities. Incremental Increases are essential to cover expenses related to population growth and the rightful full funding of binding agreements such as CSC. However, even with an overall increase of 50 percent from FY 2010 to FY 2020, this falls far short of addressing medical inflation. The roughly two to three percent annual increase to the IHS budget does not keep pace with year-to-year increases in medical inflation, which are projected to be four to 10 percent in 2021, according to PricewaterhouseCooper's annual medical cost trend study. Moreover, except for FY 2006, the IHS budget has not passed on time, leading to a partial or full-year Continuing Resolution (CR). Because of the inherent budget constraints under a CR, which also do not account for medical inflation, the IHS budget is effectively decreasing over time in terms of its purchasing power and competitiveness with the mainstream healthcare system. Further, despite these incremental increases, IHS is funded on a per-user level far below other federal programs, as the graphic illustrates. Addressing these disparities will take much more than incremental increases.



EXISTING SYSTEMIC BARRIERS

At the core of the federal trust responsibility to Tribal nations is the fact that the federal government has charged the Department of Health and Human Services (HHS) and IHS with the health and welfare of Native peoples. During the nation's development of its public health infrastructure, Tribal nations have largely been left behind, thereby lacking the construct of the foundation necessary to responsibly implement Tribal public health authorities. Tribal nations lack the basic public health infrastructure and resources required to implement emergency preparedness and response protocols, establish preventative public health services, and develop the capacity to engage in disease surveillance, tracking, and response. And even though Tribal governments and all twelve Tribal Epidemiology Centers (TECs) are designated public health authorities by statute, they continue to encounter severe barriers to exercising these authorities due to a lack of education and enforcement.

The recent COVID-19 pandemic has given the federal government an opportunity to uphold its trust responsibility in a way that is perhaps unparalleled in modern American history. However, Tribes are increasingly running into systemic barriers that impede their ability to receive federal government help, slowing or even outright denying access to aid.

One reason is that in all but the latest COVID-19 relief packages, the federal government decided to use competitive grant-making to distribute funds to Tribes. To apply for competitive grants, Tribes need staff knowledgeable in grant writing to put together applications. Tribes that were lesser resourced found themselves having to use a skeleton staff to respond to requests for proposals to obtain access to the necessary funds to provide care for their people. If Tribes could not pull together the proposal within the time requirements, they were excluded from being able to access these critical resources.

Federal trust obligations to fund healthcare and public health in Indian Country cannot, and must not, be achieved through the competitive grant mechanism. By their very design, competitive grants create an inequitable system of winners and losers. The federal obligation to fully fund health services in Indian Country was never meant to be contingent upon a Tribe's ability to produce a grant application – yet that is the construct under which the federal government has forced Tribes to operate. That is unacceptable and goes against the principle of a government-to-government relationship.

Instead, a more effective way to distribute aid to Tribes would be through a fixed funding formula that ensures sufficient, recurring, and sustainable funding reaches all Tribal nations. Doing so would allow Tribes to know what funding was available to them, how much they were getting, and plan to utilize that money to help their citizens. It would also alleviate the burden on Tribes to use their over-extended staff to take time away from their primary duties to apply for grant funding. The United States ***must*** commit to making the direct allocation of funding the norm in the future.

FY 2024 NATIONAL TRIBAL BUDGET RECOMMENDATIONS

The TBFWG puts forward the following recommendations as the national Tribal request for FY 2024. The narrative describes the national Tribal priorities for proposed program budget increases and explains the importance of each program within the Indian Health system.

First Recommendation:

Fully Fund the Indian Health Service at $51.4 Billion.

Since 2003, Tribal leaders have been working collaboratively to develop national Tribal priorities for healthcare to arrive at a fully funded Indian Health Service (IHS) budget. In the years since, Tribal leaders, technical advisors, and other policy advisors have met during the annual national Tribal Budget Formulation work session to fully update the amounts needed to fund the IHS budget. Tribal Budget Formulation Work Group (TBFWG or "the Workgroup") has consistently supported the full funding request necessary to provide quality health care to all AI/AN beneficiaries. As the years have gone by, the needs have not remained static. Emerging technologies have made health IT modernization more important than ever. Growing obligations such as 105*(l)* leases and contract service costs (CSC) have strained an already constrained budget. As needs have evolved, the gap between what was appropriated, and the actual need, have only continued to grow.

The annual increases to the IHS budget fail to account for facilities upgrades, including newly authorized facilities under the Indian Health Care Improvement Act (IHCIA). Existing space in IHS facilities is only at 52 percent of need based on the size of the IHS population. While the average age of hospitals nationwide is ten years, it is nearly four times older in Indian Country, at 37.5 years. Without the full funding of IHS, these needs cannot be addressed.

The failure to appropriate the necessary funding each year has caused the health disparities between American Indian/Alaska Natives (AI/ANs) and other populations to widen. The cost and time required to close these funding and health disparity gaps have predictably grown. The full-funding estimate is updated annually, using the most current available population and per capita health care cost information. The IHS need-based funding aggregate cost estimate for fiscal year (FY) 2024 is approximately $51 billion.

The IHS is the only federal healthcare system created due to treaty obligations. It is also the most chronically underfunded federal healthcare system and the only federal healthcare system not exempt from government shutdowns or continuing resolutions. IHS's existence as a mechanism for fulfilling trust and treaty rights places an enhanced onus on the federal government to ensure that it is funded fully. Without full funding, access to health care remains an unfulfilled promise.

Current Services and Binding Agreements | $2.032 Billion

Tribal leaders are adamant that the FY 2024 budget request covers Current Services and all other binding requirements. Tribes have long insisted that the annual request transparently disclose all known expected cost obligations to demonstrate the true funding base required to sustain current services and meet obligated fiscal requirements. Deliberately understating the true cost necessary to meet the entire fiscal obligation for these financially binding agreements hides the fact that less money is available to expand needed services when incremental increases in funding are appropriated. In past years, funding increases have not even been sufficient to cover these expenses, effectively resulting in an actual decrease in funding for other budget lines compared to the previous year. These real obligations include actual federal and Tribal pay costs, true medical and non-medical inflation, population growth, planned increases in staffing for new and replacement facilities, CSC, healthcare facilities construction priorities, Section 105*(l)* lease costs, and all expected off-the-top mandatory assessments. The workgroup strongly recommends that full funding for Current Services and other "binding" fiscal requirements at the true projected costs of $2.023 billion be requested, as reflected in this section.

CURRENT SERVICES (FIXED COSTS) — $245.1 MILLION

The Workgroup recommends funding of $245.1 million for direct and Tribally provided health care services to cover increased costs associated with population growth, pay cost increases for workers, medical and non-medical inflation, and ensure base funding to continue existing levels of health care services. The $245.1 million of increased costs (pay act, inflation, etc.) are spread throughout the appropriate IHS budget lines and reflected within the total fully funded budgeted amounts (Hospital & Clinics (H&C), purchased/referred care (PRC), etc.) reflected in the budget narrative.

Tribal and federal facilities cannot continue to offer salaries below the competitive market. According to a 2018 report by the US General Accountability Office (GAO), the provider vacancy rate varies by IHS Area from 13 percent to 31 percent, with an average of 25 percent vacancy rate.[1] No health system can run a quality program lacking one-fourth of the necessary staff. According to the report, IHS has difficulty matching local market salaries, a factor in the high vacancy rates. In May 2021, IHS reported to GAO that they had utilized a contractor provider tracking system to better inform decisions about staffing and budget. This budget request uses current data to address staffing shortages. Further, the Workgroup feels strongly that commissioned officers, civil service, and Tribal employees should be exempt from any federal pay freeze that may be imposed in FY 2024. We cannot allow pay scales for our health professionals to be so substandard that they are forced to look elsewhere to seek a fair wage.

The Current Services request also includes $5.36 million for Non-Medical Inflation and $42.5 million for Medical Inflation. This is the minimum amount necessary to inflation-proof services as the actual inflation rate for different components of the IHS health care delivery system is much greater. The Consumer Price Index (CPI) increased by 7.66 percent over the past 12 months and is calculated at 6.5 percent for all items less food and energy.[2] The medical inflation for 2022 is predicted to be 6.5 percent.[3] The Workgroup asserts the inflation rates applied to H&C, Dental Health, Mental Health, and PRC in developing the IHS budget should correspond to the appropriate components in the CPI to reflect the true level of funding needed to maintain current services.

BINDING AGREEMENTS (FIXED COSTS) — $1.78 BILLION

The National Budget Formulation Workgroup recommends funding of $1.78 billion for estimated costs associated with Binding Obligations, including $75 million for staffing costs for newly constructed facilities, $1.03 billion for CSC, $100 million for binding obligations related to the Health Care Facilities Construction (HCFC) Priorities List, and $572.5 million for 105*(l)* leases.

1 Indian Health Service. (2018, Aug. 15). *Agency Faces Ongoing Challenges Filling Provider Vacancies*. Retrieved from: https://www.gao.gov/products/gao-18-580#.

2 Calculated from April 2021 to March 2022 using https://www.bls.gov/data/inflation_calculator.htm and https://www.bls.gov/charts/consumer-price-index/consumer-price-index-by-category.htm

3 https://www.pwc.com/us/en/industries/health-industries/library/behind-the-numbers.html

STAFFING COSTS $75 MILLION

The Workgroup recommends funding $75 million in FY 2024 to pay for staffing for new facilities opening in FY 2024. This amount is an estimate and must be adjusted to match the requirements for current facility staffing obligations.

CONTRACT SUPPORT COSTS — $1.030 BILLION

The Workgroup recommends $1.030 billion to fund statutory, fully, and legally obligated CSC funding for current, new, and expanded programs. The Workgroup recognizes that this amount is subject to change based on the actual CSC obligations and reconciliation requirements of the IHS-CSC Manual. Tribes operate approximately 60 percent of the IHS budget under the Indian Self-Determination and Education Assistance Act (ISDEAA). The Act allows Tribes to assume the administration of programs, services, functions, and activities previously carried out by the federal government. IHS transfers operational costs for administering health programs to Tribes through the "Secretarial amount," which is the amount IHS would otherwise have spent to administer the health programs. In addition, Tribes are authorized to receive an amount for CSCs that meet the statutory definition and criteria. The ISDEAA, Supreme Court decisions, requires that these costs be paid and are a statutory and legal requirement for IHS to comply.

Additionally, the Workgroup recommends the United States Department of Health and Human Services (HHS) Secretary, IHS Director, and OMB work with Congress to create a mandatory appropriation account to fund CSC payments, in addition to 105*(l)* lease agreements. While there is currently an indefinite discretionary account to fund CSC and 105*(l)* leases, the way this funding is structured continues to compete with discretionary spending caps assigned to the various Appropriation Co mmittees. This diverts discretionary funding that could be directed to other program increases in the IHS accounts. Moving CSC and 105*(l)* funding to a mandatory account would alleviate this problem.

HEALTH CARE FACILITIES CONSTRUCTION — $3.22 BILLION

The recognition of federally recognized Tribes has expanded the IHS system covering more Tribes such as the Nashville area. The IHS system comprises 46 hospitals (24 IHS operated, 22 Tribal) and 640 health centers, health stations, village clinics, and school health centers (85 IHS operated, 471 Tribal).[4] At these facilities, there were an estimated 40,563 inpatient admissions and 15.825 million outpatient visits in 2023.[5]

	Hospitals	Health Centers	Alaska Village Clinics	Health Stations	School Health Centers
IHS	24	51	N/A	25	12
Tribal	22	319	146	79	8

Aging health facilities are a factor for ongoing facility upkeep that impacts the quality of health services and access to care. The number of aging facilities worsens maintenance and repair costs, risks building code noncompliance, lowers productivity and compromises service delivery. On average, IHS hospitals are 40 years old, almost four times more than other United States hospitals, with an average age of 10.6 years.[6] A 40-year-old facility is about 26 percent more expensive than a 10-year facility.[7] In many cases, the management of existing facilities has relocated ancillary services outside the main health facility, often to modular office units, to provide additional space for primary health care services. Such displacement of programs and services creates difficulties for staff and patients, increases wait time, and creates numerous inefficiencies within the health care system. For example, ongoing concerns about electrical and sewer systems at Gallup Indian Medical Center limits medical service expansion and compliance with infection control and regulatory requirements.[8] Consequently, the older facility cannot handle the needed services even if staffing levels are adequate.[9]

4 Source: Indian Health Service. Fiscal Year 2023 Congressional Justification. See page CJ-33.

5 Source: Indian Health Service. Fiscal Year 2023 Congressional Justification. See page CJ-53.

6 *Almanac of hospital financial & operating indicators: a comprehensive benchmark of the nation's hospitals* (2015 ed., pp. 176-179): https://aharesourcecenter.wordpress.com/2011/10/20/average-age-of-plant-about-10-years/

7 Adams, Tim, et al. Operations and Maintenance Benchmarks for Health Care Facilities. International Facility Management Association, 2010

8 Testimony from Randy Grinnell, MPH on Examining Federal Facilities in Indian Country before House Committee on Natural Resources. Statement by Randy Grinnell, MPH, Deputy Director for Management Operations, Indian Health Service, United States Department of Health and Human Services on Examining Federal Facilities in Indian Country before House Committee on Natural Resources Subcommittee for Indigenous Peoples of the United States. June 17, 2021. https://www.hhs.gov/about/agencies/asl/testimony/2021/06/17/examining-federal-facilities-indian-country.html

9 *The 2016 Indian Health Service and Tribal Health Care Facilities' Needs Assessment Report to Congress*. Indian Health Service. July 6, 2016. Accessed at https://www.ihs.gov/newsroom/includes/themes/newihstheme/display_objects/documents/RepCong_2016/IHSRTC_on_FacilitiesNeedsAssessmentReport.pdf on November 7, 2016. p. 12

Inadequate hospital facility capacity per population contributes to poor health outcomes. The absence of adequate facilities frequently results in either treatment not being sought; or sought later, prompted by worsening symptoms, and referral of patients to outside communities. This significantly increases the cost of patient care and causes travel hardships for many patients and their families. AI/AN populations have risen substantially in recent years resulting in severely undersized facility capacity relative to the larger actual population, especially the ability to provide current outpatient services.

The facilities within the IHS system can accommodate 52 percent of the user population, contributing to overcrowding and even unsafe conditions among staff, patients, and visitors. Furthermore, these aging facilities are primarily based on a simplistic and outdated design, making it difficult for the agency to deliver modern services.[10] **Improving healthcare facilities is essential for:**

- Eliminating health disparities and health care disparities.
- Increasing access.
- Improving patient outcomes.
- Reducing operating and maintenance costs.
- Improving staff satisfaction, morale, recruitment, and retention.
- Reducing medical errors and facility-acquired infection rates.
- Improving staff and operational efficiency.
- Enhancing regulatory compliance.
- Modernizing medical, laboratory, and information equipment technologies.
- Increasing patient and staff safety.

Over the last several years, investigators at the Centers for Medicare and Medicaid Services (CMS) and the HHS Office of the Inspector General (OIG) have cited those outdated facilities directly threatening a patient's care. For example, in more than half of the hospitals surveyed by the OIG in 2016, administrators reported that old or inadequate physical environments challenged their ability to provide quality care and maintain compliance" with the Medicare Hospital Conditions of Participation (CoPs).[11]

"Further, according to administrators at most IHS hospitals (22 of 28), maintaining aging buildings and equipment is a major challenge because of limited resources. In FY 2013, funding limitations for essential maintenance, alterations, and repairs resulted in approximately $166 million backlogs."[12] In fact, over one-third of all IHS hospitals deficiencies are related to facilities, with some failing on infection control criteria and others having malfunctioning exit doors. Other facilities are just not designed to be hospitals, and IHS has had to work around historical buildings which are not equipped for a modern medical environment.[13]

For many AI/AN communities, these failing facilities are the only option patients have. Tribal communities are often located in remote, rural locations, and patients do not have access to other forms of health insurance to treat them elsewhere. As several Tribal leaders have testified, all our patients want is to feel comfortable and safe within the environment where care is provided. It is well known that improving the physical healthcare environment is linked to better patient outcomes, reduced medical errors, reduced stress and anxiety, and improved patient and staff safety.[14] This is difficult to do when facil-

10 *The 2016 Indian Health Service and Tribal Health Care Facilities' Needs Assessment Report to Congress*. Indian Health Service. July 6, 2016. Accessed at https://www.ihs.gov/newsroom/includes/themes/newihstheme/display_objects/documents/RepCong_2016/IHSRTC_on_FacilitiesNeedsAssessmentReport.pdf on November 7, 2016. p. 12

11 Indian Health Service Hospitals: Longstanding Challenges Warrant Focused Attention to Support Quality Care. Department of Health and Human Services, Office of the Inspector General. October 2016. OEI-06-14-00011.

12 Indian Health Service Hospitals: Longstanding Challenges Warrant Focused Attention to Support Quality Care. p. 14..

13 Indian Health Service Hospitals: Longstanding Challenges Warrant Focused Attention to Support Quality Care. p. 15.

14 Facilities Appropriations Information Report (Package). Indian Health Service. March 7, 2019.

ities are in disrepair or overcrowded and medical equipment has outlived its useful life.

BACKGROUND

The total funding required to complete the projects on the current Health Care Facilities Construction Priority List is $2.02 billion, plus the funding required for the new construction system and projects already identified by IHS Areas at $14.5 billion was identified in the 2016 IHS and Tribal Health Care Facilities' Needs Assessment Report to Congress.

The summary of the findings notes that "the cost to increase IHS facilities to needed capacity is enormous, about $14.5 billion with expanded and active authority facility types. Our findings identify an aging infrastructure in which many facilities were constructed before the advent of contemporary health care delivery models. The aging network escalates maintenance and repair costs, risks code noncompliance, lowers productivity and compromises service delivery. Facility space capacity is inadequate for actual and projected AI/AN user populations. The shortage is a consequence of AI/AN demographic trends, modern facility codes/standards, and the gradual obsolesce of older space and equipment. The problem will worsen if current demographic trends continue in future years."

An updated report, the "2020 Facilities Appropriations Information Report (Package)," was completed by IHS on January 30, 2020. It updated the five-line items within the IHS Facilities Appropriation to describe in more detail the potential benefits, challenges, and impact of various funding levels in its own section.

SECTION 105*(l)* LEASES — $572.476 MILLION*

The Indian Self-Determination and Education Assistance Act (ISDEAA) at 25 U.S.C. § 5324*(l)* authorizes IHS to enter a lease for a facility upon the request of a Tribal nation or Tribal organization for the administration or delivery of programs, services, and other activities under the Act. Lease requests have grown exponentially in the past four years, with many Tribal nations increasingly turning to 105*(l)* leases in response to the chronic underfunding of facility maintenance, repair, and replacement costs.

As held by the United States District Court for the District of Columbia under *Maniilaq Association v. Burwell* in 2016, Section 105*(l)* leases must be paid in full by IHS. However, in response to growing lease proposals and failing to adequately project costs in FY 2018 and FY 2019, IHS disregarded Tribal recommendations obtained through government-to-government consultation by unilaterally reprogramming critical funding twice from other line items to fund these obligations. This included $25 million in FY 2018 from inflationary increases and $72 million in FY 2019 from inflationary increases and staffing packages due to construction delays. For FY 2020, Congress provided $125 million for 105*(l)* lease funding, an $89 million increase from the FY 2019 enacted level. While this increase helped to prevent another large reprogram within the IHS budget, it impacted overall funding for IHS by consuming approximately 50 percent of the agency's total appropriations increase in FY 2020.

For FY 2021, IHS supported a separate, indefinite appropriation for 105*(l)* leases by recommendations from Tribal nations. While Tribal nations are pleased that Congress honored our guidance and provided a separate, indefinite appropriation for this binding obligation, this is only a short-term solution to address the impacts of rising 105*(l)* costs. Although this mechanism insulates other IHS budget lines from future reprogramming, IHS's estimate of total funding for 105*(l)* obligations is funded as a part of its total allocation from Congress.

With every likelihood that this obligation, and therefore, IHS's estimate, will grow, Tribal nations are concerned that 105*(l)* costs could have a detrimental impact on overall increases for IHS, including funds for patient care. With this in mind, the Workgroup continues to urge funding for 105*(l)* leasing to be moved to the mandatory side of the federal budget. We urge IHS to support this move to ensure its other lines are insulated from its binding obligations.

In addition, in the FY 2024 Budget Request, IHS proposed statutory limitations to 105*(l)* leases in the absence of Tribal consultation. Rather than making unilateral proposals that undermine IHS's obligation to seek the guidance of Tribal nations, the Workgroup asks that IHS convene a joint Tribal-federal workgroup to assist with policy development around 105*(l)* lease negotiations and calculations. The Workgroup further expects that any 105*(l)* leasing policy be developed in consultation with Tribal nations.

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

Program Expansion Increases | Services Budget

The recommended FY 2024 program increases outlined in this section represents a critically needed infusion of resources, totaling $36.57 billion above the FY 2023 Workgroup recommendation. These national priorities identified and agreed to by Tribal leaders are the result of a year-long Tribal consultation process that includes a discussion by individual Tribes and urban Indian health programs, meetings held by each IHS Area Office, and a final national session in which Tribal leaders representing each region of the country came together to develop the national priorities for the Indian health care system. These recommendations build upon prior progress gained through efforts by IHS, Tribes, and Urban Indian programs to improve the delivery and quality of health care and reduce the high level of health care disparities that are magnified among the AI/AN population.

HOSPITAL AND CLINICS — $12.388 BILLION

For FY 2024, the Workgroup recommends an amount of $12.388 billion, which is $9.685 billion above the FY 2022 enacted level for the Hospital and Clinics (H&C) line item. Sufficient funding for H&C remains the top priority for FY 2024, as it provides the base funding for 605 hospitals, clinics, and health programs that operate on Indian reservations, predominantly in rural and frontier settings. This core funding provides direct medical care services to AI/AN. Increasing H&C funding is critical as it supports medical care services provided at IHS and Tribally operated facilities, including emergency care, inpatient and outpatient care, and specialized care, including for diabetes prevention, maternal and child health, youth services, contagious and infectious disease treatment, and women's and men's health. Importantly, H&C funds provide the greatest flexibility to support the required range of services needed to target chronic health conditions affecting AI/ANs.

The demands on direct care services are a continuous challenge in our facilities. We experience constant and increased demand for services due to population growth and the increased rates of chronic diseases that result in growing patient workloads. In addition, rarely do the two to three percent increases to the annual appropriated IHS budget adequately account for rising medical inflation yearly. This effectively means that, over time, IHS and Tribal health systems are losing funding. Medical inflation impacts the H&C line item as IHS, and Tribal facilities fail to keep up with rising medical costs. Underfunding of H&C translates to rationed care that is less accessible and of lower quality, further limiting efforts toward making meaningful improvements to AI/AN health disparities.

Adding chronic challenges in recruiting and retaining providers in rural health care settings and lacking adequate facilities and equipment, H&C resources are stretched. As a result, any underfunding equates to limited health care access, especially for patients that are not eligible for, or who do not meet the medical criteria for, referrals through Purchased/Referred Care (PR) 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. For these reasons and the numerous accesses to care issues that Tribal members experience, an increase of $569 million is not exorbitant but realistic in fulfilling unmet needs across Indian Country.

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

A critical component to achieving the full potential of hospitals and clinics is fully funding the Indian Health Care Improvement Act. The provisions in this law represent a promise made by the federal government to improve the health of our people significantly, yet this law remains unfunded. For Tribes, this is a huge disappointment. We renew our request to the federal government to keep its promise by funding IHCIA authorities. Tribes also request that funding for these new authorities should be in addition to the base level H&C funding.

LONG-TERM CARE

The Workgroup recommends funding long-term care facilities as this item is authorized under the IHHCA

and currently has an unfunded mandate. AI/AN communities continue to experience an increasing need for AI/AN elders accessing clinical (Skilled Nursing Facility, Nursing Facility, Rehabilitation after hospitalization) and non-clinical (Activities of Daily Living, Residential Care Adult Day Care, Independent Living Homes, Assisted Living Homes) long-term care facilities. Current long-term facilities operated in Tribal community's experience a lack of consistent resources for startup and operational sources from federal agencies.

The 2016 IHS and Tribal Health Care Facilities' Needs Assessment Report to Congress showed long-term facilities for clinical and non-clinical services in the top five priorities. The preliminary estimated need for this expanded authority is $734.1 million for long-term clinical facilities and $478.7 million for long-term clinical facilities. A budget line item for long-term facilities is a priority to our Tribal leaders and AI/AN communities. AI/AN elders prefer to remain on Tribal lands among their people and maintain a cultural connection through kinship and relationship networks that support their healing, health, and well-being.

PURCHASED/REFERRED CARE — $8.304 BILLION

For FY 2024, the Workgroup recommends a total of $8.303 billion for the Purchase Referred Care (PRC) line item. IHS and Tribally operated facilities serve primarily rural populations and provide limited primary care and community health services. With only 46 hospitals throughout the Indian Health Care Delivery System, PRC is vital to ensure adequate care is provided to AI/ANS and remains a top funding priority.

PRC was established to allow IHS and Tribally operated facilities to secure essential health care services from private sector providers when such services, especially emergent and specialty care services, are unavailable within our systems. Much of the secondary care and nearly all the tertiary care 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.

Inadequate funding for the Indian Healthcare Delivery System and PRC forces IHS and Tribal nations to ration health care based on an antiquated ranked medical priority system because the federal government has not met its trust and treaty obligations. Often PRC funding does not extend beyond Priority I or Priority II status, which creates significant challenges in the health status of individual AI/ANs and communities.

Unfortunately, the adverse impacts of COVID-19 in Indian Country extend far beyond these sobering public health statistics. Tribal economies have been shuttered by social distancing guidelines that have also severely strained Tribal healthcare budgets. Because of the chronic underfunding of IHS, Tribal governments have innovatively found ways of maximizing third-party reimbursements from payers like Medicare, Medicaid, and private insurance. For many self-governance Tribes, third-party collections can constitute up to 60 percent of their healthcare operating budgets. However, because of cancellations of non-emergent care procedures in response to COVID-19, many Tribes have experienced third-party reimbursement shortfalls ranging from $800,000 to $5 million per Tribe per month. In a hearing before House Interior Appropriations on June 11, 2020, former IHS Director Rear Admiral (RADM) Weahkee stated third-party collections had plummeted 30-80 percent below last year's collections levels and that it would likely take years to recoup these losses.

The Portland Area has proposed the Regional Specialty Referral Center Demonstration Project under Section 143 of the Indian Health Care Improvement Act that will provide culturally sensitive access to specialty care. The three regional facilities are planned to enhance the services available from existing Tribally operated and direct services facilities and is a solution to the continual barriers faced by AI/AN people accessing specialty care in the Northwest.

Without annual increases to PRC, Tribal health programs without access to an IHS or Tribal hospital go severely underfunded for inpatient care. Through the Director's Workgroup on Improving PRC, the IHSC developed a formula for increased funding for those Tribal health programs without access to an IHS/Tribal hospital — often referred to as the access to care factor. However, the access to care factor is only funded when there are increases to PRC, which has only happened three times—in FY 2010, 2012, and 2014. When this access to care factor is not funded, those Tribal health programs must cover all inpatient care, limiting their ability to cover additional services in higher priority tiers.

Investments in PRC would 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 reduce health disparities among our nation's first people.

INDIAN HEALTH CARE IMPROVEMENT FUND — $3.972 BILLION

In FY 2024, the workgroup recommends a total of $3.972 billion for the Indian Health Care Improvement Fund (IHCIF) to address the Indian health system's significant funding disparities within IHS among Areas and Tribes within each Area. Because of its limited funding, IHS currently spends only $4,078 per user nationwide compared to the average national healthcare spending of $9,726.

The IHCIA established the IHCIF to eliminate these deficiencies and inequities in the health status and health resources of Indian Tribes. The legislation requires a Congress report documenting the funding level needed to address the current health status and resource deficiencies for each IHS Service Unit, Indian Tribe, or Tribal organization.

Despite significant AI/AN health disparities, a rising user population, and legislative authority to fund the IHCIF to address resource deficiencies and inequities, Congress has only provided $259 million for distribution to IHS Service Units, Indian Tribes, or Tribal organizations through the IHCIF via the Level of Need (LNF) formula since adopted in 2001. Unfortunately, gains in parity are negated by rescissions and sequestration. While Tribes appreciate the allocation of $259 million, the IHCIF has not been allotted additional funding since the FY 2018 allocation. Since the user population is increasing year over year and health disparities continue to grow, consistent funding is necessary to achieve the goals of the ICHIF.

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

- Finalize the IHCIF report.
- Adopt the recommendations on the new allocation methodology for better articulation of the IHCIF in the future through Tribal consultation.
- Update the IHCIF allocation methodology data and release it to all Tribes annually.
- Increase and equitably distribution of the IHCIF will ensure greater access to high-quality, culturally appropriate care and services across the IHS/Tribal/Urban system.

DENTAL SERVICES — $3.572 BILLION

The Workgroup recommends a total of $3.572 billion for Dental Services. Many native communities are struggling under the continued weight of oral health disparities. Oral Health is one of the 23 Leading Health Indicators in Healthy People 2030, which identifies public health priorities to help individuals, organizations, and communities across the United States improve health and well-being.

The reasons for poor dental health in Tribal communities include geographic isolation that continue to limit available providers, economic and racial disparities, and the historical trauma of decades of inadequate health care. The three oral conditions most affecting overall health

and quality of life are cavities, severe gum disease, and severe tooth loss.[15]

AI/AN children with dental caries do not receive the necessary treatment. More than 70 percent of AI/AN children aged two to five years have a history of tooth decay, compared to 23 percent of White children.[16] Untreated tooth decay causes pain and infections that may lead to problems with eating and speaking for all age groups and children growing and learning.

AI/AN adult dental patients also suffer disproportionately from untreated decay, with twice the prevalence of untreated caries as the general United States population and more than any other racial/ethnic group.[17] Of the AI/AN dental patients aged 40-64, 83 percent had teeth pulled because of tooth decay or gum disease compared to the national average of 66 percent.[18] Having missing teeth can impact a person's quality of life by lowering self-esteem and, for some, reducing employment opportunities. In addition, persons with extensive or complete tooth loss are more likely to substitute easier-to-chew foods such as those rich in saturated fats and cholesterol.

An IHS oral health survey was conducted in 2019 on 5,223 13–15-year-old AI/AN youth, the largest-ever sample size of this age group. Following the trends of the 2016-17 and the 2018 oral health surveys, this survey not only highlighted the oral health disparities between AI/ANs but also compared disease rates to previous surveys of this age group.[19] Subsequently, the survey showed a 10 percent reduction in caries experience from 1999 to 2019 (83.6 percent to 75.4 percent) and a 30 percent reduction in untreated decay from 1999 to 2019 (64.0 percent to 45.0 percent). Despite this success, AI/AN children and adults continue to suffer disproportionately from dental disease compared to the rest of the United States: three to five times as many cavities across all ages and twice as much gum disease in adults.[20]

IHS and Tribal Dental Programs have long been challenged to meet the very high level of need for oral healthcare services. Many communities do not have on-site services to provide dental services to treat advanced caries. Lack of access to professional dental care significantly contributes to the disparities in oral health in the AI/AN population. Two major factors contribute to inadequate access to care: the relative geographic isolation of Tribal populations, particularly in Alaska, and the inability to attract dentists to practice in IHS or Tribal health facilities in rural areas.[21] Another potential reason is that the dental hygienist-to-population ratio within the Indian Health Service is 1:9,300 while the general population is at 1:2,000. Additionally, IHS cannot fill all vacant positions for dentists, with vacancy rates ranging between 10 percent-32 percent.[22]

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

ALCOHOL AND SUBSTANCE ABUSE — $3.481 BILLION

The most used drug among AI/ANs is alcohol, according to American Additions Centers statistics (2022). AI/AN annual alcohol use rates (54.3 percent), binge drinking rates (10 percent), and alcohol use disorder rates (7.1 percent) are significantly higher than other ethnic groups. Three in 10 young adults (age 18-25) report binge drinking, one in 11 reports heavy alcohol use, and one in 10 have an alcohol use disorder, according to the 2018 National Survey on Drug Use and Health. More shocking, the highest rate (one in six) of alcohol use and underage drinking among all racial/ethnic groups belongs to AI/AN adolescents (age 12-17).

Alcohol directly impacts the health of AI/AN individuals, families, and communities. The consequences of heavy alcohol use contribute to increased risks of many adverse

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

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

17 Phipps KR, Ricks TL. The oral health of American Indian and Alaska Native adult dental patients: results of the 2015 IHS Oral Health Survey. Available at: http://www.aaiohi.org/wp-content/uploads/2015/07/IHS-Data-Brief-March-2016-2016-Oral-Health-Survey-of-AIAN-Adults-35.pdf. Accessed January 29, 2017.

18 Phipps KR, Ricks TL. The oral health of American Indian and Alaska Native adult dental patients: results of the 2015 IHS Oral Health Survey. Available at: http://www.aaiohi.org/wp-content/uploads/2015/07/IHS-Data-Brief-March-2016-2016-Oral-Health-Survey-of-AIAN-Adults-35.pdf. Accessed January 29, 2017.

19 1999 & 2010-2020 IHS oral health surveys, IHS National Dental Data Mart, 2019 national GPRA results, and National Health and Nutrition Examination Survey data.

20 1999 & 2010-2020 IHS oral health surveys, IHS National Dental Data Mart, 2019 national GPRA results, and National Health and Nutrition Examination Survey data.

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

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

health factors such as diabetes, heart disease, cancer, obesity, tuberculosis, hepatitis, depression, mental health disorders, sexually transmitted diseases, and liver disease. Cirrhosis, an alcoholic liver disease, is a leading cause of death for AI/AN.

Consuming alcohol during pregnancy is a leading cause of birth defects and developmental disabilities. A 2022 *Morbidity and Mortality Weekly Report* (MMWR) states many women drink during pregnancy. CDC researchers found that nearly 14 percent (or one in seven) of pregnant people reported current drinking, and about five percent (or one in 20) reported binge drinking in the past 30 days. According to the CDC report, unique to the AI/AN population, the rate of fetal alcohol syndrome (FAS) among some Tribes is more than eight times the national average.

In conjunction with the unacceptable rates of FAS, birth defects, and other direct adverse health impacts are the corresponding increases in unintentional injuries and violent crimes experienced by AI/AN who are under the influence of alcohol. A Bureau of Justice Study (Perry, 2004) reflects alcohol is involved in nearly half of the violent crimes experienced by AI/AN and is involved in more than six in 10 violent crimes. AI/AN men have the second-highest self-reported rates of driving under the influence and the second highest arrest rates for drunk driving compared to men from other racial and ethnic groups.

Research shows that illness leads to chronic stress, increased disease risk factors, suicide, and higher incidences of alcohol and drug abuse and addiction (Sinha, 2009). Key issues that contribute to the development of alcoholism, drug addictions, and other adverse health factors among AI/AN include economic disadvantages, cultural loss, historical trauma, and racism.

AI/AN economic disadvantages include poor education, poverty, poor health, and limited access to adequate health resources (Neetha, 2020). AI/AN attain below-average high school and college completion rates (less than one in five earn a BA). High unemployment rates directly reflect the twenty percent of AI/AN who live below the poverty level, double the rate of Whites.

The COVID pandemic and generations of cumulative emotional and psychological wounds from forced relocation, brutality, assimilation, genocide, racism, sexual abuse, and the blatant destruction of cultural practices resulted in unresolved grief, increased stress, and loss of traditions, land, identities, relationships, and families due to the traumatic experiences inflicted. Negative coping factors include alcohol and drug use and abuse, compounding psychological distress, poor health, cycles of abuse, and poor health choices, leading to a vicious cycle of negative adversity.

Alcohol abuse is not the only factor where AI/AN use rates are higher than other races or ethnic groups. According to Young and Joe (2009), Native Americans have the highest rates of marijuana, cocaine, inhalant, and hallucinogen use disorders compared to other ethnic groups.

According to Kaliszewski 2022, the rate of substance dependence or abuse is higher among Native Americans than any other population group in the country. Nearly one in five AI/AN young adults (aged 18-25 years) has a substance use disorder, including 11 percent with illicit drugs. AI/AN have the highest methamphetamine abuse rates of any ethnic group, including past month use at more than three times the rate of any other group. Results from the 2018 NSDUH survey (SAMHSA, 2019) indicate approximately four in 10 AI/AN adolescents (aged 12-17 years) have a lifetime prevalence of illicit drug use and have the highest rates of lifetime tobacco product use, marijuana use, nonmedical use of pain relievers, and nonmedical use of prescription-type psychotherapeutics.

The opioid use disorder (OUD) crisis in the United States. and our Tribal communities is dire. Nearly 50 percent of adults with OUD have low incomes, and almost 25 percent live in poverty. Every day, 136 people in the United States die from an opioid overdose, which continues to grow yearly (Davis, 2022). The opioid epidemic affects most racial and ethnic groups in the United States, but not in equal numbers. Among adults, opioid use has been highest among people who identify as being of two or more races and among AI/AN people. More than five percent of AI/AN populations are affected by the most significant risk factor - prescription opioid misuse. Recent opioid death rates per 100,000 people in rural areas are highest among AI/AN at 47.4. In urban areas, the numbers are even higher at 49.3. Opioid use varies by education and employment but can still affect anyone. 4.2 percent of people with some college or an associate degree, misuse opioids, a higher rate than college graduates and those who did not finish high school combined.

The segue from opioid misuse to methamphetamine (meth) is standard. Methamphetamine use is linked to various severe health risks, including overdose deaths. According to research conducted by the National Institutes of Health's (NIH) National Institute on Drug Abuse (NIDA), overdose deaths surged in the last eight

years. Racial and ethnic groups, specifically AI/AN, realized the highest death rates overall and have more than quadrupled from 4.5 to 20.9 per 100,00 people. Unlike opioids, there are currently no FDA-approved medications for treating methamphetamine use disorder or reversing overdoses. However, behavioral therapies such as contingency management therapy can be effective and reduce harms associated with drug use recent clinical trial reported significant therapeutic benefits with the combination of naltrexone with bupropion in patients with methamphetamine use disorders.

A five-fold increase in overdose deaths demands the need to develop culturally tailored interventions, as the one-size-fits-all approaches are not working (Han, 2021). Integrated care and holistic approaches to wellness that respect AI/AN traditions and perspectives in Tribal communities are needed. Incorporating traditions offers a unique and culturally resonant way to promote resilience, help prevent drug use among young people, and develop culturally appropriate and community-based prevention strategies and education.

Another alarming statistic directly related to alcohol and drug misuse is suicide rates. According to a report detailing suicide rates (Leavitt, RA. et al., 2018), AI/AN have had the highest rates of suicide of any racial/ethnic group in the United States since 2003, and the rates continue to increase. In 2015, AI/AN suicide rates in the 18 states participating in the National Violent Death Reporting System (NVDRS) was 21.5 per 100,000, more than 3.5 times higher than those among racial/ethnic groups with the lowest rates. More than one-third (35.7 percent) of AI/AN decedents were aged 10–24 years (versus 11.1 percent of Whites). Compared with Whites, AI/AN decedents had 6.6 times the odds of living in a nonmetropolitan area, 1.8 times the odds of a reported alcohol problem, were more likely to have reportedly used alcohol in the hours before death, had 2.1 times the odds of a positive alcohol toxicology result, and had 2.4 times the odds of suicide due to a friend or family member's death. In addition, AI/AN who died by suicide were significantly more likely to test positive for marijuana and amphetamines.

These findings highlight the urgent need to develop culturally tailored, gender-specific prevention and treatment strategies for AI/AN with substance use disorders to meet the unique needs of those most vulnerable to the growing crises. The Substance Abuse and Mental Health Services Administration (2019) reports that 13 percent of Native Americans need substance use treatment, but only 3.5 percent receive any services. Noted limitations to treatment services include transportation issues, lack of health insurance, poverty, and a shortage of appropriate culturally sensitive treatment options in their communities.

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

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

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

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

Of utmost importance is funding that aids prevention and education and promotes healthy choices that align with cultural traditions. Individual Tribal communities must have the ability to respond to and address their specific emerging concerns. Commercial tobacco use,

domestic violence rates, and sexual and domestic abuse join the rising concerns of many Tribal nations. Domestic violence rates are alarming, with four in five AI/AN women experiencing violence in their lifetime (Rosey, 2016). The need to address issues of violence and sexual and domestic abuse against AI/AN women is critical in breaking the cycle of violence and addiction. This is apparent in the alarming statistics among Alaska Native children regarding witness to violence and the serious implications from this exposure in relation to children's cognitive development. Consideration must be given to The National American Indian/Alaska Native Behavioral Health Strategic Plan as it provides a comprehensive approach to addressing alcohol and substance abuse and its tragic consequences, including death, disabilities, families in crisis, and multi-generational impacts. Paramount is the focus needed to integrate and align primary care and behavioral health services with each Tribal nation's cultural traditions.

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

MENTAL HEALTH — $3.461 BILLION

Mental Health is a significant priority for FY 2024. Tribal leaders recommend $3.461 billion to fully fund mental health services in Indian Country. Funding increases would be used to implement Section 127 of the IHCIA, allowing for the rise in the number of mental health providers and funding training/education; Section 702 to expand behavioral health care for prevention and treatment; Section 704 to provide more comprehensive care through detox, psychiatric hospitalization and, community-based education and rehabilitation programs; Section 705 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 asset-based, innovative and effective approaches to address issues like Indian youth suicide. The additional increase would also fund the new provisions in the IHCIA (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. Additional funds would enable the social-behavioral workforce to serve the population better and provide adequate behavioral health training and community educational programs.

This would result in more than a 600 percent increase in funding for mental health services in Indian Country above the FY 2021 enacted level. This significant increase is needed to allow Tribal communities to further develop innovative and culturally appropriate prevention and treatment programs that build upon the resiliency factors and inherent strengths already existing in Tribal communities. AI/AN people continue to demonstrate alarming rates of psychological distress throughout the nation. Inadequate funding resources limit Tribes from implementing cultural and asset-based approaches to address these issues. Thus, Tribes seek additional resources to enhance current services and to fund the implementation of the above-listed provisions highlighting the following two as examples:

Behavioral Health Prevention and Treatment Services: Establishes the authorities for comprehensive services and emphasizes collaboration among alcohol and substance abuse, social service, and mental health programs.

Mental Health Technician Program: Authorizes comprehensive training of community mental health paraprofessionals, including Behavioral Health Aides under CHAP, to provide community-based mental health care that includes identification, prevention, education, and referral for treatment services and the use and promotion of traditional health care practices.

The high incidence of mental health disorders, suicide, violence, and behavior-related chronic diseases among AI/ANs is well documented. Research has demonstrated that AI/ANs do not prefer to seek Mental Health services through Western models of care due to a lack of cultural sensitivity; furthermore, studies suggest that AI/ANs are not receiving the services they need to help reduce the

disparate statistics.[23] 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 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. It is important to note that the recent increases in behavioral health funding have only been allocated through limited time-sensitive competitive grants. The grant-funded nature is an inefficient funding mechanism that does not support long-term program sustainability and has created haves and have-nots in Indian Country, which serves as a barrier to addressing behavioral health crises and interventions and does not support an integrated continuum of care. Mental Health resources must be recurring and allocated equitably across the IHS/Tribal/Urban system via a non-grant and non-competitive distribution.

Coordinated telehealth psychiatric services for complex cases with multiple medications is crucial to patient care. Funds are needed to support infrastructure development and capacity in tele-behavioral health, workforce development and training, recruitment and staffing, integrated and trauma-informed care, long-term and after-care programs, screening, asset-based approaches, and community education programs. Mental Health program funding supports community-based clinical and preventive mental health services, including outpatient counseling, crisis response and triage, case management services, community-based prevention programming, outreach, and health education activities, as well as address adverse childhood events and historical traumas to break the cycles and conditions that contribute to perpetuating or exasperating poor mental health outcomes.

Mental health crises and emergency services are generally provided through local hospital emergency rooms. Inpatient services are generally purchased from non-IHS facilities or provided by state or county mental health hospitals. The goal in the emergency setting is to stabilize patients and assess and refer to the appropriate level of care. Many communities and areas lack enough hospital beds for patients with mental health emergencies requiring further hospitalization, which puts pressure on emergency rooms and urgent care services to provide this care beyond initial stabilization. It is the costliest method of care and, unfortunately, leads to patients not receiving the appropriate level of care and emergency rooms routinely being on divert for regular medical emergencies due to beds being occupied with mental health patients who are waiting for appropriate beds to become available.

Lack of behavioral resources is evident in the disproportionate number of suicides, higher depression rates, acts of domestic violence, and drug and alcohol addiction in Indian Country. The Centers for Disease Control and Prevention (CDC) reported in 2018 that reviewing data from 2003-2014, approximately 70 percent of AI/AN decedents resided in nonmetropolitan areas, including rural areas. Residential status can affect the circumstances surrounding suicide. In addition, programs focusing on individual life skills development and interpersonal social emotional learning programs to promote healthy relationships and conflict resolution might address the higher occurrence of intimate partner problems and arguments preceding AI/AN suicides. Also, the need for postvention, such as establishing survivor support groups, are key to interrupting or reducing the potential of suicide contagion.[24] An increase in funding can support increased use of tele-behavioral health services and support training of local mental health paraprofessionals, which would allow a greater percentage of the AI/AN population to be screened, seen by behavioral health specialists, and most importantly, treated.

Although overall AI/AN suicide rates are like those of Whites, there are significant differences among certain age groups (CDC, 2019). The suicide death rate for AI/AN between the ages of 15-19 is more than double that of non-Hispanic whites (WISQARS, 2019). Out-of-the-box prevention solutions must be vetted as barriers abound in rural Tribal areas. Mental facilities are severely understaffed, waiting states to get into a mental health provider can be weeks, and transportation is a significant barrier. The impacts of COVID have helped many rural communities gain better access to wireless connectivity. Mobile health interventions with culturally trained response personnel can provide an AI/AN 24/7 suicide hotline that would benefit all Tribal nations. Immediate access to a trained mental health professional via a hotline would reduce the caller's immediate stress, provide culturally informed prevention, offer follow-up assistance, and may reduce suicide rates. Follow-up mental health services can be arranged with the caller's area mental health service provider. In addition, providing culturally competent

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

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

care, case management services, and a warm handoff to a professional who values AI/AN cultural tradition and respects the holistic mind-body-spirit collective worldview of Native people will help decrease the stigma of seeking mental health assistance and contribute to culturally informed treatment services desperately needed.

Tribes have expressed that mental health program increased funding needs specifically for long-term treatment, housing first, and after-care facilities/staffing to combat mental health diseases. Strengthening funding for Section 702 of the Indian Health Care Improvement Act (IHCIA) would include support in meeting these needs. For example, displaced or homeless veterans returning home from active-duty service, individuals returning home after a long period of incarceration, and returning home after substance use treatment will benefit from a transitional living environment that assists them while they readjust to their environment and surroundings. The TBFWG has made behavioral health services a major budget priority for many years and continues this emphasis in FY 2023 as an investment in behavioral health services has shown positive return. For example, treating depression and anxiety has shown between 3.3 to 5.7:1 return on investment in reduced/avoided medical costs, improved productivity, and improved health status. This request identifies the need to improve programs' ability to reduce health-related complications, prevent the onset of unhealthy lifestyles, and educate our communities to deal with behavioral health issues.

HEALTHCARE FACILITIES CONSTRUCTION AND OTHER AUTHORITIES — $3.220 BILLION

Tribes have waited for years for the funding to alleviate the lack of space and old infrastructure to increase the quality of patient health care. Navajo Area has three facilities on the Priority List — the Pueblo Pintado Health Center, the Bodaway-Gap Health Center, and the Gallup Indian Medical Center). Phoenix Area's two major inpatient replacement projects include two hospitals - the Phoenix Indian Medical Center (PIMC) and the White River Indian Hospital and in the Tucson Area, the Sells Indian Hospital. Tribes in Nevada in the Phoenix Area had begun discussions in their Master Plan in 2015 to increase specialty care services in that state as there are no IHS hospitals in that region since the closure of the facility in Schurz, Nevada. They sought alternatives other than traveling to PIMC in Phoenix for these services, which are not optimal and puts patients at risk of exponentially using of PRC resources. They worked on the concept of a specialty care facility through the PIMC project but were apprised that it may require congressional authorization.

The Indian Health Care Improvement Act encourages the establishment of Indian health care delivery demonstration projects[25] and developing innovative approaches to address all or part of the total unmet need for the construction of health facilities[26] to provide health care services. Essential specialty health care services are difficult to access for many AI/ANs in Contract Health Service dependent areas. One solution is to fund demonstration projects and an area distribution fund to include planning, design, construction, and staffing of regional specialty referral centers to improve access to specialty care. An important provision of the law under the new priority system is the establishment of an Area Distribution Fund (1), in which a portion of health facility construction funding could be devoted to all Service Areas. It requires that the Secretary shall consult and cooperate with Indian Tribes and Tribal organizations, and confer with urban Indian organizations, in developing innovative approaches to address all or part of the total unmet need for construction of health facilities. It also requires each IHS Area to generate an updated priority list every three

25 25 U.S.C. § 1637. Indian health care delivery demonstration projects.
26 25 U.S.C. § 1631(f)(1). Establishment of an area distribution fund.

years for a combined submission of top Area priorities to the United States. Congress. A robust consultation and conferring process will help to identify the most pressing facility and infrastructure needs in each Area and ensure that these needs are addressed more expeditiously.

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

MAINTENANCE AND IMPROVEMENT — $3.139 BILLION

The Budget Formulation Workgroup proposes $3.139 Billion to fully facility maintenance and improvements in FY 2024. M&I funding is consistently ranked a top priority in the Areas due to its essential purpose that is required to ensure that patients receive services in well-functioning health care facilities that meet building and life safety codes, conform to laws and regulations, and satisfy accreditation standards. Without sufficient M&I funding the continued deterioration of critical health facilities is the reality that AI/AN people experience across the nation whether they are served at and IHS facility or Tribally owned or leased building. The Indian Health Service Facilities Appropriations Advisory Board (FAAB) provided the following data on the M&I program in the Facilities Appropriations Information Report dated January 30, 2020.

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

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

The FY 2024 Tribal M&I budget request will bring the Indian health care system closer to addressing critical backlog and will support maintenance and improvement objectives including exceeding environmental standards and ensuring compliance with accreditation standards of The Joint Commission (TJC), or other applicable accreditation bodies. Investments that improve the quality of patient care improve our health outcomes, increase access, reduce operating costs and therefore proven to be cost-effective.

SANITATION FACILITIES CONSTRUCTION — $2.287 BILLION

On November 15, 2021, President Biden signed the Infrastructure Investment and Jobs Act (IIJA), which appropriates $3.5 billion over five years (FY 2022-2026) for the IHS Sanitation Facilities Construction program. These funds are likely sufficient to address the current estimate for all known deficiencies. Since the IIJA was not finalized during the FY 2024 budget formulation meetings, Tribal leaders continued to prioritize sanitation, sewer, and waters related health concerns and recommended a $2.28 billion increase for the IHS Sanitation Facilities Construction (SFC) line item in FY 2024. Despite the sizable investment that the IIJA will provide to meet sanitation needs, additional funding will continue to be needed to support extreme inflation costs associated with these types of projects and an ever-growing need for operation and maintenance costs to support the federal investment that has been made in these projects and maximize their useful life.

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

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

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

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

Despite the federal investment that has been made in SFC projects, one element not provided under the present Federal and State scheme is funding for operation and maintenance of SFC projects. Considering the federal investment and expense associated with these projects it simply does not make sense to not support their operation and maintenance to maximize the useful life of the projects. In the absence of external financial assistance, Tribes are often forced to use their limited funds to support operation and maintenance. In many instances support may not be available at all because the Tribes may not have the resources to carry out these functions. Continued dependence on this practice will not ensure proper operation and maintenance of sanitation projects, and most likely will continue to shorten the useful life of existing sanitation projects or cause their breakdown. Under the IHCIA, IHS is authorized to provide operation and maintenance assistance for, and emergency repairs to, Tribal sanitation facilities, when necessary to avoid a health hazard or to protect the federal investment in sanitation facilities, however resources have not been appropriated specifically for this purpose.

The unprecedented amount of funding for construction and repair of these facilities through the IIJA underscores the need to protect that investment and ensure sustainable operation of these systems. Because of this, the TBFWG recommends IHS establish and fund an Operation and Maintenance account for the SFC program. It is estimated by sanitation engineers that the need is $55 to $240 million annually.

COMMUNITY HEALTH REPRESENTATIVES — $1.247 BILLION

Tribal leaders on the National Tribal Budget Formulation Workgroup recommend that the FY 2024 budget provide $1.247 Billion. Community Health Representatives (CHRs) during the COVID pandemic have shown tremendous strength of their connection to communities and a bridge to health facilities. Due to their large contribution to the COVID pandemic many found them valuable and have reignited efforts to expand similar professionals such as community health workers nationally. As highly trusted members in the community for the last 50 years, CHRs deliver preventive health education and case management to Tribal members in home and community settings. Many continue to provide health information in our Native languages that is culturally relevant and appropriate with a focus on the holistic wellness that encourages Tribal members to receive health and public health services clinically and at home. CHRs are also considered a valued team member of the medical or patient-centered medical home teams whose role is to follow-up on patients discharged from health facilities.

CHRs are part of the direct provision of health services to Native Americans and are authorized in in the Indian Health Care Improvement Act (25 U.S.C. § 1616). Without the services provided by the estimated 1,600 CHRs employed across Indian Country, thousands of patients will not receive their necessary follow-up services, and many will have difficulty accessing health services only for health conditions to worsen. In FY 2018, IHS reported that more than half of the visits performed by CHRs were made to patients with chronic diseases. In short, CHRs help to bridge the gap between AI/AN patients and health care resources through outreach by specially trained Tribal community members. Therefore, the Tribal CHR programs must remain present in Tribal communities.

Inadequate and continued provisions to eliminate funding for the CHR Program will result in staff reduction leaving insufficient staff to address the chronic health and infectious diseases that require constant follow-up. Further elimination or reduction of the CHR Program is detrimental to provider-patient communication through the CHRs to improving patient health outcomes. This will result in a serious public health threat wherein high risk, elderly and disabled clients with chronic diseases

will be left without case management and home health care services such as bathing, personal care, feeding and medication adherence. Overall, the inadequate funding and the elimination of the CHR Program will severely affect high-risk clients who receive preventive health screening education, monitoring, patient assessments and home visits.

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

In 2020 to present, the CHRs have remained instrumental in responding to the COVID-19 pandemic across Indian country. CHRs serve as frontline workers for victims of COVID-19 and their families to much needed resources. For example, during the COVID pandemic many CHRs are implementing COVID mitigation strategies while focusing on high-risk individuals and those impacted by COVID illness. For example, the Navajo Nation CHRs continue to ensure food, PPE, and COVID prevention education are shared with clients and the public. CHRs are the trusted messengers for all COVID-19 prevention education including addressing vaccine hesitancy, misinformation, and mistrust about the COVID-19 vaccines. Post-COVID impact will be immeasurable, but it is significant to keep the CHRs as vital members to follow-up with recovery efforts.

To maintain these efforts, Tribes who rely on CHR programs to coordinate and conduct preventative education efforts will have difficulty maintaining their current system of support to high-risk clients who need screening, education and monitoring visits as well as lose their local knowledge that helps keep communities safe.

URBAN INDIAN HEALTH — $973.59 MILLION

The federal government owes a trust responsibility to Tribes and American Indians and Alaska Natives (AI/ANs) that is not restricted to the borders of reservations. That trust responsibility includes the provision of health care. Following the Termination[27] and Relocation[28] Eras of federal Indian policy, Tribal leaders advocated for the trust and treaty health rights for AI/ANs living off Tribal land — "urban Indians" —and thus urban Indian organizations (UIOs) were established. Today there are currently 41 UIOs, which operate 77 facilities in 22 states. UIOs provide a wide range of culturally focused health care and social services to urban AI/AN communities, including primary care, oral care, HIV treatment, substance use disorder treatment, behavioral health, and other preventive services.

The TBFWG recommends $973.59 million to fully fund Urban Indian Health in FY 2024. UIOs receive direct funding primarily from one-line item — urban Indian health — and do not receive direct funds from other distinct IHS line items, including the Hospital and Health Clinics, Mental Health, Alcohol and Substance Abuse, Indian Health Care Improvement Fund, Health Education, Indian Health Professions, or any of the line items under the IHS Facilities account. Due to historically low funding levels for urban Indian health, UIOs are chronically underfunded. Full funding of UIOs will directly benefit urban AI/ANs that rely on UIOs to access care.

HOT TOPICS AND PRIORITIES FOR URBAN INDIAN HEALTH

Ensure Urban Indian Health funding keeps pace with population growth: Although more than 70 percent of AI/ANs reside in urban or suburban areas, only 1 percent of the underfunded IHS budget is spent on urban Indian health care. The urban AI/AN population is growing and will require UIOs to increase access to care by hiring additional staff and expanding services to meet the growing need. Funding for urban Indian health must be significantly increased if the federal government is to finally, and faithfully, fulfill its trust responsibility. Urban Indian health funding should adequately support staff in terms of being paid a fair wage and expanding personnel. UIOs are faced with the challenge of low retention and recruitment for their facilities as the static nature of urban Indian health funding limits the capacity of UIOs. It is imperative that such an increase not be paid for by diminishing funding for already hard-pressed IHS and Tribal providers.

Increased Funds for UIO facilities: The Bipartisan Infrastructure Framework (BIF) included the Padilla–Moran–Lankford Amendment, which allows UIOs to

27 Act of August 3, 1956, Public L.aw 84–959, 70 Stat. 986.
28 Act of August 3, 1956, Public L.aw 84–959, 70 Stat. 986.

utilize their existing contracts to upgrade their aging facilities. However, because UIOs do not receive facilities funding, unlike the rest of the IHS system, and must use their line item for this purpose, it is critical that funding for the urban Indian health line-item accounts for the cost of facility needs. As of 2021, UIOs report needing at least $200 million to fund construction and renovation projects nation-wide.

Ensure Parity in the Indian Health System: As we inch closer to increased parity for urban Indian health, it is imperative that UIOs be deemed eligible for cost-saving measures available to the other components of the IHS/Tribal/Urban system, including, among others, Community Health Aide Program (CHAP), and permanent 100 percent Federal Medical Reimbursement Percentage (FMAP) for services provided at UIOs.

Many urban AI/AN 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. In accordance with its original 2016 policy interpretation, which it subsequently reversed in 2018, IHS should allow UIOs to participate in the nationalization of CHAP, which trains residents to provide basic health care, assuring that health services are available in the local community from culturally focused providers. Many UIOs would greatly benefit from a national CHAP, as well as Dental Health Aide Therapists, and Behavioral Health Aide Therapists. It is thus imperative that UIOs are included in the nationalization of CHAP so that the entire IHS/Tribal/Urban system can offer patients increased access to quality dental care.

Unlike other Indian healthcare providers, UIOs have historically been deemed ineligible for 100 percent FMAP, which is a dereliction of the federal trust responsibility. On March 10, 2021, the American Rescue Plan Act temporarily authorized two years of 100 percent FMAP to UIOs for Medicaid services for IHS-beneficiaries beginning April 1, 2021. Although this change represents a step forward, associated issues remain. Most UIOs are yet to see a dollar from this provision and are still not receiving the IHS all-inclusive rate while states are collecting the savings but not supporting or improving Indian healthcare, which was not the intent of the law and is in violation of the trust obligation. To address these issues, Congress must extend permanent 100 percent FMAP to services provided at UIOs – ensuring parity across the IHS health care system.

Retain and expand eligibility for IHS UIOs to participate in grant programs: Because UIOs have long suffered from significant underfunding, they often must seek additional funding opportunities to provide more services and serve more patients, including grants. This includes behavioral health funding for IHS's current initiatives and the Special Diabetes Program for Indians (SDPI). The preservation of grant funds for UIOs should not impact the ability of grant distribution to transfer to direct funding for IHS and Tribal facilities. Similarly, UIOs should always be eligible for new programs designed to benefit AI/ANs, like CHAP (see above) and other programs IHS creates from novel funding opportunities as appropriated by Congress from time to time (for instance, the FY 2019 Special Behavioral Health Program for Indians). As UIOs work to provide for a growing population of urban Indians, their continued eligibility for grant or funding initiative opportunities, including behavioral health initiatives and SDPI, is essential.

When new grants are created to benefit the health of AI/AN, it is imperative that these programs include opportunities for UIOs to serve the population that does not reside on reservations. Additionally, the Tribal Opioid Response grants should be extended to UIOs to combat the harsh realities of the opioid epidemic impacting AI/ANs.

No funding from Urban Indian Health line item withheld or reprogrammed from Urban Indian Organizations: As one prong of the federal government's health care delivery system for AI/ANs, Urban Indian Organizations (UIOs) are significantly impact by changes to, or cessation of, federal funding. In recent years, critical funding for UIOs has been reprogrammed to fulfill unrelated budgetary shortfalls under programs for which UIOs are ineligible. For example, in FY 2018 and FY 2019, IHS reprogrammed more than $1.5 million from the already budget constrained UIOs to satisfy the cost of 105*(l)* leases for which UIOs are ineligible. Unfortunately, reprogramming funds designated to UIOs can greatly impact their abilities to provide services.

In addition, when the federal government fails to fund or operate at full capacity, such as periods of a government shutdown, IHS is unable to provide most funds to UIOs, resulting in a loss of critical funding and operational shortfalls. This was evident during the 2018-2019 federal government shutdown, which had the following impacts on UIOs: facility closures, staff layoffs, reduced hours, canceled programs/ services, and more – ultimately impacting the abilities of UIOs to provide services to their AI/AN patients. When more shutdowns loomed in 2019 and then again in 2020, and the ability of UIOs to provide services was again at risk, IHS only requested an exception apportionment from the OMB for some Indian health programs and did not request an exception apportionment for programs operated by IHS (serving direct service Tribes) and UIOs. The safety of patients' lives is important at all times of the year and should not be dictated by a shutdown. The mission of IHS is to raise the physical, mental, social, and spiritual health of AI/ANs to the highest level and should always be protected from budget uncertainty.

ELECTRONIC HEALTH RECORD/ HEALTH IT — $491.97 MILLION

The TBFWG requests a program increase of $491.97 million to fully fund HIT in FY 2024. 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. IHS HIT also supports the mission-critical health care operations of the IHS/Tribal/Urban system with comprehensive health information solutions, including an Electronic Health Record and more than 100 applications.

A properly resourced IHS HIT program directly supports better ways to:

- Care for patients.
- Pay providers.
- Coordinate referral services.
- Recover costs.
- Support clinical decision-making and reporting.

Since FY 2020, the TBFWG and the President's Budget for IHS has supported a new budget line specifically for HIT. TBFWG also has recommended a meaningful investment into the IHS HIT system to address the impact of the Veteran Health Administration's (VHA) recent decision to transition from its legacy VISTA system to a Commercial Off-the-Shelf (COTS) system. In preparation for future modernization, HHS and IHS evaluated the current electronic health record system, the Resource and Patient Management System (RPMS), and, based on the evaluation, developed the Roadmap Report to guide modernization efforts over the next five years. The Roadmap Report lays out several opportunities for FY 2020-2022, including establishing a Project Management Office and governance structure, acquisition planning, HIT selection, and procurement, implementation planning, and testing.

Tribes are very concerned that a more accelerated funding strategy is critical to advance the $3 billion 10-year investment appropriately and realistically, which will be needed to allow IHS to either update the current EHR and RPMS suite or initiate an alternatives analysis like the VHA. Therefore, TBFWG maintains its recommendation for a separate HIT budget line-item investment to ensure H&C funds are not diverted to pay for necessary HIT improvements at the expense of direct care for patients.

An adequately resourced IHS HIT program is critical to ensure quality and safe care as well as to save costs related to inefficient processes and unnecessary duplication of testing and procedures. The President's Budget request for FY 2024 must include substantial, separate investments for HIT modernization to be realized in the face of a change technology and resource environment and must include funding for both the IHS and Tribal Health IT modernization efforts.

FACILITIES AND ENVIRONMENTAL HEALTH SUPPORT — $441.56 MILLION

Facilities and Environmental Health Support (FEHS) programs provide and support an extensive array of real property, health care facilities and staff quarters construction, maintenance and operation services, as well as community and institutional environmental health, injury prevention, and sanitation facilities construction services. The programs directly and indirectly support all IHS facilities performance measures and improved access to quality health services.

The TBFWG recommends that $441.56 million be provided for the FEHS which 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 includes operations and management staff for facilities and staff quarter and construction management support. Environmental Health Support provides staff and operating costs for environmental health service, injury prevention, institutional environmental health, and sanitation facilities construction staffing. OEHE support includes IHS headquarters staff, engineering services staff and direct support and management of overall facilities appropriation services and activities.

IHS delivers a comprehensive, national, and community-based and evidence-based Environmental Health program which has five focus areas:

1. Children's environment
2. Safe drinking water
3. Vector-born and communicable disease
4. Food safety
5. Healthy homes

They work hard to identify environmental health hazards and risk factors in communities and propose control measures. Additionally, they conduct investigations of disease and injury incidents, and provide training to federal, Tribal, and community members.

PUBLIC HEALTH NURSING — $958.71 MILLION

Public Health Nursing (PHN) is a community health nursing program that focuses on promoting health and quality of life and preventing disease and disability. The FY 2024 total budget request is $958.71 million, which will allow for critical expansion of public health nursing services. The PHN FY 2022 enacted appropriated funding is $102,466 and is intended to provide quality, culturally sensitive primary, secondary, and tertiary health promotion and disease prevention nursing services to individuals, families, and community groups in throughout Indian country. Unfortunately, the funding levels are not adequate to achieve this goal.

For example, one small Tribe in Alaska serving just under 400 citizens only received $2,053 in FY 2021 for PHN services. Home-based services, where available, are most often related to chronic disease management, safety and health maintenance care for elders, investigation and treatment of communicable disease, breastfeeding promotion, pre/postnatal education, parenting education, and screening for early diagnosis of developmental problems. Some PHN programs can use funds to supplement traditional food programs that focus on food choices that are not only culturally appropriate but consider health challenges for AI/ANs. Others might support health system patient navigator assistance programs, tobacco cessation programs, cancer screening programs, onsite emergency care assistance, and community mental health support, and education programs. The request for full funding of $958.71 million would provide a more reasonable level of PHN services within all Indian communities and would provide the funds necessary for Tribes to develop the foundation for a stronger infrastructure to implement Tribal public health authorities.

HEALTH EDUCATION — $678.04 MILLION

The TBFWG seek $678.04 million for the Health Education line item in FY 2024. Since the COVID-19 pandemic was declared a national emergency, the national Health Education programs have redeployed health educators and reoriented its activities to face the pandemic head on. Health Education programs are an integral component of culturally appropriate primary, secondary, and tertiary prevention, as well as, bridging primary care with community health outreach and preventive education. The goal of the Health Education program is to help Indian people live well and stay well. Cross-cutting prevention approaches aimed at

education-driven voluntary behavior change activities offer the best hope of improving disease-related AI/AN mortality and morbidity.

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

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

Health Educators are extremely valuable in AI/AN communities by raising awareness of lifestyle choices and decisions, they help prevent countless sick days for workers and students, also assist individuals to restore or maintain optimal health, and they guide individuals to practice sanitary and hygiene habits that prevent crippling and deadly diseases from being transmitted and spread. Health Educators are a vital source to interpret health education messages from English to a Native language, i.e., breaking the chain of infection, prevention measures on new and emerging diseases, detailed provider instructions during patient visits and medication tutoring; the availability of Native speaking staff trained in Medical Interpretation will become compromised, including bridging the generation gap between elders and youth.

With past funding shortfalls, Health Educators were limited in the scope of services offered to an AI/AN population. All the Indian Health Areas are underfunded and require immediate attention, as demonstrated during the COVID-19 pandemic. Tribal leaders request no less than $678.04 million for this line item.

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

EQUIPMENT — $546.16 MILLION

The Tribal leaders along with IHS are committed to the quality of care. It is a Tribal and agency priority in providing the highest-level healthcare delivery system to the AI/AN people we serve. It is with this in mind the equipment program budget line request is $546.16 million. This fund is needed to maintain quality bio-medical equipment, insuring the 1,500 Tribally and federally managed health care facilities are timely replacing, performing preventive maintenance and repair of the over 90,000 biomedical devices. Medical equipment has a high level of complexity, typically having high installation and maintenance costs associated with it. Repair of components, training and service contracts are also high costs associated with highly technical medical equipment. As the demand for medical equipment to interface with electronic health records increases, the need for compatible equipment replacing outdated, inefficient, and unsupported equipment will greatly increase. The newer equipment will enhance speed, accuracy of diagnosis, heighten quality decision making, increase efficiency, quality, and productivity, thereby reducing referrals to the private sector and saving on PRC costs.

INDIAN HEALTH PROFESSIONS — $335.27 MILLION

A total of $335.27 million is recommended for the Indian Health Professions line item in fiscal year 2024. IHS and Tribes continue to struggle to recruit and retain qualified medical professionals to work in facilities serving Indian Country. This is an on-going issue and comprehensive efforts are needed to "grow our own" AI/AN health professionals. Broader efforts to encourage and support AI/ANs entering health careers are needed including accessing federal and state scholarships, loan repayment programs and working with educational institutions.

BACKGROUND

IHS and Tribal providers have long contended with provider shortages, which has made providing care to

patients extraordinarily difficult. The provision of health care is a fundamental element of the federal trust responsibility, which was upheld by the Eighth Circuit Court of Appeals in *Rosebud Sioux Tribe v. United States*. In that case, the Court discussed the duty of the government to provide "competent physician-led health care." The Court found that this duty did exist and that it had been strengthened by the Snyder Act and the IHCIA. Funds must be appropriated to honor this promise and ensure that "competent physician-led health care" can be provided throughout Indian Country.

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

RECOMMENDATIONS

The proposed amount of $335.72 million for the Indian Health Professions line item in FY 2024 would help to increase funding for scholarships, loans and expand loan forgiveness options to individuals seeking to work in Tribal communities. Regarding the CHAP implementation in the lower 48 states, a portion of the recommended amount should be made available for scholarships for students seeking a career as a CHAP mid-level provider. A portion of the funding should be made available for grants to establish course work for Dental Therapists, Behavioral Health Aides and Community Health Aides at Tribal colleges, universities, and partner institutions. Expanding the use of these funds in this manner remedies a major need for training in or near Tribal communities. These measures elevate our ability to train, recruit and retain AI/AN professionals and mid-level providers seeking to enter health professions through comprehensive efforts.

DIRECT OPERATIONS — $101.87 MILLION

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

and systems accountability. These types of direct operations performed at the Headquarters and Area Office levels provide the foundation necessary to carry out the Agency mission.

The IHS Headquarters (HQ) provides overall program direction, authorities, and oversight for the 12 IHS Areas and 170 Service Units. HQ staff formulate policy and distributes resources; also provides technical expertise to all components of the Indian health care system, including IHS direct service, Tribally operated programs, and urban Indian organizations. Headquarters also hosts the Resource and Patient Information. Resource and Patient Management System - or RPMS – which is a decentralized integrated solution for management of both clinical and administrative information in IHS/Tribal/Urban healthcare facilities. HQ also provides data management including collection of national statistics and performing public health surveillance, identifying trends, and projecting future needs. The IHS Headquarters works in partnership with HHS and sister agencies to formulate and implement national health care priorities, goals, and objectives for AI/ANs within the framework of its mission. The IHS Headquarters also works with HHS to formulate the annual budget and necessary legislative proposals and respond to congressional inquiries.

By delegation from the IHS Director, the 12 Area Offices distribute resources, carry out policies and internal controls, monitor and evaluate the full range of comprehensive healthcare and community-oriented public health programs, and provide technical support to local Service Units and IHS/Tribal/Urban staff. They ensure the delivery of quality health care through the 170 Service Units and participate in the development and demonstration of alternative means and improvement models to support health services management and delivery. Program increases for Direct Operations will allow the enhanced implementation of quality and patient safety measures and will enable the agency to be responsive to deficiencies cited in the previous GAO High Risk Report.

A funding increase will enable the operational support necessary for carrying out the functions of the new Office of Quality (OQ). The OQ provides for quality systems integration and address quality assurance, patient safety, business intelligence, risk management, and quality improvement. Funds will also be used to strengthen the agency's capacity for oversight in key areas such as workforce management and development, finance, acquisitions, and other evolving areas identified by Tribal and agency leadership. This will increase the efficiency and effectiveness of Headquarters programs focused on policy management and compliance, competency training, evaluation, data analysis and reporting, and accountability. The non-inherent federal function portion of Direct Operations funds are available for Tribal Shares distribution if a Tribe or Tribal Health Organization exercises its right to assume management of federal functions under ISDEAA Title I or Title V. The funding history for Direct Operations has only shown moderate growth despite growing responsibilities and demands of the health industry and rising inflation. From FY 2018 – FY 2020 funding remained flat at $72 million and rose to $82 million in FY 2021 and $95 million in FY 2022. In FY 2021 and FY 2022, the IHS Direct Operations had the added burden of administering COVID related activities and resources.

SELF-GOVERNANCE — $55.89 MILLION

To support and expand Self-Governance training and technical support in FY 2024 through the Office of Tribal Self-Governance (OTSG), the Workgroup is requesting $55.89 million. OTSG is responsible for a wide range of agency functions that are critical to honoring IHS's relationship with AI/AN nations, Tribal organizations, and other AI/AN groups, under authorization of Title V of the ISDEAA, as amended 25 U.S.C. § 5381 et seq., 42 C.F.R. Part 137. Title V authorizes Tribes and Tribal Consortia to enter Self-Governance compacts, self-determination contracts and related funding agreements to assume federal programs, functions, services, or activities (PFSA), and associated Tribal Shares, placing the accountability of PFSA service provision with Tribal nations. This request supports expansion of the implementation of the IHS Tribal Self-Governance program, funding for Planning and Negotiation Cooperative Agreements to assist Indian Tribes to prepare and enter the IHS Tribal Self-Governance program, and funds Tribal shares needs in IHS Areas and Headquarters for any AI/AN Tribes that have decided to participate in the IHS Tribal Self-Governance program.

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

of IHCIA authorities; Self-Governance planning and negotiation of Cooperative Agreements; and supporting the activities of the IHS Director's Tribal Self-Governance Advisory Committee which advises the IHS Director on Self-Governance policy decisions.

SELF-GOVERNANCE PLANNING AND NEGOTIATION COOPERATIVE AGREEMENTS

Title V of the ISDEAA provides IHS statutory authority to enter Planning and Negotiation Cooperative Agreements. These agreements assist Tribes in planning and negotiation activities; technical assistance, analysis and systems review are all part of those negotiation activities. IHS ALN's, Tribal technical advisors and financial expertise are required to successfully advance Tribes wanting to assume administration of their health systems. The budget supporting Planning and Negotiation Cooperative Agreements assist Tribes to secure expertise, and IHS to ensure staff are available to respond to technical assistance requests.

There are two types of cooperative agreements to assist Tribes in attaining Self-Governance:

The Planning Cooperative Agreement provides resources to Tribes entering Title V compacts and to existing Self-Governance Tribes interested in assuming new or expanded PSFAs. Costs supported by the planning cooperative agreements include legal and budgetary research, internal Tribal government planning, and organization preparation relating to the administration of health care programs. The planning phase helps Tribes to make informed decisions about which PSFAs to assume and what organizational changes or modifications are necessary to successfully support those PSFAs.

The Negotiation Cooperative Agreement provides resources to Tribes to help defray the costs related to preparing for and conducting Self-Governance program negotiations.

The design of the negotiation process:

- Enables a Tribe to set its own priorities when assuming responsibility for IHS PSFAs.
- Observes the government-to-government relationship between the United States and each Tribe.
- Involves the active participation of both Tribal and IHS representatives, including the OTSG.
- These cooperative agreements provide funds to support Tribal and federal negotiation teams, who work together in good faith to enhance each Self-Governance agreement.

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

ALASKA IMMUNIZATION — $42.54 MILLION

Eighty percent of Alaskan Native communities are located off the road system, and rural residents travel an average of 147 miles one way to access the next level of health care, often by a combination of air and surface transportation. Supplies are limited and subsistence hunting is often relied on for food. The remoteness of many villages means they lack regular access to law enforcement, courts, or related services, including internet and broadband access. The 1918 influenza (Flu) pandemic was devastating for Alaska Native communities. Some historians estimate that eight percent of the Alaska Native population died from the flu, resulting in some villages being reduced to a single household. Villages were abandoned and surviving members moved to join other

villages. History, language, and culture were lost for many Native communities. The Alaska Immunization Program works to ensure that this atrocity will never happen again.

The Alaska Immunization Program works to eliminate disparities in vaccine-preventable disease in Alaska Native people. Through strong collaboration with local Tribal health partners and regional immunization coordinators, the State of Alaska Immunization Program and the IHS Area Immunization Program, the Alaska Immunization program offers clinical expertise in advancing immunizations, vaccine reporting and data management capacity in an environment of evolving and expanding electronic health record systems. The immunization program works with statewide Tribal health partners to coordinate and advocate for the needs of Tribal immunization programs, educate Tribal staff on immunization recommendations, and administer vaccine for preventable disease in Alaska Native communities.

Building on the Alaska Immunization Program, state and Tribal leaders co-led the COVID-19 vaccination effort including allocation, distribution, funding, and communication. As a result, many Alaska Native people received COVID-19 vaccinations at significantly higher rates than the general population despite Alaska's geographic and transportation challenges. Alaska's state public health and Tribal health partnership for COVID-19 was built on a framework of collaboration and co-leadership that leveraged existing resources of the Alaska Immunization program. The National Governor's Association (NGA) recently featured this collaboration as an NGA state-Tribal case study that provides best practices for the states to replicate in their relationships with IHS and Tribal health programs.[29]

In FY 2024 the Workgroup recommends $42.5 million to fully fund the Alaska Immunization Program. The Hepatitis B Program: Viral hepatitis, including hepatitis B, and other liver diseases continue to be a health disparity for AIANs in Alaska. The Alaska Native Tribal Health Consortium (ANTHC) Hepatitis B Program continues to prevent and monitor hepatitis-B infection, as well as hepatitis-A, immunizations maintained high vaccine coverage rates; health curricula, workforce policy and educational materials for patients as emerging health risks effect the populations.

TRIBAL MANAGEMENT GRANTS — $15.78 MILLION

$15.78 million is the recommended budget amount for the Tribal Management Grant (TMG) program which was authorized in 1975 under Sections 103 (b) (2) and 103 (e) of Public aw (P.L) 93-638, ISDEEAA, as amended. Under the authority of the ISDEAA the program was established to assist all federally recognized Indian Tribes and Tribally sanctioned organizations (T/TO) to plan, prepare, or decide to assume all or part of existing IHS programs, functions, services, and activities (PFSAs). Other options to plan, develop or enhance their health program management capacity. The purpose of the Tribal Management grant is to assist federally recognized Tribes and Tribally sanctioned Tribal organizations in assuming all or part of existing IHS PSFAs through a Title I contract and to assist established Title I contracts and Title V compactors to further develop and improve their management capabilities. This grant award is an important resource for Tribal capacity building and technical assistance when needed.

Although the IHS agency has made this discretionary competitive grant program a lessor priority than direct health services, a high level of interest and awareness by Tribes and Tribal organizations to explore their sovereign right to assume all functions of their own health delivery systems. Additionally with options for recovering CSC and the option for 105 leasing costs this offers Tribes increased options to explore for long-term financial recovery and sustainability. TMG's are available to Tribes and Tribal organizations to pursue planning and feasibility studies and or evaluation of health management structure framework. There are four types of awards designed to assist Tribes which are: Planning, Evaluation and Feasibility are one-year grants. Health Management Structure is a three-year grant.

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

29 "Partnering With Tribal Nations For Covid-19 Vaccinations: A Case Study Of Alaska," August 25, 2021, National Governors Association, available: https://www.nga.org/center/publications/partnering-with-tribal-nations-for-covid-19-vaccinations-a-case-study-of-alaska/

Second Recommendation:

Preserve Medicaid, Medicare, the state Children's Health Insurance Program, the Indian Health Care Improvement Act, and Indian specific provisions in the Affordable Care Act, and provide dedicated funding to begin implementing the new authorities and provisions of the Indian Health Care Improvement Act, which have not yet been implemented and funded.

MEDICAID AND CHIP

More 40 years ago, Congress authorized the Indian Health Service and Tribal facilities to bill Medicaid for services provided to Medicaid-eligible American Indians/Alaska Natives (AI/ANs) to supplement inadequate Indian Health Service (IHS) funding.

The House Report stated: "These Medicaid payments are viewed as a much-needed supplement to a health care program which has for too long been insufficient to provide quality health care to the American Indian."

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

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

We urge the Administration to work with Tribes and strengthen its Tribal consultation practices on issues like Medicaid work requirements and block grants, so that fiscal strain does not unintentionally fall back to the IHS and Tribal health programs.

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

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

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

- Establish standardized oral health care benefits for AI/ANs under state Medicaid programs.
- Work with Tribes to develop a methodology for calculating Medicaid Disproportionate Share Hospital (DSH) payments that considers the uniqueness of the Indian health care system.
- Clarify that states cannot mandate AI/ANs into managed care plans, including those enacted through waivers. This exemption cannot be bypassed using

the United States Department of Health and Human Services (HHS) Secretary's waiver authority.
- Work with states to help them file Section 1115 waivers to obtain Medicaid reimbursement for traditional practices.
- Encourage Tribal consultation at the state level and enforce State Plan Amendment (SPA) requirements for Tribal consultation.

MEDICARE

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

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

Tribal protections in the Medicare program must be enacted. These include:
- Direct sponsorship of Medicare Part B premiums for Tribal citizens. Currently, to cover Medicare Part B premiums, Tribes must reimburse the beneficiary for their premium payment. For a person who cannot afford that premium, paying it and waiting for reimbursement results in undue financial hardship. Employers and unions can sponsor premiums and, by extending the same opportunity to Tribes, it would both recognize Tribal sovereignty and streamline the payment process for the Tribe and beneficiary.
- To equitably account for workforce shortages and other inequities in Indian Country, CMS should set aside Medicare funding for the Graduate Medical Education (GME) program to Tribal facilities and remove administrative impediments to participation in GME funding by Tribe-operated hospitals.
- Expand Medicare reimbursement of audio-only telehealth and communications technology-based services. This includes expanding the ability to provide direct supervision via audio-only means, adding more services to the telehealth benefit permanently, and removing other restrictions on telehealth and communications technology-based services.
- Simplify and streamline reimbursement for Medicare Part D by ensuring that claims from IHS and Tribal facilities are reimbursed at the highest possible rate — not a discounted rate — by Pharmacy Benefit Managers (PBMs).
- Require all Medicare Advantage (MA) plans to automatically deem Indian Health Care Providers (IHCPs) as in-network even if they do not enroll in a provider agreement and reimburse IHCPs at the Office of Management and Budget (OMB)/IHS all-inclusive encounter rate. This automatic deeming and rate-setting should not supersede rates that an IHCP has negotiated and prefers over the OMB/IHS all-inclusive rate.
- Authorize reimbursement for traditional healing services through Medicare.
- Include pharmacists, Licensed Marriage, and Family Therapists (LMFTs), licensed professional counselors, and other providers as eligible provider types under Medicare for reimbursement, as this level of provider is incredibly necessary to Indian Country.
- Create a dental benefit under Medicare that does not require enrollment in managed care.
- Exempt AI/AN people from all Medicare penalties or cost-shares, as they are in the Medicaid program.
- Ensure that Medicare is reimbursing all Indian health care providers at the OMB/IHS all-inclusive rate.

INDIAN HEALTHCARE IMPROVEMENT ACT

The IHCIA provides a range of resources and opportunities for Tribal healthcare institutions, providers, and patients. Tribes collaborated with Congress to develop legislation that included impactful and bipartisan reforms. Provisions included in the IHCIA are the result of years of negotiations, meetings, and strategy sessions. The permanent reauthorization of the IHCIA safeguards the resources of the Indian health care system and has reignited hope the of quality health care delivery.

The IHCIA's enactment and permanent authorization in 2010 protects the future of Indian health and secures a solid foundation for Tribes, Tribal organizations, and Urban Indian Organizations (UIOs) to see that authorized programs and services become realized. Indian Country continues to advocate Congress for accompanying appropriations while engaging with IHS to ensure that the agency's budget reflects Tribal priorities.

In renewing the IHCIA, Congress reaffirmed the duty of the federal government to AI/ANs declaring "it is the policy of this nation, in fulfillment of its special trust responsibilities and legal obligations to Indians."

Despite efforts to augment funding through third-party revenue, IHS remains a vastly underfunded foundation of the IHS/Tribal/Urban health system, representing yet another broken promise to Indian Country. Tribes have worked tirelessly for over a decade to renew IHCIA and it remains critical for Congress and the Administration to ensure that the full intentions of the law are realized.

To provide context for how much of the law has not been implemented, the following represents several categories of programs that have not been implemented and funded, though authorized by IHCIA:

- Continue to support Community Health Representatives despite the President's recommendation to transition to Community Health Aide Program (support both programs), and support demonstration programs to address chronic health professions shortages.
- Authorize dialysis programs, hospice care, long term care, and home/community-based care, new grants for prevention, control, and elimination of communicable and infectious diseases, and establish an office of men's health.
- Provide grants to assist Tribes in encouraging enrollment in the Social Security Act or other health benefit programs.
- Fund construction or expansion of urban facilities, authorize programs for urban Indian organizations targeting communicable disease and behavioral health.
- Authorize programs to create a comprehensive continuum of care, establish mental health technician programs, provide to for innovative community-based behavioral health programs, and encourage demonstration projects to develop tele-mental health approaches to youth suicide. Provide grants for research on Indian behavioral health issues, including causes of youth suicides
- Designate North and South Dakota as a contract health service delivery area.

Clearly, a plan must be put in place to ensure that the intended outcomes of this law are realized. It is critical that additional funds are allocated so the full implementation of these programs can continue without compromising other critical services. We urge the Administration to add appropriations to the FY 2024 request so that IHCIA can be effective.

Furthermore, any rulings by the courts on the unconstitutionality of the ACA must sever IHCIA and certain Indian-specific provisions in the ACA that are of critical importance to the delivery of health services to Indian Country, from the larger ACA. These Indian health provisions have a separate purpose and genesis from the larger ACA and should remain in effect.

Third Recommendation:

Fully and equitably Fund Critical Health Care Facilities Construction Investments made by Tribes in the absence of IHS; with respect to health care facilities construction and all available authorities of the Indian Health Care Improvement Act.

The Indian Health Service (IHS) system is comprised of over 686 hospitals and ambulatory clinics (health centers, health stations, village clinics, and school health centers. These facilities are in mostly rural and isolated areas of the United States. There are also 41 urban Indian health programs that operate out of 77 different locations. IHS estimates in FY 2023 these facilities will provide 40,436 inpatient admissions and 15.8 million outpatient visits.[30]

	Hospitals	Health Centers	Alaska Village Clinics	Health Stations	School Health Centers
IHS	24	51	N/A	25	12
Tribal	22	319	146	79	8

IHS facilities vary widely in age, capacity, design, and function. Some were constructed decades ago before the modern era of medical practice, standards, and codes. Some of the oldest facilities continue in use well past their expected useful life and many older facilities are overcrowded. This impedes access to health care and precludes increasing the number of health care providers. When a facility is replaced, the new one is typically three to four times larger than the old one. This expansion provides access to health care for the 10-year projected user population and space for additional staff and some new services. Lastly, health care providers want to work in new modern facilities with state-of-the-art medical equipment. The age and condition of IHS facilities is starting to affect the ability of IHS to recruit and retain health professionals. This issue is often cited in health professional exit interviews.

On average, IHS hospitals are 40 years of age, which is almost four times more than other United States hospitals with an average age of 10.6 years.[31] A 40-year-old facility is about 26 percent more expensive to maintain than a 10-year facility. The facilities are grossly undersized — about 52 percent — for the identified user populations, which has created crowded, even unsafe, conditions among staff, patients, and visitors. In many cases, the management of existing facilities has relocated ancillary services outside the main health facility; often to modular office units, to provide additional space for primary health care services. Such displacement of programs and services creates difficulties for staff and patients, increases wait times, and creates numerous inefficiencies within the health care system. Furthermore, these aging facilities are largely based on simplistic, and outdated design which makes it difficult for the agency to deliver modern services.[32]

Improving healthcare facilities is essential for:

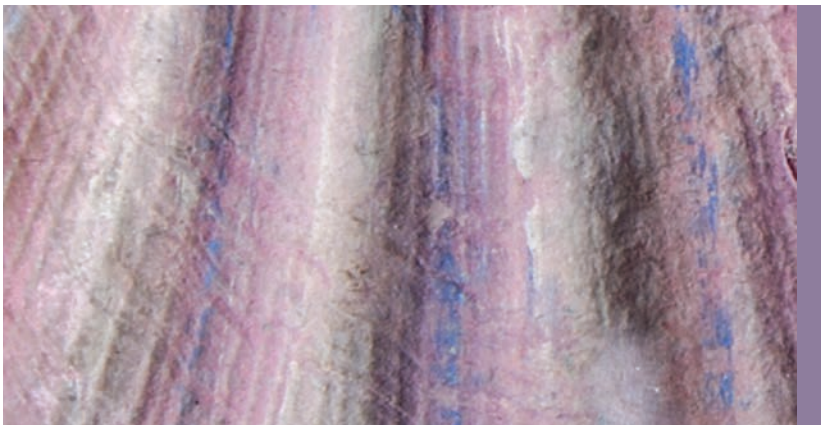
- Eliminating health disparities.
- Increasing access.
- Improving patient outcomes.
- Reducing operating and maintenance costs.
- Improving staff satisfaction, morale, recruitment, and retention.
- Reducing medical errors and facility-acquired infection rates.
- Improving staff and operational efficiency.
- Increasing patient and staff safety.

At the current rate of appropriations, a new facility opening in FY 2022 would not be replaced for 290 years! The absence of adequate facilities frequently results in either treatment not being sought; or sought later, prompted by worsening symptoms; and/or referral of patients to outside communities. This significantly increases the cost of patient care and causes travel hardships for many patients and their families. The number of aging facilities escalates maintenance and repair costs, risks code noncompliance, lowers

30 Source: Indian Health Service. Fiscal Year 2023 Congressional Justification. See page CJ33 and CJ53.

31 *Almanac of hospital financial & operating indicators: a comprehensive benchmark of the nation's hospitals* (2015 ed., pp. 176-179): https://aharesourcecenter.wordpress.com/2011/10/20/average-age-of-plant-about-10-years/

32 *The 2016 Indian Health Service and Tribal Health Care Facilities' Needs Assessment Report to Congress*. Indian Health Service. July 6, 2016. Accessed at https://www.ihs.gov/newsroom/includes/themes/newihstheme/display_objects/documents/RepCong_2016/IHSRTC_on_FacilitiesNeedsAssessmentReport.pdf on November 7, 2016. p. 12



productivity, and compromises service delivery. AI/AN populations have substantially increased in recent years resulting in severely undersized facility capacity relative to the larger actual population, especially the capacity to provide contemporary levels of outpatient services. Consequently, the older facility is incapable of handling the needed levels of services even if staffing levels are adequate.

Over the last several years, investigators at the Centers for Medicare and Medicaid Services (CMS) and the HHS Office of the Inspector General (OIG) have cited those outdated facilities directly threatening a patient's care. For example, in more than half of the hospitals surveyed by the OIG in 2016, administrators reported that old or inadequate physical environments challenged their ability to provide quality care and maintain compliance" with the Medicare Hospital Conditions of Participation (CoPs).[33] "Further, according to administrators at most IHS hospitals (22 of 28), maintaining aging buildings and equipment is a major challenge because of limited resources. In FY 2013, funding limitations for essential maintenance, alterations, and repairs resulted in backlogs totaling approximately $166 million."[34] In fact, over one third of all IHS hospitals deficiencies have been found to be related to facilities with some failing on infection control criteria and others having malfunctioning exit doors. Other facilities are just not designed to be hospitals, and IHS has had to work around historical buildings which are not equipped for a modern medical environment.[35]

For many AI/AN communities, these failing facilities are the only option that patients have. Tribal communities are often located in remote, rural locations, and patients do not have access to other forms of health insurance to treat them elsewhere. As several Tribal leaders have testified, all our patients want is to feel comfortable and safe within the environment in which care is being provided; this is difficult to do when facilities are in disrepair, overcrowded, and medical equipment has outlived its useful life.

This section addresses the Health Care Facilities Construction (HCFC) Priority List, Unmet Facilities Construction Needs in all IHS Areas, plus Urban Facility Needs. A major increase is needed to fund projects nationwide that are already identified by the Indian Health Service.

The FY 2024 recommendation provides funds to address the Health Care Facility Construction (HCFC) backlog reported to the United States Congress which includes the necessary projects and funding levels that ultimately will be necessary to fund. These include:

- Health Care Facilities Construction Priority List +$2.7 billion backlog.[36]
- New IHCIA construction system/projects already identified by IHS Areas +$14.5 billion.[37]
- Tribes also seek the continuation of the vital resources for the Small Ambulatory Program. In FY 2024, at least $25 million is requested.
- The TBFWG also recommends IHS make funds available to UIOs to make minor renovations to facilities or construction or expansion of facilities, including leased facilities, so that they can meet or maintain accreditation standards of The Joint Commission (TJC).

An updated report, the "2020 Facilities Appropriations Information Report (Package)," was completed by IHS on January 30, 2020. It updated the five-line items within the IHS Facilities Appropriation to describe in more detail under its own section the potential benefits, challenges, and impact of various funding levels.

33 Indian Health Service Hospitals: Longstanding Challenges Warrant Focused Attention to Support Quality Care. Department of Health and Human Services, Office of the Inspector General. October 2016. OEI-06-14-00011.

34 Indian Health Service Hospitals: Longstanding Challenges Warrant Focused Attention to Support Quality Care, page 14.

35 Indian Health Service Hospitals: Longstanding Challenges Warrant Focused Attention to Support Quality Care, page 15.

36 IHS FY 2022 Annual Facilities Planning (Five-Year Plan), May 30, 2021, available: https://www.ihs.gov/sites/dfpc/themes/responsive2017/display_objects/documents/projects/Planned_Construction_Priorities.pdf

37 FY 2016 IHS and Tribal Health Care Facilities' Needs Assessment Report to Congress, available: https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/RepCong_2016/IHSRTC_on_FacilitiesNeedsAssessmentReport.pdf

Fourth Recommendation:

Make Health IT funds available to both Indian Health Service and Tribes under Indian Self-Determination and Education Assistance Act (25 u.s.c. 5301 et seq.) and request Congress to allow funds to be used by Tribes for corresponding needs from Health IT modernization whether for a Tribal owned system or an Indian Health Service system.

A properly resourced Indian Health Service (IHS) and Tribal health information technology (HIT) program and electronic health record (EHR) directly supports better ways to:

- Care for patients.
- Pay providers.
- Coordinate referral services.
- Recover costs.
- Support clinical decision-making and reporting, resulting in better care, efficient spending, and healthier communities.

Since FY 2020, the TBFWG and the President's Budget for IHS has supported a new budget line specifically for HIT-EHR modernization. In FY 2022, the recurring budget line item for EHR modernization was increased to $95.2 million. Unfortunately, none of this funding will be directed to Tribes or Tribal Health Organizations that have invested and continue to implement their own HIT-EHR modernization despite numerous recommendations by Tribal leaders to direct a portion of this funding to Tribal programs. In preparation for future modernization, the Department of Health & Human Services (HHS) and IHS evaluated the current Resource and Patient Management System (RPMS) and its associated EHR. This evaluation entitled, the Roadmap Report, provides a guide to modernization efforts over the next five years. The Roadmap Report lays out several opportunities for fiscal years 2020-2022, including establishing a Project Management Office and governance structure, acquisition planning, Health Information Technology (HIT) selection, and procurement, implementation planning, and testing.

Tribes are very concerned that a more accelerated funding strategy is critical to advance the $3 billion 10-year investment appropriately and realistically, which will be needed to allow IHS to either update the current EHR and RPMS suite or initiate an alternatives analysis like the VHA. Tribes are also concerned IHS has completely disregarded the investment and current HIT-EHR modernization effort that is actively underway in Tribally operated health programs. IHS has refused to address this Tribal funding need in any meaningful way with the resources received by Congress, or in the President's budget requests over the past years. Therefore, TBFWG maintains its recommendation for a separate HIT-EHR modernization budget line-item to ensure H&C funds are not diverted to pay for necessary HIT improvements at the expense of direct care for patients. The TBFWG also recommends IHS allocate a portion of the HIT-EHR funds in the FY 2024 budget request.

An adequately resourced IHS and Tribal HIT program is critical to ensure quality and safe care as well as to save costs related to inefficient processes and unnecessary duplication of testing and procedures. The President's Budget request for FY 2024 must include substantial, separate investments for HIT-EHR modernization to be realized in the face of a change technology and resource environment and must include funding for both the IHS and Tribal HIT-EHR modernization efforts.

Fifth Recommendation:

Permanently Exempt Tribes, Tribal Programs, and Urban Indian Organizations from Sequestration and Recissions.

The *Budget Control Act of 2011* authorized sequestration and set forth caps on discretionary spending to reduce the budget deficit by approximately $1.2 trillion over 10 years. For FY 2013, Indian health programs were subject to a 5.1 percent automatic, across the board reduction. The result was a staggering $220 million cut from the severely underfunded IHS, leaving many programs and facilities renovation or repair unfunded and neglected – and more tragically, AI/AN patients suffering.

IHS should not have been subject to any sequester. Sequestration for Indian health programs is contrary to the federal trust responsibility. Tribal nations "pre-paid" for this health care in perpetuity so the funding for it should be moving forward, not backwards.

As the late Senator John McCain, former Chairman of the Senate Committee on Indian Affairs declared: "The Federal Government has continually reneged on its trusts and moral obligations to meet the educational, health care and housing needs of Indians. These needs far outweigh the imperceptible contribution that the proposed cuts will make to reducing the deficit."[38]

Indian health providers were left with an impossible choice — either deny services or finance health care through loans or debt service to make up the difference. Some providers close their doors for several days per month.

Of the four federal agencies which either fund or provide patient care, the Indian Health Service (IHS) is the only one of the four not exempted from sequestration. This inequity, which created an unsafe hardship for Indian patients seeking care, must be permanently corrected.

The *Bipartisan Budget Act of 2019* (P.L. 116-37) ended discretionary sequestration through FY 2021 but did not include a permanent exemption for IHS. In fact, the Special Diabetes Program for Indians (SDPI), which is mandatory funding currently authorized through FY 2023 at $150 million annually, was subject to a sequestration of $3 million beginning in FY 2022, reducing the SDPI funding level from $150 million to $147 million.

While other health spending programs are exempt, including Social Security, veterans' programs, Medicaid and other low-income programs, this SDPI sequester demonstrates that the Indian health care system is neither a priority or consideration for Congress or the Administration. It is unconscionable that the funding for AI/AN patients cannot be protected as it is for these other patients.

Indian health simply cannot take any more sequestration cuts. The Workgroup strongly urges the Administration to work with Congress to ensure that the Indian health care system is not subject to recissions or sequestration again. We recommend that the FY 2024 Budget Request include a permanent exemption for IHS from sequestration and recissions.

38 Fiscal Year 2006 Budget: Oversight Hearing on the President's Fiscal Year 2006 Budget Request for Indian Programs Before the S. Comm. On Indian Affs., 109th Cong. 1 (2005) (statement of Sen. John S. McCain, Chairman, S. Comm. On Indian Affs.).

Sixth Recommendation:

Enact Advance Appropriations for the Indian Health Service.

The ability to provide quality healthcare through Indian Health Service (IHS) is impacted by the lack of stable and full funding in the federal appropriations process. These impacts are particularly troubling during this ongoing COVID-19 pandemic.

Continuing resolutions (CRs) are spending bills for agencies to operate during a specific time to give Congress time to pass the final appropriations measures. During the CR period, restrictions are imposed on creating new programs and projects while operating on as minimal funding as is necessary to maintain federal agencies. If a CR is not passed and Congress cannot pass the final appropriations measures, then a government shutdown occurs. During both a CR and shutdown, IHS and Tribal health programs are greatly impacted by uncertainty and inflexibility of funding gaps.

The CR and shutdowns generate harmful impacts to the Indian health system, and ultimately, destabilize the continuity of care for the patients – to their detriment. When funding occurs during a CR, IHS can only expend funds for the duration of a CR. It further prohibits longer-term, potentially cost-saving purchases. In addition, as most of the health services provided by Indian Tribes and urban Indian organizations are under contracts with the federal government, there must be a new contract re-issued by IHS for every CR.

The Indian health providers' ability to conduct proper planning and purchasing and to recruit or retain health professionals is inhibited. The IHS, Tribal nations, and urban Indian organizations can lose health professionals because their staff either cannot get paid or are concerned about whether they will get paid because the funding is in doubt while a shutdown either is ongoing or potentially could occur. That loss increases the levels of vacancies and reduces the continuity of care that patients need.

According to a 2018 Government Accountability Office (GAO) report, average vacancy rates for physicians, nurses, nurse practitioners, and other provider types across eight IHS regions is at 25 percent, but in some areas the vacancy rate may be as high as 31 percent.[39] These vacancies are leading to more rationed and less accessible care for AI/AN people in response to COVID-19.

Every year since 1998, Congress has passed a CR to temporarily approve funding while they negotiate a longer-term deal. That means, every single year the Indian health system and patients must suffer through the uncertainty of whether they can provide services or not. The impacts of COVID-19 pandemic, CRs, or shutdowns increase the potential for more vacancies and reduced continuity and accessibility of care.

During the most recent 35-day government shutdown at the start of FY 2019, IHS was the only federal health care provider required to "shut down", preventing vital disbursements of funds to facilities in the Indian health care system. Because IHS provides both direct health care services and resources for health care services, this limitation in spending can literally put lives at risk.

This budget instability is potentially life-threatening and must end. Both Congress and the Administration must move forward with bold changes in budget structure and levels for Indian Country.

One such pathway has been provided for the Department of Veterans Affairs. According to the Government Accountability Office, "the Department of Veterans Affairs (VA) is the only federal provider of health care

39 United States Government Accountability Office. (2018). (rep.). *Indian Health Service: Agency Faces Ongoing Challenges Filling Provider Vacancies.* Retrieved from https://www.gao.gov/assets/gao-18-580.pdf.

services to have [advance appropriations] authority."[40] IHS, like the VHA, provides direct medical care to fulfill legal promises made by the federal government. According to the Congressional Research Service, VA receives advance appropriations for VHA's Medical Services, Medical Support and Compliance, Medical Facilities.[41] These three accounts have been authorized to receive advance appropriations through legislation, Pub. L. No. 111-81, passed by Congress beginning in FY 2009.

An advance appropriation is funding that becomes available for one year or more after the year of the appropriations act in which it is authorized. Advance appropriations would shield these services from the harmful impacts of CRs and government shutdowns. IHS has never received funding through advance appropriations. Tribal leaders have long supported and advocated for advance appropriations in the appropriations bills. Likewise, Members of Congress have embraced such protections and stability for the Indian health care funding and advanced several legislative efforts to authorize advance appropriations.

40 United States Government Accountability Office: Report to Congressional Committees. (2018). (rep.). *Indian Health Service: Considerations Related to Providing Advance Appropriations Authority.* Retrieved from https://www.gao.gov/assets/gao-18-652.pdf.

41 Viranga Panangala, S. (2013). (rep.). *Veterans' Medical Care: FY2013 Appropriations.* Congressional Research Service. Retrieved from https://sgp.fas.org/crs/misc/R42518.pdf.

Bill Number	Bill Title	Introduction Date	Sponsor	Latest Major Action
H.R.5567	Indian Programs Advance Appropriations Act of 2021.	10/12/21	Rep. Betty McCollum (D-MN-04)	Referred to the Committee on Natural Resources, and in addition to the Committees on Energy and Commerce, the Budget, and Education and Labor, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned., 10/12/21
H.R 5549	Indian Health Service Advance Appropriations Act.	10/08/21	Rep. Don Young (R-AK-At-Large)	Referred to the Committee on Natural Resources, and in addition to the Committees on Energy and Commerce, and the Budget, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned., 10/08/21
S. 2985	Indian Programs Advance Appropriations Act of 2021	10/07/21	Sen. Ben Ray Lujan (D-MN)	Read twice and referred to the Committee on Indian Affairs., 10/07/21
H.R.1128	Indian Programs Advanced Appropriations Act.	02/08/19	Rep. Betty McCollum (D-MN-04)	Subcommittee Hearings Held., 09/25/19
H.R.1135	Indian Health Service Advance Appropriations Act of 2019.	02/08/19	Rep. Don Young (R-AK At-Large)	Subcommittee Hearings Held., 09/25/19
S.2541	A bill to amend the Indian Health Care Improvement Act to authorize advance appropriations for the Indian Health Service by providing 2-fiscal-year budget authority, and for other purposes.	09/24/19	Sen. Lisa Murkowski (R-AK)	Read twice and referred to the Committee on Indian Affairs., 09/24/19
S.229	A bill to provide advance appropriations authority for certain accounts of the Bureau of Indian Affairs and Bureau of Indian Education of the Department of the Interior and the Indian Health Service of the Department of Health and Human Services, and for other purposes.	01/25/19	Sen. Tom Udall (D-NM)	Read twice and referred to the Committee on the Budget., 01/25/19
H.R.235	Indian Health Service Advance Appropriations Act of 2017.	01/03/17	Rep. Don Young (R-AK At-Large)	Referred to the Subcommittee on Indian, Insular and Alaska Native Affairs., 02/10/17
HR 395	Indian Health Service Advance Appropriations Act of 2015	01/14/15	Rep. Don Young (R-AK At-Large)	Referred to the Subcommittee on Indian, Insular and Alaska Native Affairs., 03/02/2015
S.1570	Indian Health Service Advance Appropriations Act of 2013.	10/10/13	Sen. Lisa Murkowski (R-AK)	Committee on Indian Affairs. Hearings held. Hearings printed: S.Hrg. 113-324., 04/02/14
H.R.3229	Indian Health Service Advance Appropriations Act of 2013.	10/01/13	Rep. Don Young (R-AK At-Large)	Referred to the Subcommittee on Health., 10/03/13

Table 1. Past legislative efforts to secure advance appropriations for the Indian Health Service.

The efforts of Tribal leaders gained significant ground during the 117th Congress. The President's Budget Request for FY 2022 included advance appropriations at a funding level of $9 billion for FY 2023. The Senate Budget Resolution for FY 2022, S.Con.Res. 14, includes authority for advance appropriations for IHS funding. For FY 2022, the proposed draft Senate bill on Interior, Environment, and Related Agencies included advance appropriations for IHS funding at $6.58 billion. However, the House bill on Interior, Environment, and Related Agencies does not include advance appropriations.

Ultimately, Congress did not pass advance appropriations in the final *Consolidated Appropriations Act, FY 2022*. However, it remains a priority and until mandatory funding is passed by Congress, the Workgroup strongly urges the Administration to retain support and include advance appropriations in all Budget Requests at no less than $9.1 billion for IHS.

Seventh Recommendation:

Authorize federally operated health facilities and Indian Health Service headquarters to use federal dollars efficiently and adjust programmatic fund flexibility across accounts at the local level, in consultation with Tribes.

The seventh request is to authorize federally operated health facilities and Indian Health Service (IHS) headquarters to use federal dollars efficiently and adjust programmatic fund flexibility across accounts at the local level, in consultation with Tribes. Supporting this flexibility will empower Tribes to maximize efficiency and effectively use of federal dollars at the local level. It is vital the Tribal healthcare priorities are addressed at the local level to ensure funded solutions are relevant to immediate health issues.

Current appropriations law often creates a barrier for IHS to fully utilize authorized annual funding. For FY 2019 and FY 2020, IHS was granted two-year authority to obligate/re-obligate funding, which has provided some needed flexibility to utilize its appropriation fully and efficiently. However, additional flexibility is still needed to allow IHS ability to reprogram funding if savings are achieved in one fund.

For example, programs such as PRC severely lack funds to meet critical health needs, and services are often denied due to lack of funding. Such programs can benefit from reallocation of savings to provide additional health services. It is requested IHS be granted greater budget flexibility to reprogram funding to meet health service delivery priorities, in consultation with Tribes.

SUPPORTING FUNDING OF TRIBES OUTSIDE OF A GRANT-BASED SYSTEM

The health needs of Indian people are chronic and multi-faceted; such needs must be addressed through committed, stable funding. In contrast, grant programs are temporary, unreliable, non-recurring, and unable to address the ongoing critical needs of Tribal communities. Under the grant making process, some Tribes may receive awards and benefit from occasional increases, while other Tribes do not. This creates two categories of Tribes – those that have the technical experience and financial resources to secure competitive awards, and those that do not. Many Tribes without the capacity to secure competitive grant funding do not benefit from increases in appropriations as a result. There are too many restrictions and requirements to federal grants including excessive reporting, limitations on use of funds, and timelines, which all detract from patient care.

This also creates additional administrative burden for receiving Tribes, who sometimes do not have the capacity to perform those tasks. Ironically, contract service costs (CSC), the administrative funds to pay for these performing of these tasks, obligated in addition to direct base funding, are not provided to manage grant awards. Only indirect costs are allowed with grant funds and must be subtracted from the total grant award, resulting in far less funding for the provision of health services. Grant programs harm the relationship between Tribal nations and the federal government and do not uphold the federal trust responsibility.

IHS SHOULD NEVER USE A GRANT PROGRAM TO FUND ONGOING CRITICAL INDIAN HEALTH NEEDS

Funding for ongoing health services should be distributed through a fair and equitable formula rather than through any new grant mechanism or existing grant program. IHS is the principal federal health care provider and health advocate for Indian people, and its goal is to raise their health status to the highest possible level. IHS provides a comprehensive health service delivery system for AI/ANs. (Indian Health Service, 2022). The grant-making process often burdens the neediest Tribal communities who lack the capacity to secure or administer such funds.

Across Indian Country, the high incidence of heart disease, suicide, cancer, substance abuse, diabetes, and cirrhosis are well documented. There are numerous other Department of Health and Human Services grant opportunities available to Tribes through the Centers for Disease Control, National Institutes of Health, Health Resources and Services Administration, Food and Drug Administration, Agency for Healthcare Research Quality, Administration for Community Living, and Administration for Children and Families that allow Tribes to compete for project specific funding. The IHS funding should be distributed to provide the best culturally appropriate care for the populations they serve.

Eighth Recommendation:

Require the Department and the Office of Management and Budget to work with Congress to create a mandatory appropriation account for the status and legal obligation to pay contract support costs and 105(l) lease agreements, to avoid competition with discretionary funding that could be directed to other program increases.

CONTRACT SUPPORT COSTS

For years, Tribal leaders have examined the options for stabilizing funding for Indian health, including the potential of mandatory funding. So long as federal funding is tied to the discretionary appropriations process, continuing resolutions, or shutdowns, it remains unreliable. It also forces Indian health providers into an untenable situation where operations may be destabilized because the funding is subject to political actions or inaction - beyond the control of Tribes. Their health care operations – and patients - rely on annual appropriations to ensure seamless administration of health care services.

A mandatory funding model, not subject to the annual political appropriations process, more closely aligns with the federal trust responsibility and treaty obligations to Tribal nations. Securing mandatory funding is a significant effort, however, two funding accounts are poised to shift to mandatory immediately.

According to Indian Health Service (IHS), "In FY 2016, Congress provided an indefinite discretionary appropriation for contract support costs in the annual appropriations bill. An indefinite discretionary appropriation allows IHS to fund contract support costs at the actual total funding need for the fiscal year, aligning the budget to the Supreme Court's decision in *Salazar v. Ramah Navajo Chapter*. This funding mechanism avoids the need to redirect funding that IHS would otherwise use to provide direct services to Tribes. These costs are more appropriately funded from mandatory appropriations, consistent with other indefinite authorities."[42]

For the first time, the President's Budget Request for FY 2022 included support for reclassifying both CSC and the Section 105*(l)* leases to mandatory funding. This is particularly notable, but a hollow promise without the requisite effort by the Administration to educate and persuade Congress to adopt this proposal. It was completely ignored during the FY 2022 funding cycle and those efforts must be renewed in earnest by the Administration to achieve this Request. We urge the Administration to join the Tribes in seeing this proposal come to fruition as soon as possible. Until it is fully achieved, the Workgroup strongly urges the Administration to continue to include this proposal in the President's Budget Requests to Congress.

The Workgroup appreciates the support to shift CSC to mandatory funding. However, the Workgroup is concerned with other recent developments on CSC. A recent D.C. Circuit Court of Appeal case, *Cook Inlet Tribal Council, Inc. v. Dotomain*, 10 F.4th 892 (D.C. Cir. 2021) wrongfully decided how contract support costs under the *Indian Self-Determination and Education Assistance Act* (ISDEAA) should be defined, contrary to Congress' direction on CSC. This decision has the potential to destabilize the Indian health system serving Tribal communities.

Already, the decision is now being applied by the IHS in federal-Tribal contract negotiations to deny millions of dollars for necessary health care operational support. Congress authorized this type of funding in the ISDEAA, and, in the absence of a clarifying amendment, the direction and intent of Congress will continue to be contravened – to the detriment of health care for AI/AN people.

Congress has long supported Tribal administration of health programs, including the requisite CSC funding. Senator Ben Nighthorse Campbell declared that "Unfortunately, the ability of Indian Tribes to continue to contract programs and services is severely hampered by the chronic under-funding of contract support costs. Without such funding, Tribes are forced to cut back on services to pay for their administrative costs."[43]

42 Department of Health and Human Services. Fiscal Year 2022. Indian Health Service. Justification of Estimates for Appropriations Committees. At CJ-298.

43 Congressional Record S2303 (March 8, 2004) (statement of Sen. Ben Nighthorse Campbell).

Congress amended the ISDEAA to authorize funding for:

- Costs for the operation of programs or portions thereof for the contract or compact period.[44]
- CSC, such as worker's compensation and overhead.[45]

In enacting these provisions, Congress recognized the importance and necessity of the CSC to the "prudent management" of Indian health programs. Moreover, Congress has supported a flexible administration of CSC which would enable Tribes to effectively operate health care programs.[46] As a matter of law, Congress has authorized full funding of these costs as well.[47] These principles reflect the cornerstones of Tribal self-determination and self-governance policy and set forth a clear direction from Congress to bolster, not arbitrarily restrict, CSC. However, in December 2021, IHS cited this new court decision as a legal basis to cut CSC reimbursements to one Tribal organization by 90 percent. With over $900 million in CSC potentially at issue, Tribal leaders and health officials were justifiably concerned.

This decision could impact the Tribes' ability to administer their health care services and programs and treat their patients. Indian health care services are chronically underfunded. Tribal health care providers already stretch limited resources to overcome significant health disparities and inequities among the Tribal population. This task is made even more complicated by funding reductions and instability. Without the CSC funding, Tribes will not be able to pay for these costs and, instead, be forced to divert funding from patient care to pay for the overhead and other CSC. These reductions will result in diminished access to care across the Indian health system. Congress specifically authorized CSC in the ISDEAA to avoid this situation.

On February 17, 2022, IHS issued a Dear Tribal Leader Letter (DTLL) seeking to reassure Tribal leaders that IHS is not changing how it approaches contract support cost issues. The DTLL explains that "IHS is not doing a retroactive review of every CSC payment to Tribal contractors." However, the letter further states that "IHS will continue to review each Tribal contractor's CSC proposal to ensure the proposed costs meet the statutory definition and terms agreed to during ISDEAA agreement negotiation."

This last statement leaves open the possibility IHS could still renegotiate CSC payments downward based on the *Cook Inlet* decision. To forestall massive CSC cuts across Indian Country, the Workgroup recommends and strongly urges IHS to suspend implementation of the *Cook Inlet* decision in current and future contract negotiations with Tribes.

RECOMMENDATION:

On April 7, 2022, Representative Tom Cole introduced H.R. 7455, the *IHS Contract Support Cost Amendment Act* which is intended to address the *Cook Inlet* decision. We urge Congress, IHS and the Administration to work with Tribes in ensuring that this bill properly addresses the decision and restores the status quo for CSC administration so that Tribal programs can continue operating their programs and treating their patients without any

44 25 U.S.C. § 5325(a)(1).

45 For CSC, the ISDEAA provides in pertinent part: (2)There shall be added to the amount required by paragraph (1) contract support costs which shall consist of an amount for the reasonable costs for activities which must be carried on by a Tribal organization as a contractor to ensure compliance with the terms of the contract and prudent management, but which— (A)normally are not carried on by the respective Secretary in his direct operation of the program; or (B)are provided by the Secretary in support of the contracted program from resources other than those under contract. (3)(A)The contract support costs that are eligible costs for the purposes of receiving funding under this chapter shall include the costs of reimbursing each Tribal contractor for reasonable and allowable costs of— (i)direct program expenses for the operation of the Federal program that is the subject of the contract; and (ii)any additional administrative or other expense incurred by the governing body of the Indian Tribe or Tribal organization and any overhead expense incurred by the Tribal contractor in connection with the operation of the Federal program, function, service, or activity pursuant to the contract, except that such funding shall not duplicate any funding provided under subsection (a)(1) of this section. 25 U.S.C. §5325(a)(2) and (a)(3)(A).

46 See S.Rep. 103-374.

47 25 U.S.C. § 5325(a)(2), (g). See also Salazar v. Ramah Navajo Chapter, 132 S. Ct. 2181 (2012).

CSC and programmatic funding reductions – including for direct service Tribes. We encourage swift passage of this remedy as soon as possible.

Indian Self-Determination and Education Assistance Act section 105(l) leasing

The *Indian Self-Determination and Education Assistance Act* (ISDEAA) at 25 U.S.C. § 5324*(l)* authorizes IHS to enter a lease for a facility upon the request of a Tribal nation or Tribal organization for the administration or delivery of programs, services, and other activities under the Act. Lease requests have grown exponentially in the past four years, with many Tribal nations increasingly turning to 105*(l)* leases in response to the chronic underfunding of facility maintenance, repair, and replacement costs.

As held by the United States District Court for the District of Columbia in the 2016 case, Maniilaq Association v. Burwell, Section 105*(l)* leases must be paid in full by IHS. However, in response to growing lease proposals and after failing to adequately project costs in both FY 2018 and FY 2019, IHS chose to disregard Tribal recommendations to seek an anomaly to their existing appropriations or pay the amounts out of the Treasury's Judgement Fund, even after government-to-government consultation. Instead, IHS unilaterally reprogrammed critical funding twice from other line items to fund these obligations.

For FY 2020, Congress provided $125 million for Section 105*(l)* lease funding, an $89 million increase from the FY 2019 enacted level. While this increase helped to prevent another large reprogramming within the IHS budget, it impacted overall funding for IHS by consuming approximately 50 percent of the agency's total appropriations increase in FY 2020.

For FY 2021, IHS supported a separate, indefinite appropriation for Section 105*(l)* leases, in accordance with long-standing recommendations from Tribal nations. While Tribal nations are pleased that Congress honored our guidance and provided a separate, indefinite appropriation for this binding obligation, this is only a short-term solution to address the need for on-going 105*(l)* funding. Although this mechanism insulates other IHS budget lines from future reprogramming, IHS' estimate of total funding for Section 105*(l)* obligations is funded as a part of its total allocation from Congress.

RECOMMENDATIONS:

With every likelihood that this obligation, and therefore, IHS' estimate, will grow, Tribal nations are concerned that Section 105*(l)* costs could have detrimental impact on overall increases for IHS, including funds for patient care. It is with this in mind that the Workgroup continues to urge that funding for Section 105*(l)* leasing be moved to the mandatory side of the federal budget. We urge the Administration to support this move to ensure that the remaining Indian health care funding is truly insulated from the agency's binding obligations.

In addition, we note that in the FY 2021 Budget Request, IHS proposed statutory limitations to Section 105*(l)* leases in the absence of Tribal consultation. Rather than making unilateral proposals that undermine IHS' obligation for comprehensive health care funding and government-to-government collaboration and consultation. The Workgroup expects that any Section 105*(l)* leasing policy be developed in consultation with Tribal nations.

Ninth Recommendation:

Permanently reauthorize the Special Diabetes Program for Indians and increase funding to $250 million per year, with built-in automatic annual medical inflationary increases, authorize Tribes and Tribal organizations to receive Special Diabetes Program awards through P.L. 93-638 contracts and compacts. Restore previous reductions to the program resulting from sequestration.

The National Tribal Budget Formulation Workgroup (TBFW) has recommended the Biden Administration support the permanent authorization of the Special Diabetes Program for Indians (SDPI). Also, the Workgroup recommends providing Tribe's flexibility in choosing how to receive SDPI funds: through 638 contracts or compacts or through direct service provided by the Indian Health Services (IHS).

Although Tribes are thankful for the current SDPI funding which was established by Congress in 1997 to combat the disease that has ravage our Tribal nations, the funding amount since 2004 has remained stagnant at 150 million. Today there are over 300 SDPI programs that serve approximately 780,000 American Indians/Alaskan Natives (AI/ANs). Tribes have lost over a third of their buying power due to medical inflation and population growth. Our major concern is SDPI renewal does not provide permanent funding and the uncertainty creates barriers to continuity of care that is essential to optimal health. Tribes and Tribal organizations have endured a high degree of uncertainty since 2019. Many Tribal health services experienced disruption of delivery of care amid the COVID-19 pandemic that continues today. This pandemic has impacted AI/ANs who already live with pre-existing health conditions at risk three and a half to four and a half times higher than the general population. Many programs experienced budgetary cuts, reduction in ability to purchase necessary diagnostic equipment and even furlough healthcare providers. Permanent funding would ensure the implementation of diabetes outreach, education, and prevention for Tribal Patients. A recent three-year extension of SDPI funding is helpful in providing short-term resources. But our current strategic planning is hindered due to the lack of guaranteed funding after the year 2023. If the SDPI funding after 2023 is not renewed or is reduced, this will negatively impact resources and Tribal members' clinical outcomes will be adversely affected.

No public health program compares to the achievements of SDPI. The continued resources provided by SDPI funding would allow us to carry on life-saving diabetes prevention and management programming. Reduction in diabetes equals a reduction of comorbidity disease rates including renal failure, heart disease and hypertension across Indian Country.

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

Tenth Recommendation:

Provide recurring funding and authority to build public health infrastructure to address current and future public health emergencies, which includes declaring the Indian Health Service as a jurisdiction for medical countermeasures, while maintaining the flexibility of Tribes to receive from both the states and the Indian Health Service. Provide Tribes with direct access to the national strategic stockpile, while also preserving Tribal flexibility to access state and Indian Health Service resources. Ensure resources and flexibility are available to address staffing shortages and healthcare facility capacity issues.

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

In 2020, 2021 and 2022, multiple COVID-19 outbreaks will occur in our rural communities lacking sufficient water and sanitation facilities. At the peak of the COVID-19 outbreaks, Indian Country saw COVID-19 positivity rates that were the highest in the country. To counteract the spread of the virus in these environments, many Tribal leaders closed their communities to the outside world; the impacts and trauma of the 1918 Spanish Flu outbreak and other pandemics weighed heavily and played a large part in these considerations.

The pandemic continues to have devastating impacts on already chronic and pervasive health staffing shortages. Numerous reports from United States Government Accountability Office and the Department of Health and Human Services (HHS) Office of Inspector General (OIG) have documented how Indian Health Service (IHS) and Tribal facilities struggle to keep providers when competing with mainstream healthcare entities that can easily offer higher wages and better working conditions. More must be done to make meaningful strides towards reducing essential provider vacancies. For instance, as reported by the HHS OIG, IHS and Tribal administrators have noted that staffing shortages have forced IHS hospitals and clinics to turn patients away due to limited capacity. Chronic underfunding of the Indian health system means that hospitals and clinics have less money to hire qualified physicians at competitive salaries. Further, limited funding for personnel can delay the physician hiring process as overburdened staff juggle multiple competing priorities and responsibilities. At the end of the day, these challenges harm the patient most – many of whom encounter long delays in scheduling appointments and have to travel hundreds of miles just to access their closest health center.

RECOMMENDATIONS:

- Recognize that Tribal Health is Public Health by ensuring adequate resources and policy flexibility for Tribal health.
- All federal public health funding programs should include Tribes and Tribal Health Organizations (THOs) as eligible entities and include direct Tribal funding set-asides. Tribal set-asides further the fulfilment of the federal trust obligation for health; but also, without a set-aside, Tribes will more than likely not receive meaningful public health funding. Many Tribal public health departments do not have the capacity to compete with state and local governments for competitive public health grants. The consequence is that Tribes, especially in rural areas, are routinely left behind in development of public health infrastructure.
- Ensure resources and flexibility are available to address staffing shortages and healthcare facility capacity issues.

Eleventh Recommendation:

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

To have a more effective process, Tribes must have the opportunity to meet directly with the Office of Management and Budget (OMB) to ensure that they clearly understand the budget priorities put forward by the Tribes. OMB must be present during the national budget formulation work session, normally held in February. Engagement prior to and in the follow-up to that meeting is also imperative. Having this direct engagement during the national budget formulation would allow for better communication and transparency on the process the government uses at a key point in time, and it would also allow Tribes to focus more directly on the specific concerns which might be raised by key decision makers by providing them with clarifying information about the funding requirements of the Indian Health Service (IHS) and Tribal health programs. The trust responsibility to the Tribes cannot be compartmentalized and having OMB present and participating in meaningful national budget formulation would be a step toward honoring that responsibility.

Twelfth Recommendation:

Expand the Community Health Aide Program nationally, which includes programs in the State of Alaska.

The Community Health Aide Program (CHAP) was established in Alaska over 50 years ago. In 2010, based on the success of CHAP at addressing health disparities and social determinants of health in Alaska, Congress included language in the Indian Health Care Improvement Act (IHCIA) at Section 111 to make the program available to Tribal health programs outside of Alaska. In 2015, Tribal leaders from the Portland Area saw the potential for CHAP and began to advocate for CHAP expansion into the Portland Area and nationally. The Indian Health Service (IHS) was not funded for CHAP expansion and therefore until that time, IHS had not taken steps to make CHAP available outside of Alaska.

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

The Portland Area has been instrumental in expanding CHAP nationally. As of 2022, there are 14 CHAP providers in the Portland Area and 29 on track to complete their training by the end of 2022. The Portland Area has three CHAP education programs. The Dental Health Aide Therapy Education Program will accept its first cohort in the fall of 2022 and the two Behavioral Health Aide Education Programs will accept their second cohorts in the fall of 2022. The Community Health Aide Education Program is expected to accept their first cohort in the fall of 2024. By the end of 2024, we expect the CHAP program in the Portland Area to be over 100 providers strong. The COVID pandemic has exacerbated provider shortages in Alaska and nationally and CHAP expansion is more important now than ever.

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

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

Tribes in Alaska and across other Areas have made it clear that standing up a Community Health Aide Program will require additional financial resources. Tribes have also instructed that CHAP nationalization should occur without negative impacts to the already insufficient resources awarded to Alaska. For the first time, the fiscal year (FY) 2020 budget included $5 million for nationalization of CHAP. That funding was repeated in FY 2021 and 2022 but it does not provide enough funding towards the expansion of CHAP nationally. In 2021 and 2022, the Alaska Dental Health Therapy education program received needed funding. That funding must be increased to include funding for the dental health aide therapist education program educating students in Washington, Oregon, and Idaho.

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

In 2017, IHS established the CHAP – Tribal Advisory Group (CHAP-TAG). This unfunded mandate was tasked to determine how to establish a Community Health Aide Program in other regions, outside of Alaska. Under IHS guidance, the focus of the CHAP-TAG has been on implementing a policy, formatted as a chapter of the Indian Health Manual and published as circular 20-06 to establish a National Federal Certification Board and support Area Certification Board development and operation. The Alaska Area and the Portland Area are the only two areas currently with active Area Certification Boards with the Billings Area CHAP Certification Board in development and expected to launch in 2022. The United State Department of Health and Human Services (HHS) Office of Minority Health has awarded a contract to James Bell Associates to identify factors that promote or restrict implementation of National CHAP and to develop, test and implement a toolkit by September 2022, to support Tribal communities in assessing their readiness for CHAP implementation.

The Northwest Portland Area Indian Health Board established the CHAP learning collaborative to provide real time resources to other Areas to learn from CHAP implementation in the Portland Area and to establish a national learning collaborative to improve CHAP implementation nationally. IHS must take advantage of the 50 plus years of experience with CHAP in Alaska and the near decade of experience in the Portland Area and tap the expertise of the CHAP TAG and task the CHAP TAG to provide further guidance regarding the development of CHAP Training Centers and CHAP programs for areas outside of Alaska with the goal of utilizing CHAP to address social determinants of health, health equity, and access issues, and determine the funding needs to expand CHAP throughout the nation.

Increased funding for CHAP expansion with the recognition that some Areas need seed funding to scope out and implement CHAP and other Areas need funding to support foundational education programs and continued operations is necessary for a successful CHAP expansion that will address health equity and social determinants of health. The CHAP budget should be increased to 60 million per year with $5 million allocated per Area for Areas with Education programs (including Alaska), at least $2 million per Area allocated for Areas with Area CHAP Certification Boards and the remainder allocated to all Areas for activities related to the design, implementation, and operation of CHAP that can address the diverse needs of the Areas at various levels of CHAP implementation and operation.

Thirteenth Recommendation:

Expand the Community Health Representatives Program.

Support the expansion of the Community Health Representative (CHR) program authorized by the Indian Health Care Improvement Act (IHCIA) Section 107 of P.L. 100-713, dated November 23, 1988. The program was enacted through the Snyder Act in 1968 and has continued to evolve alongside the Indian Health Service (IHS) system. As frontline workers during the COVID pandemic, the importance and new emergence of Community Health Workers that has long stood in Indian Country has become a national model and necessity.

The estimated 1,600 CHRs employed across Indian Country can expand and enhance services to fully meet the authorization to elevate health care, health promotion, and disease prevention services as trained health professionals with extensive knowledge of Tribal needs. Ongoing training and the response to COVID in communities is important for Congress to consider as the funding for building the health workforce and eradication of COVID are both unknown.

The unique health and public health services offered by the CHRs in American Indian/Alaska Native (AI/AN) communities are often located in clinical and community settings in rural and remote areas. CHRs provide culturally appropriate health services such as, health screening, case management, direct health services, transportation coordination, and care coordination with health teams. CHRs will require additional funding for comprehensive and consistent training that is high standard for paraprofessionals through a curriculum that combines education in the theory of health care and continuing education with practical experience and oversight. It Is important to improve and expand the CHR program in AI/AN communities. **These include:**

- Continuing Education Program for care coordination support and case management.
- Integration of Community Health Worker recognition for third-party billing.
- Support public health certifications from Tribal colleges or other accredited colleges.
- Community Health Worker training and certifications, including continuing education.
- Support Medical Assistant or Certified Nursing Assistant certifications and maintenance of certification.
- Training for community mapping and assessment to identify health disparities and social needs in AI/AN communities.

In 2010, IHCIA's enactment and permanent authorization protects the future of the IHS system and for generations to come by improving the systems at Tribes, Tribal organizations, and Urban Indian Organizations (UIOs). As the population begins to age, the demand for CHRs remains a critical need for many AI/AN communities. The lack of funding and support has resulted in collaborations with state health departments to receive Community Health Worker training and certifications other than the Indian Health Service. The ongoing attempts to eliminate the CHR program will be detrimental to many AI/AN communities and will directly impact health outcomes for individuals with access to healthcare issues due to transportation and staffing shortages such as nurses and providers.

Fourteenth Recommendation:

Indian Health Service should end the practice of competitive grant-making where not required by statute, and as appropriate, such funds should be distributed to Tribes through Indian Self-Determination and Education Assistance Act contracts and compacts, making such funds eligible for contract support costs and eliminating burdensome grants administration. funding made available under these contracts and compacts should also be increased to meaningfully fund programs that meet patient needs.

SUPPORTING FUNDING OF TRIBES OUTSIDE OF A GRANT-BASED SYSTEM

A more effective way to distribute resources to Tribes is through self-governance contracts and compacts, to ensure sufficient, recurring, and sustainable funding. Using existing funding allocation methodologies will allow Tribes to better plan for greatly needed services for their citizens. The health needs of Indian people are chronic and multi-faceted; such needs must be addressed through committed, stable funding. In contrast, grant programs are temporary, unreliable, non-recurring, and unable to address the ongoing critical needs of Tribal communities. Under the grant making process, some Tribes may receive awards and benefit from occasional increases, while other Tribes do not. This creates two categories of Tribes — those that have the technical experience and financial resources to secure competitive awards, and those that do not. Many Tribes without the capacity to secure competitive grant funding do not benefit from increases in appropriations as a result. There are too many restrictions and requirements to federal grants including excessive reporting, limitations on use of funds, and timelines, which all detract from patient care. This also creates additional administrative burden and costs for Tribes receiving these grants. If these funds were put into Indian Self-Determination and Education Assistance Act (ISDEAA) agreements, the Tribes would be eligible to receive additional contract support cost (CSC) funds which would assist to alleviate this administrative burden and cost. Unfortunately, only indirect costs are allowed with grant funds and these amounts must be subtracted from the total grant award. This results in far less funding for the provision of health services and care for patients. Grant programs harm the relationship between Tribal nations and the federal government and do not uphold the federal trust responsibility.

IHS SHOULD NEVER USE A GRANT PROGRAM TO FUND ONGOING CRITICAL INDIAN HEALTH NEEDS

IHS has now received a total of $30 million to fund its new "Community Opioid Intervention Pilot Project" program. While Congress did specify that IHS must use the funds to award grants, Congress did not dictate that a competitive grant process be used. Appropriations language did not prohibit the use of formula grant awards through compacts or contracts, which would allow Tribes to collect CSC in addition to grant funding. Instead, IHS decided to use the competitive grant award process, even after most Tribal consultation responses objected to this methodology. As a result, the initial grant cycle will award approximately $16.5 million to only two grantees per Area; six grant awards are set-aside for Urban organizations and one additional will be awarded to IHS's highest priority Alaska, Bemidji, and Billings Areas. Each grant requires semi-annual progress and quarterly financial reporting and compliance with the burdensome HHS grants management policies and procedures.

There are many administrative requirements, yet additional CSC funding was not provided for grant administration even though 1) statutes do not exempt special projects or grant funding from the mandate to pay CSC in full and 2) Congress now appropriates CSC based on actual need. The grant-making process often burdens the neediest Tribal communities who lack the capacity to secure or administer such funds. And even though one IHS Area or community may struggle most with opioid addiction, others continue to fight alcohol and methamphetamine addictions; yet, under this grant which limits qualifying needs to a single problem, Tribes cannot access additional funds to meet their community's most pressing needs.

Funding for ongoing health services in fiscal year (FY) 2024 should be distributed through a fair and equitable formula rather than through any new grant mechanism or existing grant program. Across Indian Country, the high incidence of heart disease, suicide, cancer, substance abuse, diabetes, and cirrhosis are well documented. Grants used to address any Indian health issue limits funding for and restricts access to culturally appropriate care. Increasing resources, in non-grants, for behavioral health to combat alcohol and substance abuse, including opioid, methamphetamines, and other addictions, is needed to break the cycle and reduce the disease and cost burden currently experienced by our Tribal communities.'

Tribes are often subject to the whims of federal agencies, particularly around grant making. As we have seen with COVID-19, many federal agencies have no idea about Tribal nations, resulting in grant opportunities that are often ill-fitted for serving American Indian/Alaska Native (AI/AN) people. Competitive grant making is perhaps the best example of this. Tribes are forced to compete against each other to access funding for programs and emergency items.

RECOMMENDATIONS:

A formula-based allocation of funding directly to Tribes is the best way to honor the trust responsibility and ensure that all Tribal nations, not just the ones who have access to the resources needed for competitive grant writing, are able to access funding.

The federal government has a constitutional obligation to fulfill this trust responsibility and because of this trust responsibility, federal spending for IHS should be mandatory, not discretionary.

IHS should be exempt from broad-based cuts in discretionary spending and budget rescissions.

- Federal trust obligations to fund healthcare and public health in Indian Country cannot, and must not, be achieved through the competitive grant mechanism. By the very design, competitive grants create an inequitable system of winners and losers. The federal obligation to fully fund health services in Indian Country was never meant to be contingent upon the quality of a grant application – yet that is the construct that the federal government has forced Tribes to operate under. That is unacceptable.
- All federal public health funding programs should not only include Tribes or Tribal Health Organizations (THOs) as eligible entities, but also include direct Tribal funding set-asides. Tribal set-asides further the fulfilment of the federal trust obligation for health; but also, without a set-aside, Tribes will more than likely not receive meaningful public health funding. Many Tribal public health departments do not have the capacity to compete with state and local governments for competitive public health grants. The consequence is that Tribes, especially in rural areas, are routinely left behind in development of public health infrastructure.
- Ensure resources and flexibility are available to address staffing shortages and healthcare facility capacity issues.

Fifteenth Recommendation:

Indian Health Service should remove remaining bureaucratic barriers to ensure that all Native American communities and homes have adequate access to running water. Indian Health Service should also make it a clear priority to provide sanitation services to all Native communities, and to work to achieve this by providing Operations and Maintenance assistance to ensure sanitation services are reliable and affordable.

The Indian Health Service (IHS) Sanitation Facilities Construction (SFC) Program, an integral component of IHS disease prevention activity, has carried out those authorities since 1960 using funds appropriated for SFC to provide potable water and waste disposal facilities for American Indian/Alaska Native (AI/AN) people. Adequate sanitation infrastructure has never been more critical than it is now, during the COVID-19 pandemic. Water and sanitation utility service delivery has not yet reached 100 percent across every residential household in Indian country. As a result, the rates for infant mortality, the mortality rate for gastroenteritis and other environmentally related diseases have been dramatically reduced by about 80 percent since 1973. The IHS physicians and health professionals' credit many of these health status improvements to IHS' provision of water supplies, sewage disposal facilities, development of solid waste sites, and provision of technical assistance to Indian water and sewer utility organizations. The provision of Indian sanitation facilities is a very important component of the overall effort required to achieve a reduction in waterborne disease outbreaks, a goal highlighted in Healthy People 2020 "Topics and Objectives" for Environmental Health. Safe drinking water supplies and adequate waste disposal facilities are essential preconditions for most health promotion and disease prevention efforts, as well as being a major factor in the quality of life of Indian people.

Many rural Indian communities only have fractions of residential subdivisions connected to fully operating water and sanitation for both kitchens and bathrooms. These communities typically have a washeteria building (a combination of a water treatment plant, laundromat, with toilets and showers) that the entire community uses. Most of these communities haul their water from the washeteria to their home in a five-gallon bucket and haul their sewage from their home in a different five-gallon bucket. These communities rely on water hauled from rivers and stored in drums, and honey buckets or outhouses in place of toilets. It is no longer acceptable in the twenty-first century to have entire communities without in-home water and sanitation, living with third world sanitation conditions.

RECOMMENDATIONS:

- Direct as much funding as possible directly to projects. Barriers preventing funds from directly reaching our unserved communities must be addressed. Any approach to supporting sustainable efforts on water and sanitation systems must be wholistic and include self-determination, address high construction costs and limited construction season for rural communities, workforce needs and climate change impacts on these systems. Many communities have remained unserved due to these barriers.
- IHS should fund all projects that are determined to be unfeasible in the Sanitation Deficiency System (SDS) and weigh these funds toward projects that address higher level deficiencies.
- Remove IHS SDS Cost Caps.
- Remove IHS SDS ineligible cost match requirements. IHS must work with those communities to address the required contributions. Tier one or Tier Two projects should not be passed over in any fiscal year because they do not have contributions for ineligible costs.
- Fund alternative energy systems to be designed and installed as part of sanitation infrastructure projects to reduce the operational cost.
- Recommend establishing local and/or regional utility management and operations systems. Which will support the creation of operator standards,

education, and training materials and criteria which are culturally competent and reflective of Native educational styles.

- IHS administrative set-aside should be minimal. Use IHS administrative funds to conduct community and homeowner education and outreach.
- Fund extended warranty for new community wide systems given the complex nature of work and logistics, two to three years.
- Fund interim operational costs for new communities.

Sixteenth Recommendation:

Congress should address the dire need for long term care, assisted living, home and community-based, and hospice services in American Indian/ Alaska Native communities and appropriate recurring funding for this need.

Among the most common issues and concerns across all Indian Health Service (IHS) regions, the topic of addressing elder health care needs is raised. In 2010, Section 124 of the Indian Health Care Improvement Act (IHCIA) authorized assisted living services, home and community-based services (HCBS), hospice care and long-term care services listed here. They have received minimal attention and funding has not been appropriated:

§ 1621d. Other authority for provision of services.
§ 1637. Indian health care delivery demonstration projects. (c) (1) convenient care services.
§ 1680l. Shared services for long-term care.

The efforts by Tribal leaders that led to the adoption of these provisions were driven by the concern that American Indian/Alaska Native (AI/AN) elders are severely impacted by disparities in health and healthcare access. 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. IHS was created in 1955 to meet their federal commitments to AI/AN people, but elder care services were not authorized until 2010. Long-term care needs must be fully funded so that our honored elders, who find difficulty obtaining these services, will finally have access to them.

Several ideas to implement Section 124 were noted among the regional recommendations. The Portland Area leadership noted unique needs pertaining to treatment and medication management that would require geriatric capabilities in the IHS/Tribal/Urban Indian health care system. They had identified that the infrastructure to comprehensively support these types of programs, can be cost prohibitive and recommended long-term care programs and home and community-based services, that are reimbursable under Medicaid and through qualified health plans on the Health Insurance Marketplace to become self-sustaining.

The Tucson Area leadership noted the dire need for long-term care and assisted living services. In one instance a Tribe is moving forward to plan an assisted-living facility and noted that the types of wrap-around services, such as case management and in-home services will also be required. Our elders deserve focused attention to the implementation of Section 104 IHCIA authorities.

The Phoenix Area leadership recommended the following initial investments in Elder Health in FY 2024:

- +$1.5 billion under the Hospitals and Clinics (H&C) line item to begin implementing the new authorities.
- +$12 million under the Maintenance and Improvement (M&I) line item for repairs required of existing elder care facilities or to address in-home needs identified by HCBS programs operated by Tribes.
- +$360 million in the Health Care Facility Construction (HCFC) line item to construct long term care, assisted living facilities, hospice care or convenient care services that align with the Section §1680l of the IHCIA.

Conclusion

Fulfilling the federal trust responsibility, honoring the promises made to our ancestors, and ensuring access to quality health care requires the full funding of the Indian Health Service (IHS). Tribes are grateful for the recent incremental increases to the IHS appropriation over the last several years. However, this has not been enough. We continue to have an underfunded system that must stretch limited resources beyond their capacity. The COVID-19 pandemic illustrated the perils of not having a fully funded and equipped system. Increases in the IHS annual budget since Fiscal Year (FY) 2008 have not been sufficient to even cover costs associated with medical and non-medical inflation. Increases have barely kept pace with population growth and the rightful full funding of Contract Support Costs. Incremental increases are not sufficient, we must find a better path forward.

While incremental increases are much needed to sustain the historical level of services, they do little to address the disparate health conditions of American Indian/Alaska Native (AI/AN) communities. Unfortunately, the two to five percent incremental increases to the IHS budget over the past decade have not kept pace with expenses related to population growth and medical and non-medical inflation. Leaders of our Tribal nations insist that a true and meaningful investment be made to finally eradicate the pervasive health disparities which has overwhelmed Indian Country for years. It will take a true commitment between the United States and Tribal nation leadership to put a strategy and budget in place. We have made our proposal and recommendations to the United States government, and we expect them to respond in kind. Decisive action by the United States government is needed to address the inequities that have plagued AI/AN people for generations.

The Tribal Budget Formulation Work Group implores the Administration to work with Congress in FY 2024 to enact a serious investment in Indian health that will honor and fulfill the promises made to our ancestors. One essential step is to support Advanced Appropriations for the Indian health service. Without Advanced Appropriations, Indian health providers are subjected to the whims of political machinations that could result in a government shutdown and the loss of funds to provide health care for our people. This is inherently unstable and directly places the health of our people in the hands of political actors. This must be corrected.

The IHS budget represents a sacred promise made between these United States and our ancestors to fulfill the trust and treaty obligation to provide healthcare services to all AI/ANs. Congress and the courts have repeatedly affirmed this federal trust responsibility. In August 2021, this was yet again reaffirmed by the Eighth Circuit in *Rosebud Sioux vs. United States*. This Administration must take actionable steps to fulfil this promise by putting forward a true and impactful budget proposal. Throughout this document, we have stated the impacts of not fulfilling the trust responsibility. The United States must fulfil its promise and ensure that we have the resources necessary to combat the health disparities that have plagued our people for generations.

This document reflects the Tribal budget priorities for this Administration to consider as it formulates the FY 2024 budget request. We believe that it provides a clear road map to make meaningful progress toward satisfying fulfillment of the agreement made by the United States, as our federal trustee, to provide quality health care to the 574 federally recognized Tribes in America.

We, as Tribal leaders appointed to serve on the national budget formulation workgroup, passionately believe that by working collaboratively through our government-to government relationship, together we can achieve real progress to eliminate health disparities and create wellness in AI/AN nations. It is imperative that the budget recommendations be acted on immediately if we are to build a strong and sustainable Indian health system. Doing so will honor Tribal sovereignty and the federal fulfillment of the historic trust responsibility to our nations. We look forward to working with you directly as you engage in conversations on the FY 2024 budget.

Acknowledgements

NATIONAL TRIBAL BUDGET FORMULATION WORKGROUP AREA REPRESENTATIVES

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

ALBUQUERQUE
- Beverly Coho, AAIHB Vice Chair Member, Rama Navajo School Board President

BEMIDJI
- Phyllis Davis, Councilmember, Match-e-be-nash-she-wish Band of Pottawatomi Indians of Michigan
- Dr. Leo Chugunov, Health Director, Sault Saint Marie Health Center

BILLINGS
- Lane Spotted Elk, Tribal Council Representative, Northern Cheyenne Tribe
- Lee Spoonhunter, Co-Chairman, Northern Arapaho Business Council
- Tracy King, Board Member, Fort Belknap Community Council
- Frank White Clay, Chairman, Crow Tribe

CALIFORNIA
- Michael Garcia, Vice Chairman, Ewiiaapaayp Band of Kumeyaay Indians
- Chris Devers, Tribal Representative, Pauma Band of Mission Indians

GREAT PLAINS
- Scott Herman, President, Rosebud Sioux Tribe
- Cora White Horse, Tribal Council, Oglala Sioux Tribe

NASHVILLE
- Elizabeth Neptune, Tribal Council, Passamaquoddy Indian Township Tihtiyas (Dee) Sabattus, Deputy Director, United South and Eastern Tribes

NAVAJO
- Jonathan Nez, President, Navajo Nation
- Carl Slate, Delegate, Navajo Nation Council

OKLAHOMA
- Terri Parton, President, Wichita, and Affiliated Tribes
- Del Beaver, Second Chief, Muscogee (Creek) Nation

PHOENIX
- Amber Torres, Chairman, Walker River Paiute Tribe
- Jessica Rudolfo, Health Director, White Mountain Apache Tribe

PORTLAND
- Andrew Joseph Jr, Alternate, The Confederated Tribes of the Colville Reservation
- Nickolaus Lewis, Secretary, Lummi Nation

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

TRIBAL TECHNICAL WORKGROUP

ALASKA
- Jacoline Bergstrom, Jim Roberts, and Alberta Unok

ALBUQUERQUE
- Tracy Sanchez

BEMIDJI
- Phyllis Davis and Dr. Leo Chuganov

BILLINGS
- Dylan Black Eagle and Tafuna Tusi

CALIFORNIA
- Nickolajs Berzins

GREAT PLAINS
- Sunny Colombe

NASHVILLE
- Elizabeth Neptune, Conny York, and Tihitiya (Dee) Sabbatus

NAVAJO
- Dr. Jill Jim and President Jonathan Nez

OKLAHOMA
- Melissa Gower, Melanie Fourkiller, Kasie Nichols, and Nick Barton

PHOENIX
- Amber Torres and Alida Montiel

PORTLAND
- Andy Joseph, Jr., Laura Platero, Elizabeth Coronado

TUSCON
- Peter Yucupicio, Wavalene Saunders, and Shanna Tautolo

Area Budget Narratives

Appendix A

Alaska Area Budget Narrative

INDIAN HEALTH SERVICE
FISCAL YEAR 2024 ALASKA AREA
BUDGET INSTRUCTIONS
BUDGET RECOMMENDATION NARRATIVE

BUILDING PARITY & HEALTH EQUITY WITH TRIBAL SOVEREIGNTY

Issue:

TRIBAL SELF-DETERMINATION IS HEALTH EQUITY

Background: Tribal self-governance protects, supports, and reinforces Tribal sovereignty by transferring programmatic authority and resources from the federal government to Tribes. Inherent in the government-to-government relationship between Tribal nations and the federal government is that the United States work directly with Tribes as sovereign equals in all governmental functions, including emergency preparedness and response.

We have seen with the investment in the Alaska Tribal Health Compact and Alaska Tribal Health System (ATHS) the wisdom of supporting Tribal sovereignty because Tribes know best how to solve local challenges. Not only are these investments the right thing to do because of the trust responsibility and the treaty obligations, they're good investments because Tribal programs, when given the resources, can be innovative and have remarkable outcomes for their communities and their people.

Sovereignty means Tribes should be allowed to make their own decisions about their own policies. Tribal governments have repeatedly advocated for government-wide expansion of Tribal self-governance. Self-determination and self-governance policies honor the inherent sovereignty of Tribal nations by affording local Tribal control over program and policy implementation, thus allowing for the creation of tailored programs uniquely developed to address community priorities. Not only does this improve the efficiency and effectiveness of program operations, but it is also a proven method that leads to health equity and better socioeconomic outcomes for Tribal communities.

More must be done to strengthen Tribal sovereignty and ensure the federal government upholds its trust and treaty obligations to the Tribes for the improvement of healthcare, health outcomes and public health infrastructure and capacity. Tribes are often subject to the whims of federal agencies, particularly around grant making. As we have seen with COVID-19, many federal agencies have no idea about Tribal nations, resulting in grant opportunities that are often ill-fitted for serving American Indian/Alaska Native people. Competitive grant making is perhaps the best example of this. Tribes are forced to compete against each other to access funding for programs and emergency items.

Recommendations:

- A formula-based allocation of funding directly to Tribes is the best way to honor the trust responsibility and ensure that all Tribal nations, not just the ones who have access to the resources needed for competitive grant writing, are able to access funding.
- The federal government has a constitutional obligation to fulfill this trust responsibility and because of this trust responsibility, federal spending for the Indian Health Service (IHS) should be mandatory, not discretionary.
- IHS, should be exempt from broad-based cuts in discretionary spending and budget rescissions.
- Federal trust obligations to fund healthcare and public health in Indian Country cannot, and must not, be achieved through the competitive grant mechanism. By their very design, competitive grants create an inequitable system of winners and losers. The federal obligation to fully fund health services in Indian Country was never meant to be contingent upon the quality of a grant application – yet that is the construct that the federal government has forced Tribes to operate under. That is unacceptable.

Issue:

TRIBAL PUBLIC HEALTH & PANDEMIC RESPONSE

Background: We are bearing witness to and experiencing the alarming changes to our everyday lives resulting from this unprecedented pandemic. In a matter of weeks, COVID-19 reshaped the very fabric of our economy, our society, the way we conduct business, relationships, and

our personal livelihoods – in some ways, permanently. We are continuing to face profoundly uncertain and challenging times.

In 2020 and 2021, multiple COVID-19 outbreaks occurred in our rural communities lacking sufficient water and sanitation facilities. At the peak of the COVID-19 outbreaks, the Yukon-Kuskokwim Delta region saw COVID-19 positivity rates that were the highest COVID-19 rate in the country. Forty percent of homes in this region do not have in-home water or sewer connections. To counteract the spread of the virus in these environments, many villages closed their communities to the outside world; in Alaska Native communities, the impacts and trauma of the 1918 Spanish Flu outbreak weighed heavily and played a large part in these considerations.

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

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

Recommendations:

- Recognize that *Tribal Health is Public Health* by ensuring adequate resources and policy flexibility for Tribal health.
- All federal public health funding programs should not only include Tribes or Tribal Health Organizations (THOs) as eligible entities, but also include direct Tribal funding set-asides. Tribal set-asides further the fulfilment of the federal trust obligation for health; but also, without a set-aside, Tribes will more than likely not receive meaningful public health funding. Many Tribal public health departments do not have the capacity to compete with state and local governments for competitive public health grants. The consequence is that Tribes, especially in rural areas, are routinely left behind in development of public health infrastructure.
- Ensure resources and flexibility are available to address staffing shortages and healthcare facility capacity issues.

Issue:

PARITY IN MODERNIZATION OF HEALTH INFORMATION TECHNOLOGY

Background: Adequately resourced health IT (HIT) programs are essential to ensuring quality and safe care. Alaska Tribes have invested millions of dollars of their own resources to modernize their electronic health records management system. Tribes and THOs who have already converted from the resource and patient management system (RPMS) to more efficient technological solutions should be financially supported just as IHS is being funded for its modernization. If IHS is seeking financial support from Congress for its modernization through the IHS appropriation and budget formulation process it must include a proposal to fund those Tribes that have invested their own resources for modernization as well as ongoing maintenance. Otherwise, the Alaska Area does not support any funding to be directed for IHS modernization and through the budget formulation process.

Alaska Tribes have been striving for parity between other federal agencies and departments, particularly the Department of Veterans Affairs (VA) in its endeavors to implement a new electronic health record (EHR) system. However, this parity should not come at the expense of potential program increases or other opportunities that might be displaced by funding to just the IHS modernization effort. EHR modernization must be inclusive of those Tribes and THOs that have already modernized their HIT systems and the current funding needed to support and maintain those systems — just as IHS seeks funding to begin it modernization effort.

Recommendations:

- Health IT Modernization — Provide financial resources for both, the modernization efforts that have already been carried out by Tribes and THOs in addition to the IHS EHR modernization. If a funding proposal is not inclusive of funding Tribes and THOs, then funding should not be included for IHS either.
- Recognize the lack of parity for Tribes and THOs who had to move away from RPMS for the safety and benefit of our patients.
- Honor and respect Tribal communities and stakeholders — appropriate HIT solutions should include participation from Tribal HIT experts and representatives who are given authority to represent Alaska Tribes on HIT issues.
- Support Tribes while creating an opportunity to continue to innovate around HIT solutions for rural and resource-constrained communities — IHS must commit to creatively integrating ongoing evaluation of any HIT interventions.

Issue:

NON-COMPETITIVE FUNDING FOR BEHAVIORAL HEALTH

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

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

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

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

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

Recommendations:

- Increasing resources, in non-grants, for behavioral health to combat alcohol and substance abuse, including opioid, methamphetamines, and other addictions,

is needed to break the cycle and reduce the disease and cost burden currently experienced by our Tribal communities.

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

Issue:

PERMANENT AUTHORIZATION OF THE SPECIAL DIABETES PROGRAM FOR INDIANS

Alaska Tribes continue to advocate for the permanent authorization of the Special Diabetes Program for Indians (SDPI) program and requests a minimum increase of $50 million for a new total of $200 million. Current programs should be held harmless from inflation erosion, and the additional funds will allow for Tribes not currently funded to develop programs which have shown to be highly effective in reducing the devastating impact that diabetes has in Tribal communities.

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

Recommendation:

It is time to transition the SDPI from a grant program and implement as standard practice, through permanent reauthorization and recurring funding for all Tribal and IHS programs. Interrupting the progression of diabetes has potential for far flung impacts, including risk of developing Non-alcoholic Fatty Liver Disease (NAFLD) and obesity. NAFLD, for example, "has a strong multifaceted relationship with diabetes and metabolic syndrome, and is associated with increased risk of cardiovascular events, regardless of traditional risk factors, such as hypertension, diabetes, dyslipidemia, and obesity."[48]

SUSTAINABLE INVESTMENTS IN CRITICAL INFRASTRUCTURE

Issue:

SANITATION FACILITIES

Background: Adequate sanitation infrastructure has never been more critical than it is now, during the COVID-19 pandemic. Water and sanitation utility service delivery has not yet reached 100 percent across every residential household in Alaska. Most villages only have fractions of residential subdivisions connected to fully operating water and sanitation for both kitchens and bathrooms, while there are still 30 "unserved" communities in Alaska without any water and sewer utility service delivery at all. These communities typically have a washeteria building (a combination of a water treatment plant, laundromat, with toilets and showers) that the entire community uses. Most of these communities haul their water from the washeteria to their home in a five-gallon bucket and haul their sewage from their home in a different five-gallon bucket. These communities rely on water hauled from rivers and stored in drums, and honey buckets or outhouses in place of toilets. It is no longer acceptable in the twenty first century to have entire communities without in-home water and sanitation, living with third world sanitation conditions.

48 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6747357/

Recommendations:

- Alaska Tribes recommends directing as much funding as possible directly to projects. Barriers preventing funds from directly reaching our unserved communities must be addressed. Any approach to supporting sustainable efforts on water and sanitation systems must be wholistic and include self-determination, address high construction costs and limited construction season for rural Alaska, workforce needs and climate change impacts on these systems. Many communities have remained unserved due to these barriers.
- IHS should fund all projects that are determined to be unfeasible in the SDS system. Alaska Tribes further recommend IHS weigh these funds toward projects that address higher level deficiencies.
- Remove IHS Sanitation Deficiency System Cost Caps.
- Remove IHS Sanitation Deficiency System ineligible cost match requirements. IHS must work with those communities to address the required contributions. Tier one or Tier Two projects should not be passed over in any fiscal year because they do not have contributions for ineligible costs.
- Fund alternative energy systems to be designed and installed as part of sanitation infrastructure projects to reduce the operational cost.
- Recommend establishing local and/or regional utility management and operations systems. Which will support the creation of operator standards, education, and training materials and criteria which are culturally competent and reflective of Native educational styles.
- IHS administrative set-aside should be minimal. Use IHS administrative funds to conduct community and homeowner education and outreach.
- Fund extended warranty for new community wide systems given the complex nature of work and logistics, two to three years.
- Fund interim operational costs for new communities.
- Allow and fund local climate and environmental threat monitoring in project communities and through a statewide network. Alaska is the only Arctic and Sub-Arctic state, and it is experiencing warming trends at twice the rate and having a greater impact than in most other parts of the United States on sanitation and facilities infrastructure.

Issue:

FULLY FUND MAINTENANCE & IMPROVEMENT

Background: The facilities priority system backlog means that many Tribes and Tribal health programs must rely on aging facilities and clinics are in dire need of improvement. When patients and providers lack access to a well-functioning infrastructure, the delivery of care and patient health and potentially patient safety is compromised.

Recommendations:

- With the average age of many Tribal facilities well beyond initial recommendations or design life, the need to adequately fund the maintenance is essential to prolonging the usability and life of such facilities.
- To provide the level of care necessary to ensure a minimum standard of patient care, more resources need to be provided at the facility and clinic level.

Issue:

CONTINUED FUNDING FOR THE SMALL AMBULATORY GRANTS PROGRAM

Background: In many of the rural communities in Alaska and indeed in many rural America communities, the only access to health care is the Tribal health program in those communities. In Alaska, with 80 percent of its communities off the road system spread across over 660,000 square miles, these communities are in effect islands, and therefore Alaska Tribes recommend that the eligibility of Tribal government offices that are located on an island be extended to include "or that are not on the road system". These facilities support lower cost care in home locations that allow for early interventions and preventative care. Congress recognized this fact when it authorized Section 306 of the Indian Health Care Improvement Act (IHCIA). This section allows IHS to award grants to Tribes and/or Tribal Organizations to construct, expand, or modernize small ambulatory health care facilities. The Small Ambulatory Grants Program (SAP) eligibility includes Tribes and Tribal Organizations whose Tribal government offices are located on an island.

Recommendations:

- Support appropriations for SAP and award funding to construct, expand, or modernize small ambulatory health care facilities.
- Continued appropriations of funds to support this much-needed program.

Issue:

JOINT VENTURE CONSTRUCTION PROGRAM

Background: Joint Venture Construction Program (JVCP), a partnered effort between Tribes and IHS, remains a cost-effective mechanism to address the health care facilities shortage separate from the IHS Facilities Construction Priority System. The JVCP program has increased access to care in communities with dire health care needs. The Alaska Area recommends the JVCP be expanded to allow stand-alone specialty care facilities when not developed as part of an inpatient or outpatient

facility (e.g., inpatient or outpatient behavioral health facilities, dialysis centers, long-term care, and other specialty care services).

Recommendations:

- Alaska Tribes recommends that IHS routinely and regularly offer a new cycle for the IHS JVCP applications.
- In FY 2019 there were ten JVCPs that were selected in phase one of the final application process. Five projects were selected to continue to Phase two. The Alaska Area recommends IHS proceed with the second five selected applicants in FY 2024 and request funding for the staffing packages from Congress.
- Alaska Tribes recommends allowing applications for construction projects already started, that are being developed in accordance with IHS design/construction criteria. This is especially relevant in Alaska where the construction season is extremely short, materials are particularly expensive, and must be shipped via barge, which might only arrive one or two times per year. For these reasons, Alaska Tribes must plan years in advance.
- Alaska Tribes also recommends the inclusion of dedicated behavioral health facilities in the JVCP solicitations, given the high priority of substance abuse issues and the need for residential treatment centers.

Issue:

FULL AND MANDATORY FUNDING FOR CLINIC LEASE PROGRAM

Background: Village health clinics supported by the IHS VBC Lease Program have a long and unique history in Alaska and provide the only local source of health care in many rural areas. VBC leases are vital to the provision of services by Community Health Aides/Practitioners, Behavioral Health Aides/Practitioners, and Dental Health Aides; the program provides the foundation for the health care system in villages in rural Alaska. The VBC Lease Program is also similar to the section 105*(l)* leases in that it has long been underfunded and is crucial to Tribal clinics keeping their doors open to serve patients. Alaska Tribes recommend the VBC Lease Program be treated similarly to section 105*(l)* leases, and provided full, indefinite funding for the program through mandatory appropriations. The 105*(l)* lease program and the VBC Lease Program are vital funding sources for facilities.

Recommendations:

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

Issue:

INCREASE RESOURCES FOR TELEHEALTH & TELE-BEHAVIORAL HEALTH

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

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

Recommendations:

- Increase funding for Tele-Behavioral Health - Tele-behavioral health capabilities (Video Tele-conferencing (VTC)) are essential to Alaska to expand services to rural communities. Many of our Alaskan villages are in remote areas off the road system, which severely compromises access to care. VTC offers promise, but some areas still require infrastructure development. In many villages, digital connectivity is non-existent or rely on a satellite-based Internet system that is slow and unreliable. In Alaska, recruiting and retaining clinicians, psychiatrists and other behavioral health providers

statewide is challenging. Due to the remoteness of villages across the state and difficulty with transportation to these villages, maintaining licensed providers in every rural community is impossible.

- Tele-behavioral health is a significant and crucial component to the spectrum of resources which must be provided remotely to support Alaska's Behavioral Health programs. Alaska Tribes supports the need for the IHS to increase funding for Tribal behavioral health programs to appropriately supply clinics throughout the state with Video Tele-Conferencing equipment and the necessary Internet connectivity in order to sustain and expand service delivery access to village-based services.

Issue:

STREAMLINE DATA REPORTING & MEASURES

Background: Alaska Tribes have long asserted IHS needs to collaborate with sister agencies on reporting requirements. IHS needs to budget for such collaboration in both planning and implementation. Since 2005, Alaska Tribes through the All Alaska Compact have requested that IHS address coordination/interface issues that arise when an IHS funded Tribal clinic is also a HRSA funded community health center.

The data reported internally and to these agencies are used for purposes such as clinical outcomes measurement, population health management, quality and performance improvement, and financial auditing. Many of the clinical measures and reporting requirements are nearly identical except for slight, but crucial, differences in measurement criteria. The differing reporting requirements cause a tremendous administrative burden and cost associated with the duplicative efforts of staff to satisfy the precise reporting requirements of each Agency. Without streamlining, this has a detrimental impact on Tribes and THO budgets as Tribes must continue to divert program funding to comply with the reporting requirements of both agencies, creating an unnecessary administrative burden and incurring unnecessary costs.

Recommendations:

- Streamline Measures: Tribes have requested IHS and HRSA coordinate to streamline these reporting requirements to either:
  1. (1) develop a uniform set of UDS/GPRA measures for IHS/ Health Resources and Services Administration (HRSA) funded programs to report, or;
  2. (2) have HRSA accept the GPRA measures that are reported to IHS. Promote synergy and alignment between reporting initiatives, such as Meaningful Use, MIPS, HEDIS, and UDS.
  3. (3) Alaska Tribes have long encouraged IHS to work collaboratively with sister agencies to create efficiencies and reduce non-congruent, but largely duplicative requirements to help ensure that the greatest number of resources are dedicated to providing health care services to AN/AIs.

INVESTING IN ESSENTIAL PROVIDERS & WORKFORCE EXPANSION

Issue:

INCREASING THE NUMBER OF TRIBAL ENGINEERS

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

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

emergencies (e.g., extreme weather, erosion, permafrost degradation, wildfires, and disease outbreaks).

Recommendations:

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

Issue:

INDIAN HEALTH PROFESSIONS SCHOLARSHIP & LOAN REPAYMENT

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

Indian Health Professions scholarships are critical to meet the recruitment and retention needs faced by Tribal health programs. The shortage of providers is one of the greatest barriers to access to care. One solution that invests in Tribal individuals and health programs is to "Grow Our Own." This also has the added benefit of building capacity, reduces turnover, and helps support culturally appropriate approaches.

Recommendations:

- Add CHA/P as an eligible health profession for the 437-scholarship program.
- Alaska Tribes advocate for the expansion of the Indian Health Professions scholarship program to extend opportunities for individuals interested in pursuing successful community-based alternative careers paths such as Community Health Aide/Practitioners, Behavioral Health Aide/Practitioners, and other alternative provider-extender certified programs. As this country faces shortages in all health professions, these alternative provider-extender models provide an effective way to ensure access to care in remote communities with chronic provider shortages. Scholarships are a way to finance the training and certification so that rural communities can afford to recruit and retain these essential providers.

Issue:

ESSENTIAL CHAP TRAINING & STAFFING SHORTAGE

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

Recommendations:

- Adequately fund CHAP training is an essential step in ensuring that communities have local healthcare providers.
- IHS should plan accordingly and request the true need and ensure that Alaska programs are not adversely impacted if new training programs are established.

Issue:

ADDRESS RURAL HEALTH PROFESSIONAL HOUSING

Background: Recruitment of health professionals is greatly impeded by the lack of housing. In primary care, for example, housing availability was ranked fourth out of ten important issues in primary care physician retention. In many rural Alaska communities, there is no availability

of staff housing. In many villages multigenerational families live together in overcrowded homes because there are limited housing options available for community members and even less for professional staff who are moving to a small community. Building new homes is expensive, resources are scarce and building season is short. Itinerant Staff working in rural clinics often are required to sleep on cots, or on the floor, in sleeping bags or in some areas (if available) are placed in costly lodging options. The lack of adequate housing for health professionals is greatly impeding efforts to recruit and retain staffing in rural health facilities.

Recommendations:

- IHS needs to work with the Administration and Congress on addressing the shortage of staff housing and appropriating much needed funds separate from the IHS Health Care Facilities Construction Priority System.
- Funding to maintain and replace the few existing houses, in communities fortunate to have them, has not been made available for the past 20-plus years. Not all clinics offer permanent housing for providers or even temporary housing for visiting specialists or locum staff.

Issue:

DENTAL SERVICES

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

Recommendation:

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

SUPPORTING THE CONTINUUM OF CARE

Issue:

LONG-TERM CARE/ELDERCARE

Background: Alaska Native elders prefer to be in their own home and communities throughout their lives. In the past, elders stayed at home with their families in multi-generational homes, but that is not always possible as their care needs exceed what their family and other supports can provide and they require nursing or assisted living care. Alaska has the fewest options in the United State for assisted living and long-term care, this is particularly true in rural Alaska.

More Alaska Native elders and those needing higher level of assistance are finding themselves in nursing and assisted living homes in urban areas, far from the land, family and friends where and with whom they were raised. AN/AIs reportedly have more disabilities than other ethnic groups.[49] Higher rates of disability and functional limitations along with the increasing numbers of elders, exacerbate the need for long term care planning within the Alaska Tribal Health System.

Recommendations:

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

Issue:

PURCHASED AND REFERRED CARE

Background: Purchased and Referred Care (PRC) funding levels only meet approximately half of the identified need for PRC services and the denial of care under of PRC, due to a lack of funding, is the most critical issue facing the Tribes concerning the PRC program. Many Alaska Tribal health programs still must rely on PRC funds because their programs do not have the resources or capacity to directly offer the needed or specialized medical care.

Many new facilities are for outpatient care; this has resulted in an increased need for referral to inpatient facilities with emergency rooms and higher acuity care services. While Medicaid Expansion has moved many facilities from being able to provide Priority One level of

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

care to now providing Priority Three or Four levels, again access is still highly restricted based on old PRC policies and a limited capacity to provide certain specialized services. Tribes believe that the ability to address Priority Four level of care promises the greatest return with regards to health status and quality of life improvement.

Recommendations:

- Tribes advocate for flexibility on the use of PRC funds to be based on actual patient need. To ensure safe, quality continuum of care for all AI/ANs
- The PRC manual must be updated to remove some of the existing barriers to eligibility for PRC funded services. Additionally, efforts must be made to ensure the new authorities under the IHCIA for long term care, preventative and other services are incorporated into the updated PRC manual. We fought long and hard for the IHCIA reauthorization and these new authorities must be incorporated into all the long-outdated IHS policy and program manuals and health delivery system reform.

Issue:

ADVANCE APPROPRIATION

Background: Advance appropriations would create stability for Tribal health programs rather than relying on the uncertainty of the federal appropriations process. The advance appropriations for IHS will enable IHS to continue to provide health services without potential interruption, guaranteeing access to the necessary care for patients. AI/ANs suffer disproportionately from a variety of health afflictions including diabetes, heart disease, tuberculosis, and cancer. Compounding these health issues is the lack and untimeliness of resources for the health care delivery services in Tribal communities. IHS continues to be chronically underfunded with a budget that only meets 59 percent of its documented need. With the further likelihood of reductions and delayed federal appropriations, Tribes firmly believe that advanced appropriations for IHS will allow for greater planning, more efficient spending, increased recruitment and retention of healthcare providers, and higher quality care for AI/AN patients on Tribal lands and in urban areas.

Advance appropriations would allow Indian health programs to manage budgets, coordinate care, and improve health quality outcomes for AI/ANs effectively and efficiently. This change in the appropriations schedule will help the federal government meet its trust obligation to Tribal governments and bring parity to federal health care systems. Health care services require consistent and reliable funding to be effective.

Recommendation:

We urge the Administration and Congress to take the necessary steps for IHS funding to begin an advance appropriation cycle so that Tribal health care providers, as well as IHS, will know in advance what their next year's funding will be and allow them thereby to better plan their budgets and administer their programs.

Appendix B

Albuquerque Area Budget Narrative

INDIAN HEALTH SERVICE
FISCAL YEAR 2024 ALBUQUERQUE
AREA BUDGET INSTRUCTIONS
BUDGET RECOMMENDATION NARRATIVE

1. HOSPITAL & CLINICS

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

The Mescalero Service Unit (MSU) considers that, the 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 regarding 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.

To date, the Albuquerque Area's response to the COVID-19 pandemic has understandably been focused almost entirely upon caring for those with acute illness, immunizing as many of the AI/AN community members as possible, and always encouraging COVID safe practices. Several months into the pandemic, the United States Centers for Disease Control and Prevention (CDC) began to report upon a group of symptoms that can linger for weeks and months after a COVID-19 infection. Health experts continue to study this ill-defined constellation of symptoms that some now refer to as "Long COVID," which include at a minimum neurological disorder (brain fog, headaches, and vision changes), cardiovascular disease (hypertension, blood clots, and damage to blood vessels), respiratory disease (persistent cough, hypoxia, and shortness of breath), and mental health disorders (depression, anxiety disorders, and post-traumatic stress disorder).

It is impossible to predict the precise need for Long COVID care over the coming years, but the budget consultation participants unanimously agreed that even in fiscal year (FY) 2024 the nation's health care organizations, IHS included, will probably still be deeply involved with the aftereffects of COVID-19. The bulk of this care will fall upon primary care providers within the agency's facilities, hence the recommendation for three-quarters of increased funding for long COVID care to be dedicated to the H&C line item. The group also recognized that there will be a sustained need for consultation from neurologists, pulmonologists, cardiologists, and various other specialists outside of the agency, so one-quarter of increased funding for long COVID care should go to Purchased/Referred Care (PRC).

For support current services and continued access to quality Health Care and to support Patient Center Medial Home (PCMH).

The Pueblo of Zuni supports and recommends this as a priority so that our service unit will receive the necessary funds to address the shortages of nurses and other health care professionals to meet the health care need of AI/AN people brought on by the COVID-19 pandemic. Increased funding of this priority will provide emergency room services, routine health care in our urgent care and in-patient departments and allow our hospital to continue to provide obstetrical services. Additional personnel are needed to provide testing, vaccination, and contact tracing of COVID-19 patients.

2. PURCHASED/REFERRED CARE (FORMERLY CONTRACT HEALTH SERVICES)

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

At MSU, the facility has been able to move into priority four currently primarily due to Medicaid Expansion in the State of New Mexico, however, to ensure we continue to cover services at a priority four it is recommending this increase. Patient access to services beyond what can be provided as direct care at MSU is critical to ensure that medical conditions ranging from chronic and ongoing care, cancer treatment, in-home care and catastrophic medical conditions are treated. Ongoing specialty care for chronic medical conditions can become very costly. Additionally, only one or two Catastrophic Health Emergency Fund (CHEF) cases or patients with a diagnosis such as cancer requiring very expensive medications, treatments, prolonged hospitalization can quickly utilize much of the budget.

It is crucial that there are funding increases in this line item to ensure Tribal members have access to provision of care outside IHS via referrals, to private sector facilities.

Over the past decade, IHS has received progressive increases in PRC funding, greatly expanding access to non-IHS resources for beneficiaries. With the full implementation of expanded Medicaid in 2014 under the Patient Protection and Affordable Care Act, Tribal communities in states such as New Mexico experienced an even greater access to non-IHS specialty care, with the added benefit of sizeable increases in Medicaid collections within IHS facilities to support services within the agency. Despite these very important advances in funding, certain gaps remain. Our group identified two services not provided by IHS, home health care and durable medical equipment, that are worthy of attention for funding increases. Specifically, these are often not provided by Medicaid, Medicare, or private insurance, or they are only provided under very limited circumstances

and for limited amounts of time. As the beneficiary populations continue to age, the need for home health care and durable medical equipment will continue, and most likely will increase.

The Albuquerque Area group recommends a modest increase in PRC funding to cover the cost. Effective cancer care begins with early diagnosis, and this is particularly true for the more common cancers of the cervix, breast, and colon, all of which have effective screening tests (PAP smears for cervical cancer, mammography for breast cancer, and stool blood assays or colonoscopy for colon cancer). Cancer screening is relatively inexpensive compared to actual cancer treatment, and this is a service that is already well-integrated into the agency's primary care services. Once diagnosed, however, cancer treatment can be very expensive, so to adequately address this high priority condition, funding increases to address cancer should principally be in the PRC line item.

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At the Taos Picuris Health Center, the facility has been able to move into priority four currently 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 to be used to try to maintain current priority level.

The Pueblo of Zuni supports and recommends this priority so that increased funding can be considered to have our service unit provide an effective process to have patients that are in urgent, or emergency need for referrals for a higher level from other health facilities. Increased funding will allow our service unit to cover the cost of air and ambulance transports. A well-funded PRC would also provide extended follow up care and treatment for surgery and injury-related care.

3. ALCOHOL & SUBSTANCE ABUSE

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 2024. 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 reentering the community without access to professional support services to prevent returning to the same crowds and behaviors that led to the past abuse. Additional funding would be directed to support.

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

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

Alcohol use contributes to the increased number of crises calls. Alcohol is a factor in crisis calls involving domestic violence, child abuse, and suicide calls. Alcohol related incidences have increased during the COVID-19 pandemic. Resources have been limited because of the pandemic. Crisis Interventionists have been tasked with searching for alternative resources and handling each case appropriately.

Advocate for more funding towards the substance abuse programs, specifically the manufactured chemicals being seen in the community: meth, heroin, and other pill-types. Programs would assist addicts, their families, or another wing at the JBHD specific for this particular focus.

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 hospital as well as to the private sector and local emergency departments. An increase in funding is necessary to allow opportunities for Tribal members to participate in an inpatient 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 100-200 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.

The Taos Picuris Tribal Health Board recognizes the high prevalence of alcohol and substance abuse, depression, suicide, and violence occurring in our communities. The adjustment to this percentage is less this year. Discussion was they felt they were not maximizing utilization of current funding (i.e., 8 Northern Contract) and needed program reviews.

The Pueblo of Zuni supports and recommends this as a priority to provide effective treatment and care of patients suffering from substance abuse. Currently, our community suffers from alcohol abuse that led to increased death because of alcohol abuse.

Increased funding would allow outreach programs and provide support to the Zuni Recovery Program with counseling services and inpatient treatment programs.

4. MENTAL HEALTH

Mental Health continues to be a significant priority for FY 2024 and is recommending a $500,000 increase. 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 aftercare 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 Resource and Patient Management System (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.

With the COVID-19 pandemic, mental health issues have been exacerbated among AI/AN communities. There has been an increased prevalence of grief, depression, and suicidal ideation and has amplified the need for psychotherapy services within the primary care arena, as well as schools and outlying field clinics. Similarly, local community behavioral health clinics are also experiencing full or extensive waitlists for services and recruiting/retaining behavioral healthcare professionals has been a challenge. Proactive approaches to routine screening within primary care clinics have been successful in early intervention and increased funding would allow for further expansion of much needed services within the spectrum of holistic healthcare.

The Santa Fe Service Units (SFFU) constituent Tribes have long expressed IHS in general and the SFSU have very inadequate funds to address behavioral health and mental health issues such as depression, anxiety disorders, and suicide (particularly among adolescents and young adults). PRC funds are not available to cover routine outpatient behavioral health and mental health services. When these problems go untreated, they often lead to expensive emergency department visits and inpatient psychiatric admissions, placing an increased burden on PRC. In the budget consultation session, most participants agreed the best way to deal with this top priority was to increase our capacity within the agency with increased line item funds in Mental Health.

As with the above, SFFU's Tribes consistently report IHS in general and the SFSU do not have adequate funding to address alcohol and substance abuse treatment and prevention. Inadequate funding for alcohol and substance abuse services has a ripple effect on other funding

sources, such as overloading the agency's outpatient clinics, urgent care departments, and emergency departments with unnecessary visits (typically funded by H&C funds and third-party collections). The increased number of patient visits to private sector emergency departments also puts an increased burden on PRC. In the budget consultation session, participants agreed that the best way to deal with this top priority was to increase our capacity within the agency with increased line item funds in Alcohol and Substance Abuse.

The area is seeing more dual diagnosis of alcohol and substance abuse and mental health. The Pueblo of Zuni supports and recommends this as a priority to enable our Service Unit to recruit and employ psychiatrists, psychologists, and other mental health professional to provide mental health services to patients that are suffering depression and other mental illnesses that is a result of isolation, trauma and grief brought on by COVID-19. Additional personnel will also address the need to treat mental health issues brought on by our communities increasing use of methamphetamine and other forms of substance abuse.

5. DENTAL

Dental services throughout the Albuquerque Service Unit are limited by location and services provided. Many patients within the local urban area do not have dental insurance and often defer oral health, as they do not have the means to travel to outlying facilities and/or the facilities have extensive waitlists or only provide emergency services.

Maintaining oral hygiene is an important part of overall health. Inadequacies can have a significant impact on chronic disease management in adults and can contribute to impaired nutrition and general health in children and adolescents.

At MSU, oral health is often neglected in the care of the AI/AN 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 socioeconomic status (SES) of AI/AN.

Poor dental health is not an isolated condition, it affects other medical conditions. Patients with diabetes and poor dental health have trouble maintaining a proper diet and correct glycemic control.

Additional capacity to increase access, new programs at schools, integration of new technologies, and onsite abilities for surgery through increased funding to increase staffing levels of dentists, hygienists and dental assistants will open 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.

As with mental health and substance abuse services, our constituent Tribes regularly state IHS chronically underfunds dental care in proportion to the marked unmet need in our communities. Most of the dental providers within IHS, and this is certainly true for all the SFSU's dental officers, are trained to do higher levels of care such as crowns, bridges, root canals, and other restorative dental care, but inadequate staffing levels compel most of our dental programs to focus almost exclusively on preventive care and acute dental issues. The budget consultation participants stated that the best way to address our communities' unmet dental needs is to balance an increase capacity within the agency through more funding in the Dental Services line item with increased PRC funding to support higher-level services provided by our non-agency partners.

The Taos Picuris Tribal Health Board acknowledges the Dental program is understaffed. The focus is of the 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.

The Pueblo of Zuni supports and recommends this as a priority so the service unit can provide much needed dental care to patients that require good dental care and hygiene such as diabetics and young children. Increased funds would also enable our dental department to provide more urgent dental care.

6. FACILITIES: SANITATION FACILITIES CONSTRUCTION

The Pueblo of Acoma Budget Formulation Workgroup recommends a program increase of $591,893 within the 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.

In FY 2024, the Pueblo of Acoma Budget Formulation Workgroup recommends an increase of $591,893 for sanitation Facilities Construction. The Sanitation Facilities Construction has been an integral component of IHS disease prevention activities.

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 telemedicine and telehealth 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.

MSU recommends a program increase for HCFC line item. The MSU is obsolete and has long surpassed its useful life. As the existing health care facility ages, associated building equipment and components are also deteriorating to a point of failure and the decreasing availability of replacement parts on this antiquated equipment ultimately disrupts the already limited health care services. Overall, inconsistent funding levels for health care facilities hinders progress on the construction of a much-needed facility. The delay in implementing projects in a timely manner results in higher construction costs, often doubling the cost of a project over a l0-15-year period, which is generally the lifespan of a project

from the time a project is placed on the Priority List until it is fully constructed.

These unreasonable timelines add to the growing health disparities and gaps in access to care. Without modern infrastructure, MSU has not been able to keep pace with available new and emerging health care technologies. MSU is in a remote and undeveloped area adding to the challenges we face, Increased funding for healthcare facility projects will provide greatly improved access to quality health care.

The workgroup felt funding needed to be increased to continue to address water supply, sewage, and solid waste disposal for AI/AN homes and communities.

7. MAINTENANCE & IMPROVEMENT

It is recommended an additional increase for Maintenance and Improvement (M&I) to maintain aging facilities.

8. COMMUNITY HEALTH REPRESENTATIVE

Community Health Representatives (CHRs) 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.

Community health representatives have played a key role as liaisons between healthcare providers/services and patients within the communities they serve. They are frequently the first point-of-contact when patients need assistance and maintain routine communication with clinic staff. They also coordinate/participate with health promotion/disease prevention activities such as vaccine clinics. Increasing funding for the Tribally run programs would allow for additional staffing and services within the communities.

Increase for support staff/transportation – additional driver and operating cost for salary employee and gas for transportation.

CHRs have long been a critical link between IHS clinical services, and the Tribal communities served, performing countless community-based tasks such as illness surveillance, transportation to and from clinical appointments, health education, and coordination of health fairs and community health meetings. During our COVID-19 pandemic response, local CHRs have been invaluable, oftentimes unsung heroes. Not only have they been the primary sources of accurate, up-to-date public health information for Tribal administrations and communities, but they have also provided essential day-to-day services during community lockdowns such as delivery of medications, communicating patient needs to health care providers, and ensuring our Tribal communities' most vulnerable individuals had the basic nutritional and self-care needs met. During our community-based mass testing and mass vaccination events, the CHRs played a pivotal role in maintaining accurate rosters of beneficiaries scheduled for services, communicating regularly with our public health teams to ensure timely, efficient, world class services. Even though this pandemic will eventually end, the need for well-funded, robust CHR teams will remain. The budget consultation group asserts that the CHR line item is well overdue for very substantial funding increases.

It is recommended an additional increase for the CHR program. This is a very important program for Tribal communities and IHS. Very often, the CHR is a first responder for many different types of issues identified in the home. They can provide vital information to tribal programs as well as IHS health care team.

9. HEALTH EDUCATION

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, public health, and communicable diseases, including COVID-19.

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.

Jicarilla Child and Family Education Center will always need expert training for zero- to five-year-old care: car seat training, car seats, CPR/First Aid, safety in the

home: new parent support, elder care, nutrition/diet, field nurse support, lifestyle education: std's, birth control, diversity and race inclusion, compassionate health care during a health pandemic, consistent messaging.

10. EMERGENCY MEDICAL SERVICES

More accessible Emergency Medical Services (EMS) facility for the last budget session. This is a necessary line item as the Program Director and staff have been flexible with facility-share, but for more accessibility, parking, inventory storage, and patient care it would be an asset for the health and well-being of the community members or visitors. Also, updated inventory: transport vehicles, state-of-the art training, and equipment to assist the staff in a rural, mountainous environment.

11. PUBLIC HEALTH NURSING

The Public Health Nursing (PHN) is a vital member of the team in our PCMH model. They are a resource for AI/AN communities and are counted on to assist our efforts to improve the health of the patient populations.

12. EQUIPMENT

It is recommended an additional increase for Equipment to keep medical and IT systems up to date.

13. INDIAN HEALTH PROFESSIONS

It is recommended to support Tribal members obtaining a higher education, recruit utilizing a loan repayment program.

Appendix C

Bemidji Area Budget Narrative

INDIAN HEALTH SERVICE
FISCAL YEAR 2024 BEMIDJI AREA
BUDGET FORMULATION SESSION
BUDGET RECOMMENDATION NARRATIVE

1. MENTAL HEALTH +$1.424B

The Bemidji Area recommends 36, percent or $1.424 billion of funding available be applied to the Mental Health budget line item to address the root causes of Tribal 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 Indian Health Care Improvement Act (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 Tribal community issues.

The 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 Tribal communities.

2. ALCOHOL & SUBSTANCE ABUSE +$1.241B

The Bemidji Area recommends 40 percent, or $1.241 billion, of the funding available be applied to the Alcohol & Substance Abuse (ASA) 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 American Indian/Alaska Native (AI/AN) 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.

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.

3. DENTAL +$1.264B

The Bemidji Area recommends 40 percent, or $1.264 billion, 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.

The additional funding will be key in recruiting qualified dental providers as inflation of salaries makes it challenging to recruit to rural areas as well as offsetting procedural costs associated to dental care not otherwise covered by third party payors due to aggravated oral hygiene crisis assumed by most AI/ANs for the lack of oral care opportunities.

4. HOSPITALS & CLINICS +$4.762B

The Bemidji Area recommends 36 percent or $4.762 billion, 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 to include traditional healing and long-term care.

5. PURCHASED/REFERRED CARE +$2.706B

The Bemidji Area recommends 37 percent, or $$2.706 billion, 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 two thirds 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.

6. PUBLIC HEALTH NURSING +$252M

The Bemidji Area recommends 30 percent or $252 million, 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.

With the impact of the pandemic, it is relevant to note the inflation costs associated to the detrimental need of nursing staff, including but not limited to salaries, recruiting, retention, and travel. Additional funding is needed to address shortage of nursing staff to increase rural services for testing, vaccination, and patient care efforts.

7. URBAN HEALTH +$477M

The Bemidji Area recommends 50 percent, or $477 million, of increased 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.

8. ELECTRONIC HEALTH RECORD UPGRADE +$212M

The Bemidji Area recommends 47 percent, or $212 million, of increased funding available to be applied to the Electronic Health Record (EHR) Upgrade for IHS has been pending for many years with the current system not adequately keeping up with commercial EHR packages. Many Tribes have ventured 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.

9. MAINTENANCE & IMPROVEMENT +$1.933B

The Bemidji Area recommends 70 percent, or $1.933 billion, of the funding available be applied to the Maintenance & 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.

10. COMMUNITY HEALTH REPRESENTATIVE +$149M

The Bemidji Area recommends 10 percent or $149 million, of increased funding available to the Community Health Representative (CHR) budget line item. This funding is instrumental in supporting Tribally administered program of AI/AN community members trained in basic disease control and prevention. These activities include serving as outreach workers with the knowledge and cultural sensitivity to effect change in community acceptance and utilization of health care resources and use community-based networks to enhance health promotion/disease prevention.

The CHRs are one 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.

11. HOSPITALS & CLINICS FACILITIES CONSTRUCTION +$451M

The Bemidji Area recommends 10 percent or $451 million, of the funding available be applied to the Hospitals and Clinics (H&C) Facilities Construction budget line item.

Bemidji Area, full funding priorities include the following:

1. Mental Health (MH) +1.429B
2. Alcohol & Substance Abuse +1.241B
3. Dental Service +1.264B
4. Hospital & Clinics (H&C) +5.027B
5. Purchased/Referred Care (PRC) +2.706B
6. Public Health Nursing +252M
7. Urban Health +477M
8. Electronic Health Record System (E +212M
9. Maintenance & Improvement +1.933B
10. Community Health Reps (CHR) +149M
11. Health Care Facilities Construction +452M

Appendix D

Billings Area Budget Narrative

INDIAN HEALTH SERVICE
FISCAL YEAR 2024 BILLINGS AREA
BUDGET INSTRUCTIONS
BUDGET RECOMMENDATION NARRATIVE

1. ALCOHOL & SUBSTANCE ABUSE PROGRAMS

INTRODUCTION

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

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

DATA

Data used in this report comes from the Montana death certificates collected by the Montana Office of Vital Records and were limited to American Indian Montana residents. American Indian residents were identified as those who were classified as American Indian or Alaskan Native according to the race bridging procedure of the National Center for Health Statistics (NCHS).[4]

Deaths were tabulated by underlying cause using the International Classification of Diseases Tenth Revision (ICD-10).[5] Leading causes of death are classified according to the NCHS Instruction Manual Part Nine which includes the addition of COVID-19 (U07.1).[6]

In addition to the leading causes of death, alcohol-induced deaths, and deaths due to drug poisoning were assessed in this report. Alcohol-induced deaths included deaths with one of following ICD-10 codes as the underlying cause: E24.4, Alcohol-induced pseudo-Cushing syndrome; F10, Mental and behavioral disorders due to alcohol use; G31.2, Degeneration of nervous system due to alcohol; G62.1, Alcoholic polyneuropathy; G72.1, Alcoholic myopathy; I42.6, Alcoholic cardiomyopathy; K29.2, Alcoholic gastritis; K70, Alcoholic liver disease; K85.2, Alcohol-induced acute pancreatitis; K86.0, Alcohol- induced chronic pancreatitis; R78.0, Finding of alcohol in blood; X45, Accidental poisoning by and exposure to alcohol; X65, Intentional self-poisoning by and exposure to alcohol; and Y15, Poisoning by and exposure to alcohol, undetermined intent. Drug poisoning deaths included deaths with one of the following ICD-10 codes as the underlying cause: X40-X44, unintentional poisoning; X60-X64, suicide; X85, homicide.

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

The use of alcohol and/or drugs increased during the pandemic. All our communities experienced so many deaths related to COVID-19 as well as other causes. Due to not having contact with loved ones in the hospital who passed away left some in shock, disbelief, or guilt, with limited or no funeral attendance and lack of or restrictions of family support due to social distancing and isolation to name a few outcomes that interrupted the grief process. Licensed addictions counselors train to get to the root/cause of clients use and often, an individual's use can be a result of unresolved and/or unidentified grief. The

aftermath of the pandemic will undoubtedly inundate our Alcohol & Substance (ASA) Programs.

This pandemic affected the entire world, however, our total population only accounts for a small percentage of the total human population and this monumental event was devastating and traumatic. As a people, AI/AN have higher incidences of traumatic experiences historically, generationally, and individually. The ASA programs all identify as trauma-informed facilities. The approach of trauma informed care in health care delivery has become the standard for all the ASA programs. The ASA programs will commit to continue to develop and implement trauma-informed care models and programs to meet the needs of the AI/AN people with compassion, kindness, and care.

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

BUDGET PRIORITIES

1. FACILITIES

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

Regarding facility construction, another challenge many ASA Programs face is being unable to meet health care facility standards. The lack in facility infrastructure makes it a challenge to achieve or possibly maintain accreditation to meet building codes and standards that can include energy conservation, environmental issues, handicapped accessibility, security, and patient confidentiality. The ASA programs support IHS to strengthen organizational capacity to improve our ability to meet and maintain accreditation as Health Care Facilities, work to align service delivery processes to improve the patient experience, ensure patient safety and establish program-wide immediate delivery of services in the area of ASA. With the pandemic and the varying strains of COVID-19, social distancing has become an added challenge but again the need for facility construction is undeniably a priority. These Health Care Facilities help to deliver and support prevention, education, treatment, and recovery services related to alcohol and substance abuse. Ideally, every program would like new facilities, but it may be unfeasible so maintaining, repairing, and improving existing facilities is of utmost importance. Every ASA Health Care Facility requires renovation and expansion to meet the tribal communities' needs at the local level. It is the overall desire of the ASA Health Care Facilities to modernize their health care facilities and staff quarters to expand access to quality health care services.

2. CULTURAL CONSIDERATIONS

The second highest priority as expressed from the ASA Programs is cultural considerations. Strengthening culturally competent organizational efforts is needed. The cultural development strategies, approaches and implementation are pillar for all the ASA Programs. Within an

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

3. TELEHEALTH SERVICES & EQUIPMENT

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

4. TRANSPORTATION

Many of the ASA Programs are centrally located in the main town of each reservation, however not all tribal members reside in the main town and many reservations do not have public transportation. Many people walk to their appointments as some do not have access to personal transportation, reliable vehicles, or family to support them in this way. Each reservation can easily have more than five outlying districts and the desire is to have a facility at each district would be the preferred reality. The need for development and program expansion in locations where AI/AN people have no access to quality health care services is a constant consideration. However, the ASA Programs can address immediate needs by providing and improving transportation services provided by the ASA Programs. Program vehicles would be necessary to effectively meet this need. The program vehicles would most likely include multiple passenger vehicles that can be ready for any weather condition picking up multiple clients who seek alcohol and substance abuse services.

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

5. PEER RECOVERY SUPPORT

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

Peer providers offer valuable guidance by sharing their own experiences recovering from SUDs by helping to build skills, assisting, and addressing specific needs that someone with an SUD is faced with as they are in early recovery; by improving social connectedness; and by

helping to identify new positive social environments. Peer providers have a unique perspective and an ability to empathize with those in treatment for SUDs.

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

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

6. DETOXIFICATION SERVICES

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

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

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

Throughout this region, there is a lack of available inpatient beds for all our clients when clients are ready to seek treatment. However, increased funding will provide more individuals to attend a higher level of care that includes primary residential inpatient treatment that will better address the toxicity many of our population are presenting with. A geographical move to an outside facility can be beneficial to get the client out of their using environment. One of the ASA Programs stated they only had enough funding for seven people to attend inpatient treatment in one year's time and yet there are more than seven people on this particular reservation that need this level of care. This funding shortage for treatment is attributed to all our reservations.

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

8. INDIVIDUAL PROGRAM INFRASTRUCTURE

Foundational clinical practices and approaches in program development is another priority. This includes purchasing testing and screening tools with consideration of special populations like pregnant using mothers and purchasing chemical dependency assessment packets for diagnosis and appropriate patient placement. Outpatient programming development will provide evidence-based specialty and preventive care that will help to reduce the rate of death for the AI/AN population related to alcohol and drug abuse. Program infrastructure most often includes development specific to Intensive Outpatient programming (Level 2.1), Aftercare programming (Level 1), Peer Support services & implementation (more feasible still effective), education classes that can support advance basic science knowledge and conduct applied prevention and treatment research to improve overall health and development. Program design and development for both adults and youth such as staff getting trained to provide "Prime For Life" classes. These classes

address driving under the influence (DUI) or minor in possession (MIP) assessment, course, and treatment. Prevention activities within the ASA facilities as well as outreach or program collaboration, participating in multidisciplinary teams that can include social services, probation and parole, other helping agencies, family members, and court systems. The need to incorporate family programming is essential for a strength-based approach. It is said that we are no longer treating the individual but the family. If the family receives the same message of support, it follows that a client's home environment has a greater chance to be successful in sobriety and recovery. Implementing a family support system develops strong families and healthy marriages, and will prepare children and youth for healthy, productive lives. Program infrastructure is a consistent area the ASA Programs operate and are continuously maintaining, developing, and implementing.

9. COUNSELOR RECRUITMENT & RETENTION/TRAINING/CONTINUING EDUCATION & STAFF WELLNESS

The capability to "grow your own" has been one area the ASA Programs are investing in that is to develop training programs in partnership with local schools, colleges, hospitals and expand opportunities to educate and mentor AI/AN youth interested in obtaining health science degrees. The ASA Programs have been working in partnership with the state and local colleges to assist in providing education classes related to addiction degrees as well as providing assistance with recruitment efforts. The ASA Programs are open to providing internship opportunities for students towards the completion of hours for licensure. This type of support results in employing American Indian licensed addictions counselors; as well as proving that the ASA Programs meet competitive pay related to this profession and will be a desirable place of employment. For retention efforts, training is necessary maintaining current continuing education courses (both in-person and online). Retention is another area the ASA Programs continuously consider due to the demand for alcohol and substance abuse counselors and the need for adequate staffing to provide services.

The Bureau of Labor Statistics projects 22.9 percent employment growth for substance abuse and behavioral disorder counselors between 2020 and 2030. In that period, an estimated 75,100 jobs should open. It is necessary for ASA Programs to support staff that provide valuable services for this specialized area of heath care. ASA Programs can support staff by providing retreats for staff and schedules that incorporate leisure time to prevent burnout and fatigue. This priority aligns with current efforts to recruit, develop, and retain a dedicated, competent, and caring workforce. Consistent, skilled, and well-trained leadership is essential to recruiting and retaining well-qualified health care and administrative professionals.

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

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

CONCLUSION

Drug and alcohol use is preventable and treatable. Our ASA treatment and prevention programs are effective. Our ASA Programs will continue to work towards providing treatment and recovery services and work to eliminate drugs and alcohol from the individual lives of young people, adults, couples, families, communities, and reservations. However, increased funding is needed to continue to provide accessible, effective, and culturally relevant prevention, outreach, education, treatment, and recovery services related to alcohol and substance abuse. Our American Indian Health leaders identified Alcohol and Substance Abuse as the number one health priority in the Billings Area. The reality is every single individual within the AI/AN population has been affected either personally or by someone they love, care for, or know by alcohol and substance abuse. However, successes do happen, and the services provided by our SUD recovery programs change lives for the better.

In the Billings Area, ASA Programs strive to meet the three GPRA ASAP screening measures Tobacco, Alcohol Screening, and Brief Intervention and Referral to Treatment (SBIRT) for FY 2022. ASAP is authorized by the Indian Health Care Improvement Act, 25 U.S.C. § 1621h. ASAP supports the IHS Strategic Plan FY 2019-2023, Goal 1 Objective 1.3: Increase access to quality health care services and Goal 2 Objective 2.2: Provide care to better meet the health care needs of AI/AN communities.

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1. MENTAL HEALTH

Mental Health is a top priority for the Billings Area for the FY 2024 Budget Formulation. The Billings Area Office (BAO) Indian Health Service (IHS) and Tribal Behavioral Health Departments are striving to increase behavioral health services. The BAO has devoted personnel and resources to assist behavioral health delivery in all the service units.

COMMUNITY HEALTH AIDE PROGRAM

The Community Health Aide Program (CHAP), with Medicaid authorization passed through the Montana Legislature in 2019, has great potential for increasing behavioral health clinical and community-based services. IHS and Tribes in Montana and Wyoming are working to implement this program as soon as possible.

AVEL TELE-BEHAVIORAL HEALTH SERVICES EXPANSION

Behavioral Health Services have been bolstered with the increasing provision of tele-behavioral health through Avel. IHS has contracted with Avel to provide services at all IHS Service Units.

These services are expensive, but necessary in the context of our difficulty in filling behavioral health provider positions in the service units. Avel has been instrumental in providing both emergency behavioral health assessments and ongoing psychotherapy.

RECRUITMENT AND RETENTION OF BEHAVIORAL HEALTH STAFF

BAO has had a high degree of difficulty in recruiting and retaining Behavioral Health clinicians. IHS is working to increase compensation to behavioral health providers. Furthermore, the entire State of Montana is designated as a High Professional Shortage Area (HPSAs) for Mental Health Care (Montana Department of Public Health and Human Services, Primary Care Office, 2018, p. 13). Tribal leaders for the Billings Area have expressed concern about the lack of mental health services and a need for more mental health clinicians and professionals. It is imperative that behavioral health and primary care services are coordinated between both IHS and Tribes to overcome challenges with recruitment and retention of mental health clinicians and other providers such as social workers. Increased mental health funding will assist with the ability to hire and retain quality professionals and provide improved mental health services to our patients. An increase in mental health funding will also provide for increased staffing of qualified mental health workforce.

REDUCING SUICIDES

AI/AN populations have disproportionately high rates of suicide, unintentional injuries, and drug overdose deaths. IHS Strategic Plan aims to strengthen the overall health status of the AI/AN population. The tragedy of suicide continued with suicide clusters on several reservations over the past few years. Suicide rates are high in Montana, higher for AI/ANs but also much higher

overall than the national average. From 2009 to 2018 AI/ANs in Montana committed suicide at a rate of 31.39 per 100 thousand, while Caucasians did so at a rate of 23.37 per 100 thousand**.** (Carl Rosston, MT DPHHS Suicide Prevention Specialist). From the Centers for Disease Control (CDC), in 2018 the national rate of suicide in the United States was 14.21 per 100 thousand, while the overall rate in Montana was 24.86 per 100 thousand. (CDC, cdc.gov/injury/wisqars/fatal.html on 3/1/2020).

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

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

IHS has increased our efforts to train our own staff and to provide outreach services to reduce the incidence of suicide. Numerous staff have been trained in Question, Persuade, Refer (QPR) during the past year, along with Mental Health First Aide, Community Resiliency Model and Zero Suicide. We have sent our staff to meetings with tribal and state agencies to coordinate these efforts. We are conducting trainings on the reservations and with urban programs.

MENTAL HEALTH AND SUBSTANCE USE DISORDERS

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

DEPRESSION: GOVERNMENT PERFORMANCE AND RESULTS ACT (GPRA)

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

MENTAL HEALTH FUNDING IS REQUESTED FOR THE FOLLOWING BUDGET PRIORITIES:

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

IHS STRATEGIC PLAN

The IHS Strategic Plan FY 2019-2023 advocates an increase in our ability to provide Behavioral Health Services.

Goal 1 Objective 1.3: Increase access to quality health care services

Goal 2 Objective 2.2: Provide care to better meet the health care needs of AI/AN communities.

Goal 2 Objective 2.3: Reduce the impact of mental and substance use disorders through prevention, early intervention, treatment, and recovery support.

2. PURCHASED/REFERRED CARE

The Purchased/Referred Care (PRC) Program is integral to providing comprehensive health care services to eligible AI/AN. PRC will always remain a top health care priority because of the constant and underfunded need for: standard, specialized, and emergency care/ procedures not provided by our local clinics or if a clinic is unavailable. The need for preventative medical service and program operation must maintain priority to better manage patient health care for our AI/AN population. Proper funding for the PRC Program is essential to assure our patients receive health care services not available at our IHS Unit and/or if a clinic is unavailable for prevention of minor or chronic illnesses from progressing into major complications. Research has shown that prevention helps to reduce overall costs for medical care for both the facilities and the patient. A budget increase in PRC is essential to allow for AI/AN patients to be treated in a timely manner for their current medical conditions and improving their overall health with a lower cost to the healthcare system.

The PRC Program also administers the Catastrophic Health Emergency Fund (CHEF). CHEF is established to support and supplement PRC Programs that experience extraordinary medical costs associated with treatment of victims of disasters or catastrophic illnesses. The CHEF is used to reimburse PRC Programs for high-cost cases (e.g., burn victims, motor vehicle crashes, high-risk obstetrics, cardiology, etc.)

PRC is linked to several authorized programs in the Indian Health Care Improvement Act, 25 U.S.C. § 1621r, 1621s, 1621u, 1621y, 1642, and 1646. The PRC supports the IHS Strategic Plan FY 2019-2023, Goal 1 Objective 1.3: Increase access to quality health care services and Goal 2 Objective 2.2: Provide care to better meet the health care needs of AI/AN communities.

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. 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 IHS or other Federal funding, including programs such as suicide prevention and oral health intervention.

Specialty services that were provided by our service units such as nephrology, pediatrics, obstetrics and gynecology and urology are no longer available at current funding levels. As a result, patients are forced to drive hundreds of miles 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 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. IHS is modernizing its credentialing and privileging processes to facilitate the hiring of qualified practitioners. The credentialing process evaluates the qualifications and practice history of a provider such as training, residency, and licensing.

Tribes in the Billings Area request additional funds to support and expand the Community Health Aide Program (CHAP) to improve local health outcomes related to health care access and delivery. The Montana Medicaid Program Section 53-6-101 was amended to reflect the Federal statues related to CHAP. CHAP provides a network of health aides trained to support other health professionals while providing direct health care,

health promotion, and disease prevention services. The additional funds request will assist in the development of a training network with Tribal colleges and universities, CHAP certification Boards, increased partnership, and collaboration with State and Federal partners, and for CHAP expansion in the Tribal communities of Montana and Wyoming.

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

4. DENTAL HEALTH

Dental is a top ten priority for the Billings Area because of access to Dental Care. We continue to recognize the various health care disparities associated with poor dental health. Dental and Oral Health is underfunded each year as community user populations increase and need dental services.

Increasing funding could significantly improve patient's access to care, reduce the need for emergency services and increase preventative care. Multiple factors have been affecting patient access to care in the Billings Area, even prior to the current pandemic. Shortages of staff being the core problem.

Additionally, the pandemic revealed inadequacies in the ventilation systems in several dental clinics, and the need to improve them to increase patient and employee's safety. The recent additions to PRC have been very beneficial to patient care and has helped to increase access to care, but it alone is not enough.

Many, if not all the service units are having difficulty recruiting and retaining qualified support staff. The support staff positions pay is often below entry level jobs in their communities. This is becoming a large factor decreasing patient's access to services as most clinics have unfilled assistant positions.

Ideally clinics would have two assistants per provider, most clinics currently have one assistant per provider or less. Pay scale changes need to be looked at, as well as other financial incentives to try and get quality applicants for the current vacancies. These incentives also need to be explored so we can retain the current staff that we have.

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

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

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

Prior to the pandemic, the Billings Area met all the 2020 GPRA measures for Dental: General Access, Sealants, and Topical Fluoride at 32.41 percent. 24 percent, and 44.35 percent. In one recent IHS study, some significant improvements were made in AI/AN adolescent's oral health. One study showed a decrease in untreated decay in 13–15-year-olds from 64 percent to 45 percent from 1999-2019. However, there is still a large disparity between AI/AN adolescent's vs the general population (45 percent vs 14.1 percent). These are trends we would like to see continue and increasing funding for staffing, facilities and PRC in the Billings Area will help make this possible.

Dental Health is linked to the Indian Health Care Improvement Act, U.S. Code, Title 25, Chapter 18. The Dental Health supports the IHS Strategic Plan FY 2019-2023, Goal 1 Objective 1.3: Increase access to quality health care services and Goal 2 Objective 2.2: Provide

care to better meet the health care needs of AI/AN communities.

5. PUBLIC HEALTH NURSING

The Public Health Nursing (PHN) Program is a community health, nursing-based program that supports prevention-driven nursing care interventions for individuals, families, and community groups. Area-wide PHN Programs also focus on improving health status by early detection through screening and disease case management. The PHN provides quality, culturally sensitive health promotion and disease prevention nursing care services to AI/AN communities. PHNs improve care transitions by providing patients with tools and support that promote knowledge and self- management of their condition as they transition from hospital to home to decrease hospital readmissions. The PHN provides communicable disease assessment, outreach, investigation, and surveillance to manage and prevent the spread of communicable diseases. PHNs contribute to several of IHS prevention efforts by providing communicable immunization clinics, public health education and engaging their AI/AN communities in promotion of healthy lifestyles. The program supports the IHS's Strategic Plan by remaining innovative in outreach processes, with the goal of bridging care gaps by increasing access and quality care to patients, based on the specific needs of each community. PHNs conduct home visiting services for: Maternal and pediatric populations, elder care services to include safety and health maintenance care, chronic disease care management, and communicable disease investigation and treatment. The PHN Program supports IHS's goal to decrease childhood obesity and prevent diabetes by supporting Baby Friendly designation and accomplishing the following activities: providing patient education, assessment, and referral services for prenatal, postpartum, and newborn clients during home visits. PHN Programs are key players in the COVID-19 response efforts for their designated communities. Through diligent education distribution practices, collaboration with tribal partners, and continuous management of a strict contact tracing process, the PHN unceasingly strives to reduce and mitigate COVID-19 transmission throughout AI/AN populations.

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

screening and education; Immunization promotion activities across all ages.

PHNs are linked to several authorized programs on the Indian Health Care Improvement Act, 25 U.S.C. § 1621b, 1621c, 1621h, 1621n and 1665i. The PHN supports the IHS Strategic Plan FY 2019-2023, Goal 1 Objective 1.3: Increase access to quality health care services and Goal 2 Objective 2.2: Provide care to better meet the health care needs of AI/AN communities.

6. COMMUNITY HEALTH REPRESENTATIVES

Community Health Representatives (CHR) is a vital program in the Billings Area. Nearly all the CHR programs are Tribally operated. CHRs are frontline public health workers who are trusted members of the community and serve as a link between the Indian health system, including associated health programs, and AI/AN patients and communities. The aim of the CHR program is to help AI/AN patients and communities achieve an optimal state of well- being by providing health promotion and disease prevention, wellness and injury prevention and education, language translation and interpretation, transportation to medical appointments and delivery of medical supplies and equipment within the tribal community. Without the CHR program, many patients within the Billings Area would not have access to health care. The CHR provides access to health care on the reservation for the elderly, handicapped and disadvantaged populations. The CHR program needs sustained and increased funding to provide quality health services. CHR's services for mental health, opioids, and chronic illnesses have continued to increase.

The lack of transportation is a barrier for the AI/AN to access quality health care services. Tribal nations in the Billings Area are in rural areas and long distances are travelled to access health care services. It is not unusual

that CHR's and patients they serve travel up to 6 hours or more to receive professional emergency care.

In 2020, COVID-19 was the leading cause of death among American Indian residents of Montana. (Montana Department of Public Health and Human Services (DPPHS), 2021). During the COVID-19 pandemic, the CHR's were at the front-line providing health care services including assisting with testing and vaccination activities as well as contact tracing. CHR's also assisted patients who were isolated or quarantined by providing food, medical equipment and supplies and essential items.

CHR's have not received a budgetary increase to support increased demands for services and to maintain training and education to provide community health services. The CHR's have also experienced COVID- 19 fatigue, it is known that health care work can be physically and psychologically draining. More resources are needed for CHR's to provide health care services and COVID-19 cases continue to rise in Montana.

CHR is authorized by the Indian Health Care Improvement Act, 25 U.S.C. § 1616. CHR supports the IHS Strategic Plan FY 2019-2023, Goal 2 Objective 2.2: Provide care to better meet the health care needs of American Indian and Alaska Native communities.

REFERENCES

Montana Department of Public Health and Human Services (DPPHS). (2021, December 21). *Leading Causes of Death among American Indian Residents of Montana, 2020 and 2015-2019.* Retrieved 12 21, 2021, from https://dphhs.mt.gov/assets/publichealth/CDEpi/DiseasesAtoZ/2019- nCoV/Reports/AI_AN_Leading_Causes_2020.pdf

7. HEALTH EDUCATION

The need for ongoing community health education is integral to the wellbeing of American Indians in the Billings Area, and it is particularly crucial during a COVID-19 pandemic. In a Montana Department of Public Health and Human Services (MT DPHHS) publication, it was stated, "There is substantial evidence that COVID-19 had a disproportionate impact on indigenous communities, and Montana has a relatively large American Indian population with seven reservations" (MT DPHHS, 2021, p.1). According to this source, COVID-19 was the number one underlying cause of death among American Indians in Montana in 2020 (MT DPHHS 2021, p.2). Health Education (HE) and health literacy are powerful means of bringing awareness and knowledge to the population we serve. Readable, culturally adapted health information allows those we serve to prevent and protect themselves and their families from COVID-19. The Billings Area Office's (BAO) Health Education (HE) has collaborated with the Indian Health Service Headquarters (HQs) Health Promotion/Disease Prevention (HPDP) and Health Education (HE) to bring training in health literacy while also assisting HQs HE with a review of documents for level of readability and cultural customizing. Once fitted for the population we serve, the adapted health information is disseminated widely across the BAO service area.

COVID-19 has changed how health education is delivered. Virtual platforms such as Zoom and Skype became the norm for delivering health education and telehealth/telemedicine. Since in-person programming and training were deemed unsafe due to the spread of the virus, it was safer to utilize virtual dissemination of this information. COVID-19 brought the virtual world into practice. For example, in
terms of physical activity, the BAO HE has assisted with the annual "Healthy Tribes Walk/Run" since its inception four years ago. Once the pandemic hit, this event became the "Healthy Tribes Virtual
Challenge." Although the in-person events were successful and significant health and recovery education was delivered, the outreach of the virtual challenge goes beyond our BAO service area in that it is available for everyone regardless of their location.

In a fact sheet from the MT DPHHS, it was stated, "In Montana, between 2013-2017, the highest rate of suicide is among American Indians (31.3 per 100,000) although they only constitute 6 percent of the state's population" (MT DPHHS 2020 p.3). Several BAO suicide prevention programs such as Question, Persuade and Refer (QPR) and Mental Health First Aid (MHFA) have become virtual programs. The BAO Behavioral Health and Health Education through a partnership with the IHS Office of Suicide Prevention and Sister Sky (contractor), has delivered over 1000 QPR suicide prevention trainings to the BAO service units in 2020 through an online learning module system. This basic QPR training was culturally adapted for AI/AN populations and brought directly to the BAO Indian Health Service employees/staff through their own unique email link.

When addressing *Community* Health Education in the Tribal and Urban areas, it is important to understand the potential in these communities. The BAO HE

implements both strengths-based and trauma-informed care to their health education and highlights successes. The BAO HE collaborated with the IHS HQ's HE and the University of New Mexico's ECHO (Extension for Community Healthcare Outcomes) program to be part of the ECHO hub team and facilitate the Indian Health Service's Community Health ECHO series. This venue delivered health education to Community Health Representatives (CHR) throughout all 12 IHS regions. This collaboration will continue into 2022.

Cancer was the fourth leading cause of death in 2020 for American Indians in Montana (MT DPHHS 2021, p 2). There is significant health education involved in the prevention of cancer. Health literacy trainings, along with the development of virtual dissemination of health education, is necessary. In partnership with the BAO HE and the IHS HQ's HPDP, several of the HE programs have been virtualized and implemented, such as the cancer prevention trainings, "The Sacred Circle of Tobacco," and the "Circle of Life" cancer prevention program.

Along with cancer prevention, and PREVENTION overall, important measures of HE impact are the GRPA ratings of which the BAO HE utilizes as baselines for improvement. The BAO HE was invited to join with the HQ's HPDP to participate in a Colorectal Cancer Screening pilot project in 2020. One BAO Urban facility and one BAO Service Unit were part of the project. GRPA ratings for colorectal cancer screening were the baseline measure for the project. The BAO consistently uses GPRA ratings as markers because it is a congruent measure of our health care delivery impact. GPRA ratings are also crucial in evaluation.

Partnerships are important when planning and implementing the best outreach for health education dissemination. Sharing resources and expertise has been a crucial survival strategy for Indian Country and the BAO HE utilizes the same strategy. The BAO HE collaborated with several entities to further their health education reach. Along with collaborating with IHS HQ's HPDP and HE, other partners included the Native National Network, UNM ECHO program, Montana DPHHS, and the BAO Service Units, Urban centers, and Tribal Health. Through these collaborations, HE information for the prevention of diabetes, commercial tobacco, obesity, suicide, and cancer prevention were amplified and had a greater reach into the communities we serve. The hope is to see greater positive impact for the communities we serve as more partnerships, virtual platforms and health education programs are developed.

Continued and increased funding for our BAO HE programs is essential to delivering the most impacting health care to our area. With the ongoing COVID-19 pandemic, health education is crucial to bringing awareness, protection, and prevention information to the People we serve.

Health Education is linked to several authorized programs on the Indian Health Care Improvement Act, 25 U.S.C. § 1621b, 1621c,1621h, 1621n, and 1665i. Health Education supports the I.H.S. Strategic Plan F.Y. 2019-2023.

Goal 1 Objective 1.2: Build, strengthen, and sustain collaborative relationships,
Goal 1 Objective 1.3 Increase access to quality health care services, and
Goal 2 Objective 2.2: Provide care to meet better the health care needs of AI/AN communities.

8. INDIAN HEALTH CARE IMPROVEMENT FUND

The Indian Health Care Improvement Fund (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 organizations of IHS, Tribal and Urban (I/T/U) into optimally performing organizations. IHCIF creates quality improvement capability at all levels within the organization and helps to 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 Tribes or Tribal Organizations includes health resources provided by IHS as well as other health resources utilized by the Indian Tribe or Tribal Organization, such as services and financing systems provided by other Federal programs, private insurance, and 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.

9. URBAN INDIAN HEALTH

COVID-19 has amplified health inequities in American Indian communities because of underfunded and under-resourced health systems, limited access to health services, poor infrastructure, and underlying health disparities. For example, AI/AN individuals were 3.5 times more likely to be hospitalized for the virus. Chronic underfunding increased AI/ANs vulnerability to the COVID-19 pandemic and resulted in our communities having the highest per capita COVID-19 infection, hospitalization, and death rates. The five urban health centers in the Billings Area receive approximately $4,854,366 dollars a year combined. The United States Census Bureau reports that in 2020, there were 31,201 AI/ANs living in the catchment areas of the five urban centers, a population increase of 6,074 (22 percent) from the 2017 census report. The urban AI/AN population represents 31 percent of the total population of AI/ANs in the Billings Area. Funding levels throughout IHS for the urban centers is not adequate for the needs the urban population represents. Our urban centers see a user population similar in size to what direct service or tribal health facilities might see in the same year while operating on a $970,000 yearly average budget. The Billings Area I/T/U group is advocating and in support of a 5 percent increase for FY 2024, which is a $105,000,000 increase to the current FY 2022 recommendation.

Appendix E

California Area Budget Narrative

INDIAN HEALTH SERVICE
FISCAL YEAR 2024 CALIFORNIA
AREA BUDGET INSTRUCTIONS
BUDGET RECOMMENDATION NARRATIVE

The California Area is submitting a Budget Recommendation at the full funding fiscal year (FY) 2023 recommendation. The California Area Office and California Area Tribal leaders support funding the California Area's Top 10 Budget Funding Priorities: Behavioral Health, Purchased/ Referred Care, Methamphetamines/Suicide/ Domestic Violence Obesity/Diabetes, Indian Health Care Improvement Fund, Community Health Representative, Dental, Pharmacy, Health Information Technology, Maintenance, and Improvement.

BUDGET INCREASES

1. BEHAVIORAL HEALTH

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 2020 Government Performance and Results Act (GPRA) data. Over 7,000 youth and just over 39,000 adult American Indian/Alaska Native (AI/AN) patients were not screened for depression at Indian health programs in the California Area. Additionally, approximately 20,000 women were not screened for domestic violence and over 50,000 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.

2. PURCHASED/REFERRED CARE

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 (IHS) 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 can cover inpatient services. This is reflected in the low number of California Area CHEF Cases. The CAO continues to encourage and assist programs to report PRC deferrals and denials. The need in California is greater than the data suggests. In 2020, only 26 of the 45 health programs reported deferred and denied data.

3. METHAMPHETAMINES/SUICIDE/ DOMESTIC VIOLENCE

Rates of methamphetamine addiction and related crimes, suicide and acts of domestic violence are disproportionately higher among AI/ANs.

According to the Centers for Disease Control and Prevention (CDC), suicide is second leading cause of death among AI/AN youth between the ages of 10 and 34 and eighth leading cause of death among AI/AN of all ages. An estimated 45 percent of AI/AN women and one in seven men experience intimate partner violence yet, according to our 2020 GPRA data, over 20,000 women at California tribal health programs were not screened for domestic violence. In 2020, seven California health programs received Indian Health Service (IHS) Domestic Violence Prevention Initiative funding and 14 received IHS Substance Abuse and Suicide Prevention funding which highlights the need for these programs in California. Increasing funding in these areas will allow Tribal programs to connect more individuals to help through higher rates of screening, outreach and referral processes strengthening and additional trained staffing.

4. OBESITY/DIABETES

The leading cause of death for AI/ANs is heart disease caused by obesity, diabetes, depression, and poverty. The national rate of diabetes for AI/ANs is 15.2 percent. 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 patient's battling diabetes and obesity. Behavioral health issues are also addressed which contribute to the obesity and diabetes rates of AI/ANs.

5. INDIAN HEALTH CARE IMPROVEMENT FUND

Congress established an Indian Health Care Improvement Fund (IHCIF) as one means for addressing resource disparities across the Indian health system. The fund is designed to consider many factors that result in resource gaps among the Indian IHS and Tribal sites or operating unit.

6. COMMUNITY HEALTH REPRESENTATIVE

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 five 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 together 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. DENTAL

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.

8. PHARMACY

The net prices for drugs are increasing four-times faster than the rate of inflation (approximately 133 percent 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 340B and Veterans Affairs Pharmaceutical Prime Vendor Program (VA PPVP) as a means of affording medications. There are twelve (12) Tribal pharmacies in the California Area that utilize 340B and three (3) Tribal pharmacies that utilize the VA PPVP and 340B. Tribal pharmacies can generate revenue for their respective clinics utilizing 340B, however with Governor Newsome's Executive Order (EO N-01-19), their ability to generate revenue utilizing 340B will be non-existent. Though Tribal and Urban healthcare programs can still access VA PPVP, the VA contract does not allow for resale of medications which would prevent Tribal pharmacies from generating revenue through these means. Despite the ability to purchase medications at discounted costs, Tribal and Urban healthcare centers may still face difficult decisions on how to cover remaining drug costs as their revenue margins decrease substantially.

9. HEALTH INFORMATION TECHNOLOGY

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. MAINTENANCE & IMPROVEMENT

Maintenance & 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.

Appendix F

Great Plains Area Budget Narrative

INDIAN HEALTH SERVICE
FISCAL YEAR 2024 GREAT PLAINS
AREA BUDGET INSTRUCTIONS
BUDGET RECOMMENDATION NARRATIVE

EXECUTIVE SUMMARY

Tribal leaders representing the Tribes/Tribal organizations, and Urban Clinics of the Great Plains Area met virtually on December 1, 2021, to develop the Indian Health Service (IHS) Great Plains Area fiscal year (FY) 2024 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 Indian/Alaska Natives (AI/ANs) in the Great Plains Area suffer from among the worst health disparities in the nation. Death rates from preventable causes, including type two diabetes, alcoholism, unintentional injuries, suicide, etc., are several-fold greater than the rest of the national IHS population and the general United States 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 AI/AN population in the Great Plains Area. Direct services funding has not seen an increase in over two funding years. As medical and health care costs increase, the funding is not increasing to meet our needs.

It is the position of the Great Plains Tribes that even if the estimated full funding recommendation is funded, it is inadequate to meet the needs of a growing Tribal community and uphold the trust responsibility outlined in the Indian Health Care Improvement Act (IHCIA), to provide the "highest possible health status to Indians and to provided existing Indian health services with all resources necessary to effect that policy."

The Great Plains Area Health and Budget priorities by Tribal consensus is to follow the recommendations of the National Budget Workgroup with increase of additional funding of $857.597 for FY 2024. The Great Plains Area would like to continue to focus on the following program with the increases as recommended by the National Workgroup.

1. Mental Health $5,376
2. Alcohol & Substance Abuse $9,376
3. Hospitals & Clinics $199,161
4. Health Care Facilities Construction $100,177
5. Medical Equipment $2,189
6. Dental Services $13,338
7. Purchase/Referred Care $41,746
8. Community Health Representatives $1,853
9. Health Education $2,551
10. Public Health Nursing $5,222
11. Maintenance & Improvement $4,984
12. Urban Health $2,807
13. Sanitation Facilities Construction $6,968
14. Indian Health Care Improvement $7,648

1. MENTAL HEALTH

AI/ANs 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 are the rising rate of suicides and suicide attempts in this area. The Great Plains Area 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 Great Plains Area 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 number 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 & Substance Abuse ASA) 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 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 four 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 (H&C). Great Plains Area identifies this as a priority because it provides the base funding for the hospitals, clinics, and health programs that operate on the Area reservations, which are predominately rural.

Increasing H&C funding is necessary to support the following: primary medical care services, impatient care, routine ambulatory care, and medical support services—such as laboratory, pharmacy, medical records, information technology, and other ancillary services. In addition, H&C funds provide the greatest flexibility to support community health initiatives targeting health conditions disproportionately affecting AI/ANs 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 AI/ANs experienced substantially higher burden of Syphilis, and other recent outbreaks. The all-cause of mortality rate between 1990 and 2013 among AI/ANs 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 have 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 IHS currently report exceeding these standards. IHS hospitals, which now average 39 years of age, are more than three times older than United States 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 because of increased sophistication and specialization of equipment, integration with electronic health records (EHR), 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), AI/AN children aged two to four years old have five times the rate of dental decay compared to all children, and six- to eight-year-old AI/AN 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. AI/AN 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 paid 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 percent of children requiring general anesthesia, this rate is at least 50 times (i.e., 5000 percent) higher than the United States, other races rate.

7. PURCHASE/REFERRED CARE

The Great Plains purchase/referred care (PRC) service area of is comprised of four states (North Dakota, South Dakota, Nebraska, and Iowa), with six states being included in the PRC Delivery Areas (North Dakota, South Dakota, Nebraska, Iowa, Minnesota, and Montana). A total of 83 counties are included in the PRC Delivery Area for the Great Plains Area Tribes. Most 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 IHS, are typically reserved for emergency and specialty services following a priority schedule used by 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 (WHO), 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 Maintenance & Improvement (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 through 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 two 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.

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 (IHCIA) requires IHS to identify the universe of sanitation facilities needs for existing 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 non-profit 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 Great Plains Area 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

AI/ANs 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**

Appendix G

Nashville Area Budget Narrative

INDIAN HEALTH SERVICE
FISCAL YEAR 2024 NASHVILLE AREA BUDGET INSTRUCTIONS
BUDGET RECOMMENDATION NARRATIVE

The Nashville Area offers the following budget recommendations for fiscal year (FY) 2024:
Fully fund the Indian Health (IHS) at $50 billion.

Approximately 80 percent of funding increase will be spread across all budget lines, with 20 percent of funding increase, at $8.7 billion, for the specific following Clinical Services programs as Nashville Area priorities:

- Hospitals & Clinics $1,757.8 billion
- Purchase Referred Care $1,424 billion
- Alcohol/Substance Abuse $1,223.8 billion
- Mental Health $1,179.3 billion
- Electronic Health Record System (New) $934.5 million
- Dental Health $645.2 million
- Community Health Reps $467.2 million
- Maintenance & Improvement $467.2 million
- Health Education $378.2 million
- Self-Governance $289.2 million

TOP 10 BUDGET INCREASES

1. HOSPITALS & CLINICS +$1,757.8B

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 percent of IHS outpatient workload and 50 percent 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) +$1,424.8B

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

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

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

3. ALCOHOL/SUBSTANCE ABUSE PROGRAM +1,223.8B

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 AI/ANs 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 alcohol/substance abuse program (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 +$1,179.3B

Mental Health is a top Tribal health priority. The high incidence of mental health disorders, suicide, violence, and behavior-related chronic diseases among AI/ANs is well documented. A mental illness regularly disrupts a person's thinking, feeling, mood, ability to relate to others and function, however outcomes can be improved through early intervention and proper support. Lack of access to timely, high-quality treatment is the greatest barrier to healthy Native American individuals and communities. Many IHS, Tribal, and Urban Indian Mental Health programs across the nation offer access to community-based integrated primary care and preventive mental health services that are culturally appropriate and integrated with primary care with options for specialty tele-behavioral services. However, most programs are small and staffed with one provider. To ensure that everyone who seeks treatment can receive it, additional resources are required.

5. ELECTRONIC HEALTH RECORD SYSTEM (NEW) +$934.5M

Resource and Patient Management Systems (RPMS) have been utilized by IHS for 34 years and through partnership and cost sharing with the United States 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 the electronic health record (EHR) system 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 +$645.2M

AI/ANs suffer disproportionately from dental diseases: three to five year-old AI/AN children have approximately four times as much tooth decay as the general United States population (43 percent vs. 11 percent), causing significant consequences such as delayed speech development, poor self-esteem, and high costs to repair; six to nine year-old AI/AN children suffer almost twice as much decay as the general United States population (83 percent vs. 45 percent), 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 United States population (53 percent vs. 11 percent). 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 United States population (16.2 percent vs. 2.9 percent).

As a result of these disparities in oral disease, IHS has created national initiatives. The IHS Early Childhood Caries (ECC) Collaborative is focused on preventing tooth decay (ECC) in 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 percent and significantly increased prevention and early intervention efforts (sealants increased by 65.0 percent, the number of children receiving fluoride varnish increased by 68.2 percent, and the number of therapeutic fillings increased by 161.0 percent), resulting in a net decrease of ECC prevalence from 54.9 percent in 2010 to 52.6 percent in 2014. To support this initiative, IHS conducted a nationwide surveillance of one- to five-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 IHS to support – through the continuation of existing initiatives – increasing the workforce, improving efficiency of programs, and prioritizing oral health to reduce the aforementioned disparities in oral health in the AI/AN population.

7. COMMUNITY HEALTH REPS $467.2M

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 AI/ANs 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 & IMPROVEMENT 467.2M

Maintenance & 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. 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 AI/ANs.

8. HEALTH EDUCATION $378.2M

Health educators are a necessary part of a culturally appropriate approach to addressing health concerns by teaching people about behaviors that promote wellness in AI/AN 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.

9. SELF-GOVERNANCE $289.2M

The IHS 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 AI/AN 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 (IHCIA) 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 FY 2024.

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 Operation & Management (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 Five-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.

Additionally, SARS-COVID2 the virus that causes COVID 19 is transmitted via respiratory droplets. During the pandemic, Nashville Area found that most facilities' ventilation systems, including protective barriers, could be optimized to mitigate the spread of COVID. The Area also found a lack of negative pressure rooms necessary to isolate positive COVID 19 patients. Environmental engineers that review the systems felt that due to age of the buildings that installation of true negative pressure rooms were not feasible due to lack of ventilation. As a result, facilities found themselves having to improvise with creating negative pressure rooms that were not ideal to prevent the spread of COVID 19. Ventilation system upgrades or improvements can increase the delivery of clean air and dilute potential contaminants. These upgrades are important for control of spread

of the infection within all health facilities who were seeing COVID positive patients, or for future pandemic response.

FACILITIES AND ENVIRONMENTAL HEALTH

The Facilities Support, Sanitation Facilities Construction and Environmental Health Services programs are funded out of the Facilities and Environmental Health Account. Facilities and Environmental Health support funds are used for the planning, construction and maintenance of hospitals and clinics to provide the highest quality of care in a safe clean environment; to assure new facilities meet or exceed health care accreditation standards; for identifying environmental hazards and risk factors in Tribal homes, healthcare facilities, food service establishments, Head Start centers, and many other types of Tribal establishments and proposing control measures to prevent adverse health effects; for monitoring and investigating disease and injury; and to collaborate with AI/AN, other agencies, and IHS programs to prevent unintentional injuries (motor vehicle-related, falls, burns, drowning, poisoning) and intentional injuries (suicide and violence- related) through technical assistance, training, and the Tribal Injury Prevention Cooperative Agreement Program (TIPCAP).

In recent years the Nashville Area has grown to include 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 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 regarding increased inspections and technical assistance.

ADVANCE APPROPRIATIONS

Since FY 1998, appropriated funds for IHS have been released after the beginning of the new fiscal year. Most often caused by a Congressional failure to enact prompt appropriations legislation, late funding has severely hindered Tribal and IHS health care providers' budgeting, recruitment, retention, provision of services, facility maintenance, and construction efforts. Congress has recognized the difficulties inherent in the provision of direct health care that relies on the appropriations process and traditional funding cycle and has appropriated beginning with FY 2010, advance appropriations for the VA medical care accounts. As the only other federally funded provider of direct health care, IHS should be afforded the same budgetary certainty and protections extended to the VA.

Advance appropriations is a budgetary solution that would protect these services from future lapses in appropriations and ensure they do not count against spending caps. The IHS advance appropriations is a budgetary solution that would protect these services from future lapses in appropriations and ensure they do not count against spending caps.

Moving federal Indian programs to the advance appropriations process will protect Tribal governments from cash flow problems that regularly occur due to delays in the enactment of annual appropriations legislation. President Biden affirmed this solution by putting advance appropriations for FY 2023 in his FY 2022 budget request for IHS.

FUNDING OBLIGATION FOR 105*(l)* LEASES

ISDEAA authorizes IHS to enter a lease with Tribal nations for a facility used to administer and deliver PFSAs. Historically, the appropriations for facilities have 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, 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 decide 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 IHS behavioral health initiatives.

HEPATITIS C

Hepatitis C (HCV) infection is the most common bloodborne disease in the United States, disproportionately impacting racial and ethnic minorities, including AI/ANs. In 2015, AI/ANs experienced a rate of acute HCV higher than that of other minority populations, with AI/AN women more than 50 percent likely to die from viral hepatitis compared to their non-Hispanic white counterparts. As a result, IHS 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 percent and 90 percent, with higher HCV viral load, more rapid progression to HCV-related liver disease, and increased risk for cirrhosis and liver cancer. Approximately one in four 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.

Appendix H

Navajo Area Budget Narrative

INDIAN HEALTH SERVICE
FISCAL YEAR 2024 NAVAJO AREA
BUDGET INSTRUCTIONS
BUDGET RECOMMENDATION NARRATIVE

HOSPITALS & HEALTH CLINICS PUBLIC HEALTH INFRASTRUCTURE

1. **HOW THE RECOMMENDED BUDGET INCREASES SHOULD BE ALLOCATED, I.E., WHY EACH INCREASE IS IMPORTANT AND HOW IT WILL AFFECT CERTAIN PROGRAMS OR INITIATIVES. INCLUDE ANY EFFECTS OF PREVIOUS YEARS INCREASES. INCLUDE ANY DATA THAT HIGHLIGHTS EFFECTS OF PREVIOUS YEARS INCREASES.**

The Navajo Area is requesting a funding increase to the Hospitals & Health Clinics (H&C) major line item budget account to support Public Health and Preventive Health Services programs, including building and sustaining essential Public Health Infrastructure. There is not a separate Public Health and Preventive Health Services budget, hence these functions are supported by the H&C budget category. The priority of the Navajo Area is to strengthen public health programs, community partnerships and planning, health promotion, and epidemiology. This will support effective response, recovery, and prevention for ongoing and emerging health challenges – including infectious disease outbreaks; chronic illnesses like diabetes, heart disease and cancer; injuries and violence; and environmental issues like access to safe water, healthy food, and uranium exposure.

The COVID-19 pandemic demonstrated the need for coordinated, data-driven programs, systems, and responses to public health crises, as well as the effectiveness of working together with communities and across programs. During the pandemic, staff members were pulled from ongoing clinical and public health activities to focus on crisis response, leading to delays in care and significant reductions in other vital public health services.

Our Public Health and Prevention Teams successfully implemented an extensive COVID-19 data sharing program with the Navajo Nation, established one of the only culturally appropriate Navajo Contact Tracing teams local to the Navajo Nation, and assembled efficient COVID-19 testing and vaccine teams, therefore vaccinating 70 percent of our Navajo Nation.

Despite our small and underfunded Public Health Team, we were able to implement prevention programs to slow the spread of COVID-19. These programs include: 1) Partnering with the State of New Mexico to help fund and implement COVID-19 hotels for unsheltered Navajo population, 2) Creating isolation facilities on the west and east side of the Navajo Nation that people could go to isolate while recovering from COVID-19, 3) Developing culturally sensitive Public Health Announcements to stop the spread of COVID-19, 4) Training public health staff on motivational interviewing to contact trace and conduct post Covid interviews linking patients back to their medical homes, and 5) Implement a test and treat protocol to increase access to monoclonal antibody treatment for the high-risk individuals.

Our Public Health Teams innovated by creating new programs like the cluster investigation unit to identify epidemiological links and increase communication to all people within the clusters. The Public Health Team provided critical 24-hour COVID-19 test result notifications. In addition, our Teams provided Mental Health First Aid training to the community and trained community members to teach the course. Our Team also connected patients to resources to receive food boxes and isolation kits to allow the family to stay home and recover. When there was a downward trajectory in cases, our Public Health Teams reached out to our recovered patients to follow up on lingering COVID-19 symptoms and connecting them back to their medical home. Our Public Health Teams continue to respond and pivot to COVID-19 by providing vaccines, conducting data analysis, administering boosters, and communicating public health education and messaging to our patients. Our Public Health Teams have been extremely effective in responding to the COVID-19 pandemic and having the funding to bring in more Public Health Professionals to respond, train, and prepare for future pandemics and prevention initiatives are essential for the Navajo Nation community and the Indian Health Service's (IHS) Public Health infrastructure.

Public Health and Prevention Programs serving Indigenous communities have historically been significantly under-funded. Proactive, recurring support

for Public Health Infrastructure, rather than one-time, crisis-based funding, is essential to sustain systems to protect families and communities.

Balanced, effective Public Health Infrastructure for American Indians/Alaska Natives (AI/ANs) communities includes the elements of observation (surveillance, data collection, and community listening); planning (data analysis, meaning-making, and dialogue with communities and partners); action (direct preventive and public health services to support families and communities); and keeping track (epidemiology and reporting).

Flexible, respectful partnerships between local communities, Tribal programs, Nongovernmental organizations, and IHS during the COVID-19 pandemic resulted in high levels of vaccination, direct support to thousands of families to successfully complete isolation/quarantine and limit spread, mitigate risks at the individual, family, community, and nation levels, and promote transparent systems for epidemiologic data collection and sharing. Similar partnerships over the years have contributed to improvements in behaviors and conditions related to risk and protective factors for diabetes and other chronic diseases.

Building public health skills and competencies among all staff and partners are vital for an effective response to both acute, and chronic health issues facing AI/AN. There is a need for increased capacity for data collection, reporting, analysis, and community engagement for public health planning. Community-based programming and services can support and strengthen families and communities.

Sustained investment in expanded Public Health Infrastructure serving Indigenous communities should be balanced, support partnerships, and build the skills and competencies of all staff and partners.

2. LINK TO INDIAN HEALTH CARE IMPROVEMENT ACT PROVISIONS.

- SUBCHAPTER I-INDIAN HEALTH PROFESSIONAL PERSONNEL
  - 1616b Recruitment activities.
  - 1616c Tribal recruitment and retention program.
  - 1616n. Tribal health program administration.
- SUBCHAPTER II-HEALTH SERVICES
  - 1621b. Health promotion and disease prevention services.
  - 1621c. Diabetes prevention, treatment, and control.
  - 1621d. Other authority for provision of services.
  - 1621h. Mental health prevention and treatment services.
  - 1621k. Coverage of screening mammography.
  - 1621m. Epidemiology centers.
  - 1621n. Comprehensive school health education programs.
  - 1621q. Prevention, control, and elimination of communicable and infectious diseases.
- SUBCHAPTER III-HEALTH FACILITIES
  - 1638c. Contracts for personal services in IHS facilities.
  - 1638e. Other funding, equipment, and supplies for facilities.
- SUBCHAPTER III A-ACCESS TO HEALTH SERVICES
  - 1647b. Access to federal insurances.
- SUBCHAPTER V-ORGANIZATIONAL IMPROVEMENTS
  - 1662. Automated management information system.
- SUBCHAPTER VI-MISCELLANEOUS
  - 1677. Nuclear resources development health hazards.
  - 1680d. Infant and maternal mortality: fetal alcohol syndrome.
  - 1680q. Prescription drug monitoring.

3. LINK TO GOVERNMENT PERFORMANCE AND RESULTS ACT PERFORMANCE TARGETS AND OUTCOMES.

The H&C funds allow the Navajo Area to meet and improve its annual Government Performance and Results Act (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. Increased funding for Public Health Infrastructure will allow innovative, focused interventions to improve the GPRA Prevention performance measures.

During 2020, with COVID-19 restrictions in place, GPRA performance measures were negatively impacted due to our small, yet strong Public Health Teams focusing on preventing COVID-19 spread. The closure of several health services occurred throughout the Area due to the COVID-19 pandemic and this negatively impacted our GPRA measures.

Below are the 2021 GPRA performance measure results for dental, diabetes, and prevention:

The Navajo Area met zero of the three Dental measures.

- Dental General Access: Target: 26.60 percent; Navajo Area: 18.28 percent.

- Sealants: Target: 13.8 percent; Navajo Area: 6.1 percent.
- Topical Fluoride: 27.6 percent; Navajo Area: 13.69 percent.

Navajo Area met one of the five Diabetes care measures – Statin Therapy.
Statin therapy: Target: 49.0 percent; Navajo Area: 52.67 percent. Four diabetes GPRA measures were not met.

- Controlled Blood Pressure: Target: 59.10 percent; Navajo Area: 44.53 percent
- Nephropathy Assessment: Target: 45.50 percent; Navajo Area: 45.2 percent.
- Poor Glycemic Control: Target: 16.80 percent; Navajo Area: 21.76 percent.
- Retinopathy Exams: Target: 51.4 percent; Navajo Area: 42.24 percent.

The Navajo Area met three of the four Immunizations measures.

- Adult Immunizations – all age-appropriate immunizations: Target: 55.1 percent; Navajo Area: 42.44 percent.
- Childhood Immunizations: Target: 42.8 percent; Navajo Area: 51.81 percent
- Influenza Vaccinations for Ages 18 and over: Target: 24.40 percent; Navajo Area: 25.87 percent.
- The GPRA measure for Influenza Vaccines for ages six month to 17 years was not met: Target: 26.60 percent; Navajo Area: 27.3 percent.

The Navajo Area met three of the Prevention measures.

- CVD Statin Therapy: Target 33.30 percent; Navajo Area: 40.71 percent.
- Breastfeeding at Age Two Months: Target: 40.0 percent; Navajo Area: 44.32 percent.
- HIV Screening Ever: Target: 32.0 percent; Navajo Area: 44.39 percent.

The GPRA measures that were not met in 2021 were: Mammography Screening: Target: 43.40 percent; Navajo Area: 25.21 percent.

- Cervical PAP Screening: Target: 38.40 percent; Navajo Area: 35.09 percent.
- Childhood Weight Control: Target: 22.60 percent; Navajo Area: 27.46 percent.
- Colorectal Cancer Screening: Target: 32.60 percent; Navajo Area: 30.64 percent.
- Controlling High Blood Pressure (MH): Target: 42.90 percent; Navajo Area: 38.05 percent.
- Tobacco Cessation Counseling, Aid, or Quit: Target: 34.0 percent; Navajo Area: 15.67 percent.

4. LINK REQUESTS TO INDIAN HEALTH SERVICE STRATEGIC PLAN.

Increasing H&C funding to support the Public Health and Preventive Health Services programs is a budget priority which is in line with the IHS mission to raise the physical, mental, social, and spiritual health of AI/ANs 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/ Alaska Native people;

The H&C funds ensure comprehensive, culturally appropriate personal and public health services are available and accessible to AI/AN. The Navajo Area uses an interdisciplinary approach to delivering health care, using medical and behavioral therapeutics, traditional healing practices, and public and community health methods to achieve and improve positive health outcomes. One of the factors that drives positive health outcomes is a commitment to increasing access to care for the population served. Continual H&C funds facilitate Public Health and Preventive Health Services availability, and the Navajo Area strives to ensure services are relevant and effective to allow patients, families, and communities to gain access to care.

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

The H&C funds support and promote Public Health and Preventive Services excellence and quality through innovative initiatives that support population health management and healthy communities. The H&C funds would help us hire and sustain qualified candidates to extend disease surveillance projects, implement more preventative programs, and increase our GPRA screenings.

3. To strengthen Indian Health Service program management and operations.

The H&C funds permit strengthening IHS program management and operations by employing and retaining qualified individuals who are subject matter experts in their professions. This expertise grows and strengthens leadership, management and operations which benefit AI/AN patients and communities, leading to dynamic relationships between healthcare providers/workers and patients, families, and communities. The strength of health programs and operations stem from individuals and teams who make up the organization, their passion for excellence, compassion for serving underserved populations, and dedication to advancing Indian health care.

ALCOHOL AND SUBSTANCE ABUSE

1. HOW THE RECOMMENDED BUDGET INCREASES SHOULD BE ALLOCATED, I.E., WHY EACH INCREASE IS IMPORTANT AND HOW IT WILL AFFECT CERTAIN PROGRAMS OR INITIATIVES. INCLUDE ANY EFFECTS OF PREVIOUS YEARS INCREASES. INCLUDE ANY DATA THAT HIGHLIGHTS EFFECTS OF PREVIOUS YEARS INCREASES.

The Navajo Area is requesting a funding increase to the Alcohol and Substance Abuse major line item budget category. Alcohol use disorder is a critical public health concern on the Navajo Nation and San Juan Southern Paiute reservation. According to the 2019 National Survey on Drugs Use and Health (NSDUH), 10.2 percent of AI/ANs have a substance use disorder and 3.8 percent of ≥18-year-old had both substances abuse and mental illness.

The alcohol and drug use statistics for AI/AN are higher than other ethnic groups in the United States.

AI/ANs 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 COVID-19 pandemic has exacerbated the increased substance use. Social distancing has created isolation and loneliness. Relapse and new onset of substance use has created a significant influx of emergency use related to 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 medical and social detoxication facilities are available on Navajo and San Juan Southern Paiute lands. All inpatient facilities for substance use disorders are located off the reservations. No evidence-based practice interventions are available for patients with methamphetamine and opioid use disorder.

Recruitment of qualified substance abuse providers is a barrier to providing quality performance-based care. Recruitment challenges include the inability to offer competitive salaries and lack of housing. 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. Telepsychiatry and behavioral health services are limited because of the frontier and rural area and minimal access to broadband internet services. Additional support is needed to establish a secure internet and robust Information Technology infrastructure to support the delivery of quality patient care services.

Past funding for Alcohol and Substance Abuse Program had allowed the Navajo Area to meet its GPRA performance targets for alcohol screening and intervention for treatment referrals prior to the onset of the COVID-19 pandemic.

2. LINK TO INDIAN HEALTH CARE IMPROVEMENT ACT PROVISIONS, WHERE APPLICABLE.

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

3. LINK TO GOVERNMENT PERFORMANCE AND RESULTS ACT PERFORMANCE TARGETS AND OUTCOMES.

There are two GPRA measures relevant to the substance abuse budget line item: 1) Universal Alcohol Screening and other Substance Use Disorders, for ages 9-95 years old and; 2) Screening Brief Intervention Referral for Treatment (SBIRT) for all ages. In 2021, Navajo Area did meet the Universal Alcohol Screening target of 39.00 percent with Navajo Area's performance at 39.24 percent. In 2021, Navajo Area did not meet the SBIRT target of 14.30 percent with Navajo Area's performance at 9.03 percent. In 2020, Navajo Area did not meet the Alcohol Screening target of 42.40 percent with Navajo Area's performance at 41.96 percent and Navajo Area did meet its Screening, Brief Intervention, and Referral for Therapy

(SBIRT) target of 15.22 percent while the national target was 12.20 percent. During the COVID-19 pandemic in 2020 and 2021, meeting the GPRA targets became a challenge due to closures of health clinics, including behavioral health care services which also affected access to care problems for patients.

4. LINK REQUESTS TO INDIAN HEALTH SERVICE STRATEGIC PLAN.

In the past, increased funding allowed the Navajo Area to meet the GPRA Universal Alcohol Screening target for ages 20 and greater and this effort supports the IHS Strategic Plan Mission to raise the physical, mental, social, and spiritual health of AI/ANs 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/ Alaska Native people;**

Increased funding supports the IHS and Navajo Area to meet GPRA targets for Universal Alcohol Screening for ages 20 and greater, using relevant culturally appropriate approaches to screening and care/treatment. The Navajo philosophy of healing and well-being were incorporated into counseling and intervention therapies and treatments, thereby treating the whole person within a network of relationships. In addition, evidence-based alcohol screening tools were utilized to ensure appropriate level of intervention and individualized treatment plans.

SBIRT was implemented in primary care clinics and the emergency departments to improve access to care. The Navajo Area is using the Primary Care Behavioral Health model and Trauma- informed Care Approach. Both have significantly contributed to personal and culturally oriented care. Unitization of telehealth services significantly increased during the COVID-19 pandemic to ensure patient access to care.

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

To support innovation, significant efforts have been made to integrate mental health screening and intervention with medical primary care service. A collaborative model, the Primary Care Behavioral Health Model supports the aforementioned integration of care activities, and the Model also supports population-based care and holistic approach to care. The Model facilitates early intervention and referral to treatment services. Trauma-Informed Care is being used throughout Navajo Area to promote healing and recovery from the effects of trauma throughout one's life. Cultural sensitivity to historical trauma and the impacts of trauma related to COVID-19 pandemic require ongoing training for incoming and long-term employees. Robust development of tele-behavioral health technology and practice through the Navajo Area will significantly improve access to care. The remote and frontier geographical location and large land-base of the Navajo reservation are challenges for patients to establish consistent patient care at the outpatient behavioral health clinics.

Unreliable transportation is a barrier to health care services; therefore, the use of tele-medicine is another option for ongoing patient access. Though digital technology needs to be improved across the reservation to optimize tele-medicine practice.

3. **To strengthen Indian Health Service program management and operations.**

To strengthen the Navajo Area's behavioral health program and operation, the following approaches to care, Primary Care Behavioral Health and Trauma-Informed Care, and the use of a reliable information technology to support the above- mentioned best practice models must be fully realized and integrated to achieve excellence with population-based behavioral health outcomes In addition, staff must be trained in utilizing these best practices to achieve the desired outcomes and to ensure technology support for efficient behavioral health care practices. A significant Information Technology infrastructure development will need to occur on Indian reservations and rural areas of American to improve access to care, including behavioral health care. The availability of the latest information technology assures the recruitment and retention of staff and facilitates virtual training to enhance staff development and support best practices.

The advent of COVID-19 pandemic has forced health care providers to capitalize on digital technology for reaching patients, i.e., the increased need to do substance use interventions by professional staff. The significant impact of loss, social isolation, and adjustment to rapid change of daily living activities have compounded the trauma experienced by AI/A peoples.

COMMUNITY HEALTH REPRESENTATIVE

1. HOW THE RECOMMENDED BUDGET INCREASES SHOULD BE ALLOCATED, I.E., WHY EACH INCREASE IS IMPORTANT AND HOW IT WILL AFFECT CERTAIN PROGRAMS OR INITIATIVES. INCLUDE ANY EFFECTS OF PREVIOUS YEARS INCREASES. INCLUDE ANY DATA THAT HIGHLIGHTS EFFECTS OF PREVIOUS YEARS INCREASES.

The Navajo Area and Navajo Nation are requesting a funding increase for the Navajo Community Health Representative (CHR) Program major line item account budget category. The Navajo Nation operates and manages the Area's CHR Program. The CHR workforce roles and competencies mimic nationally recognized Community Health Workers' core roles and competences. The increase in funding will be used to hire additional Community Health Representatives and provide operational and training support across all communities on the Navajo Nation. There are 110 communities and current CHR staff cover several communities. The current funding is inadequate for upgrading and replacing information technology equipment, broadband coverage, phone and radio devices, training, and augment staffing level.

The role of a CHR is vital in a community-public health setting. A CHR has cultural, traditional, and linguistic experience and knowledge along with professional education, training, and certification including public health that is unique to Navajo. A CHR is also a frontline worker during public health emergencies, major disasters, and responsible for community assessments to address needs in the field. In 2020 the CHR Program responded to the COVID-19 public health emergency by teaming up with local response teams and medical workers to complete contact investigations and other community mitigation efforts, provide home support to patients who were in home isolations or quarantines, and continued their home visits to follow up high risk patients. Most high-risk patients are elders and incapacitated individuals who live in remote parts of the reservation. The increase in funding will provide additional training in public health emergency response, public health competencies, expand community health worker competences, deliver logistical support to staff for communicable disease prevention and management, and provide awareness training of post-COVID-19 patients and their on-going symptoms and long-term effects of COVID-19 infection.

An escalating demand has been placed on the Navajo CHR Program that requires increasing resources to meet the demand. The United States and Navajo Nation are experiencing aging populations, where elders will soon require more health visits at home and in the clinic. The Navajo Nation Epidemiology Center Five-Year American Community Survey, 2019, projected that between 2010 and 2015 the Navajo population on Navajo lands had increased by 3 percent, while the United States had a population growth of 6.6 percent. A population growth, permanently, places stress on a local healthcare delivery system and the CHRs are a part of the local delivery system that must respond to the growing requirements. When there is population growth and life expectancy increase, there are more senior citizens with chronic health conditions, a natural part of aging, which impact the existing healthcare delivery system, creating demands for more providers of care, expanded and advanced medical services, public health, and a robust information technology. When proper resources are not made available to address the demand, health disparities will intensify for the Tribal members. When adequate funding for a healthcare delivery system is lacking or falls shorts, it becomes a deterrent to accessing health care services.

Past funding increases for the CHR Program have supported a patient care model of bridging continuity of care from a clinical health care environment to a patient's home setting and linking the patient to community resources and support. This philosophy of care successfully reduced readmissions to inpatient and emergency department services because the patients are better managed in their homes surrounded by family members and their community resources. Past funding increases have supported the CHR in their roles as members of the local primary care teams. The Navajo Area has implemented the Primary Care Medical Home model and the CHR are part of the primary care teams by serving as health provider extenders into the patients' homes and communities.

2. LINK TO INDIAN HEALTH CARE IMPROVEMENT ACT PROVISIONS, WHERE APPLICABLE.

- 1616. Community Health Representative Program.
- 1616c. Tribal recruitment and retention program.
- 1660f. Community Health Representatives.
- 1616l. Community health aide program.
- 1621b. Health promotion and disease prevention services.
- 1621c. Diabetes prevention, treatment, and control.
- 1621d. Other authority for provision of services.
- 1621q. Prevention, control, and elimination of communicable and infectious diseases.

3. LINK TO GOVERNMENT PERFORMANCE AND RESULTS ACT TARGETS AND OUTCOMES.

The Navajo Nation's CHR Program serves the geographic population of the Navajo Area and the Community Health Representatives are members of the Area's local IHS Units' health teams. As members of the local primary care medical home teams, the roles of the Health Representatives are critical in meeting the Area's GPRA performance targets and outcomes. These health indicators measure the work of providers of health care in relation to effects of their care on the health status of the population. In 2020 and 2021 the Area did not meet a significant number of established national GPRA performance targets due to the COVID-19 pandemic. The pandemic resulted in restricting health care services to core services that treat and care for COVID-19 patients, emergency types of patients, and high-risk patients.

The 2021 Navajo Area's GPRA performance targets and outcomes: The Navajo Area has met zero of the three Dental measures.

- Dental General Access: Target: 26.60 percent; Navajo Area: 18.25 percent.
- Sealants: Target: 13.80 percent; Navajo Area: 6.10 percent.
- Topical Fluoride: 27.60 percent; Navajo Area: 13.67 percent.

Navajo Area has met one of the five Diabetes care measures.

- Controlled Blood Pressure: Target: 59.10 percent; Navajo Area: 44.50 percent
- Nephropathy Assessment: Target: 45.50 percent; Navajo Area: 41.14 percent.
- Poor Glycemic Control: Target: 16.80 percent; Navajo Area: 21.74 percent.
- Retinopathy Exams: Target: 51.40 percent; Navajo Area: 42.12 percent.
- Statin therapy: Target: 49.00 percent; Navajo Area: 52.67 percent.

The Navajo Area has met three of the four Immunizations measures.

- Adult Immunizations – all age-appropriate immunizations: Target: 55.10 percent; Navajo Area: 42.37 percent.
- Childhood Immunizations: Target: 42.80 percent; Navajo Area: 51.68 percent.
- Influenza Vaccinations for Ages 18 and Over: Target: 24.40 percent; Navajo Area: 25.71 percent.
- Influenza Vaccines for Ages Six Month to 17 years: Target: 26.60 percent; Navajo Area: 27.17 percent.

The Navajo Area has met four of the 14 Prevention measures.

- Cervical PAP Screening: Target: 38.40 percent; Navajo Area: 35.10 percent.
- Childhood Weight Control: Target: 22.60 percent; Navajo Area: 27.38 percent.
- Colorectal Cancer Screening: Target: 32.60 percent; Navajo Area: 30.58 percent.
- Controlling High Blood Pressure (MH): Target: 42.90 percent; Navajo Area: 33.25 percent.
- CVD Statin Therapy: Target 33.30 percent; Navajo Area: 40.71 percent.
- Depression Screening or Mood Disorder 12 – 17 years old: Target: 43.20 percent; Navajo Area: 27.12 percent.
- Depression Screening or Mood Disorder 18 years and older: Target: 49.40 percent; Navajo Area: 38.18 percent.
- Breastfeeding at Age Two Months: Target: 40.00 percent; Navajo Area: 44.39 percent.
- HIV Screening Ever: Target: 32.00 percent; Navajo Area: 44.39 percent.
- IPV/DV Screening: Target: 37.50 percent; Navajo Area: 35.61 percent.
- Mammography Screening: Target: 43.40 percent; Navajo Area: 25.08 percent.
- SBIRT: Target: 14.30 percent; Navajo Area: 9.15 percent.
- Tobacco Cessation Counseling, Aid, or Quit: Target: 34.00 percent; Navajo Area: 15.63 percent.
- Universal Alcohol Screening: Target: 39.00 percent; Navajo Area: 39.19 percent

4. LINK REQUESTS TO INDIAN HEALTH SERVICE STRATEGIC PLAN.

The purpose of the Community Health Program is in alignment with the mission of the IHS which is to raise the physical, mental, social, and spiritual health of AI/ANs 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. **Ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian/Alaska Native people;**
   As front-line health care workers, the CHRs are culturally competent in delivering comprehensive, culturally appropriate personal and public health services. The CHRs are equipped with knowledge, skills and abilities to effect change in community acceptance and use of health care resources, use community-based networks to enhance health promotion and disease prevention, and provide public health outreach.

2. **To promote excellence and quality through innovation of the Indian health system into an optimally performing organization; and**
   The Navajo Community Health Representative Program promotes excellence and quality through innovation using their training and cultural competencies to effectively deliver safe in-home care and meet the cultural, social, and linguistic needs of patients and their families to improve health outcomes. The presence of a CHR in a patient's home supports and solidifies kinship- or relationship-based health care, while pulling together community resources to support the patient and their family. Placing the patient at the center of care is a successful innovative approach to healing and well-being that stems from the Navajo Philosophy.

3. **To strengthen Indian Health Service program management and operations.**
   Increase funding for the Community Health Representative Program will strengthen IHS program management and operations by adding a supply of CHR to the NAIHS healthcare delivery system. The added Health Representatives will further support and enhance relationship-based care, culturally appropriate health care, and connect networks of community resources on behalf of the patients and their families, which all effect positive population health status outcomes.

HEALTH FACILITIES CONSTRUCTION

1. **HOW THE RECOMMENDED BUDGET INCREASES SHOULD BE ALLOCATED, I.E., WHY EACH INCREASE IS IMPORTANT AND HOW IT WILL AFFECT CERTAIN PROGRAMS OR INITIATIVES. INCLUDE ANY EFFECTS OF PREVIOUS YEARS INCREASES. INCLUDE ANY DATA THAT HIGHLIGHTS EFFECTS OF PREVIOUS YEARS INCREASES.**

The Navajo Area is requesting for an increase in funding for the Health Facilities Construction Program major line item account to support, nationally, the IHS seven new Inpatient and Outpatient and Small Ambulatory facilities, Staff Quarters Program, and Joint Venture Construction Program planned for construction, none of the facilities on the current five year plan are currently funded for construction.

The Navajo Nation requests the United States Congress to continue to support health care facility construction projects, including infrastructure development and the design of Navajo Area's next major project, the Gallup Indian Medical Center, 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, and improve the health of the Navajo Nation, San Juan Southern Paiute Tribe and other AI/ANs that will be served by these facilities. Congress is also asked to acknowledge other facility needs and to be cognizant of future Navajo health care facilities, which require expansion, renovation and/or replacement.

The most current IHS Annual Facilities Planning document (Five-Year Plan) lists seven 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	$ 615,000,000	$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 $888,600,000 million. The existing facilities are obsolete with an average age of 50 years and have long surpassed their useful lives. The facilities are grossly undersized for the identified user populations, which has created crowded conditions among staff, patients, and visitors. In many cases, existing services are relocated outside the main health facility. Often to modular office units to provide additional space for medical primary health care and specialty services. Such displacement of medical services creates difficulties for staff and patients and increases wait times, resulting in numerous inefficiencies within the health care system which delays care.

Previous increases in Health Facilities Construction have allowed for the completion of the planning documents for the Pueblo Pintado Health Center and the Bodaway/Gap Health Center. Pueblo Pintado Health Center is currently in design with Bodaway/Gap soon to follow. The new Gallup Indian Medical Center is currently completing the planning phase and design projected to start in late FY 2023.

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

2. LINK TO INDIAN HEALTH CARE IMPROVEMENT ACT PROVISIONS, WHERE APPLICABLE.

The 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, resulting in improved lives and health of AI/ANs In line with the IHICA is the IHS Health Care Priority System that identifies Health Facilities Construction projects for priority inpatient, outpatient, staff quarters development, Joint Venture, and Youth Regional Treatment Centers. Increased funding eliminates deficiencies in health status and health resources, eliminates backlogs in the provision of health care services, and meets the health care needs of people in an efficient and equitable manner.

3. LINK TO GPRA PERFORMANCE TARGETS AND OUTCOMES.

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

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

4. LINK REQUESTS TO INDIAN HEALTH SERVICE STRATEGIC PLAN.

The mission of IHS is to raise the physical, mental, social, and spiritual health of AI/ANs 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/ 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. 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 Indian Health Service 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 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.

HOSPITALS & HEALTH CLINICS

1. HOW THE RECOMMENDED BUDGET INCREASES SHOULD BE ALLOCATED, I.E., WHY EACH INCREASE IS IMPORTANT AND HOW IT WILL AFFECT CERTAIN PROGRAMS OR INITIATIVES. INCLUDE ANY EFFECTS OF PREVIOUS YEARS INCREASES. INCLUDE ANY DATA THAT HIGHLIGHTS EFFECTS OF PREVIOUS YEARS INCREASES.

The Navajo Area requests funding increase to the Hospitals and Health & Clinics (H&C) Program major line item account as the category funds essential personal health services through medical and surgical inpatient care, emergency, ambulatory, and specialty services, and medical support services such as laboratory, pharmacy, nutrition, diagnostic imaging, electronic health information management, and physical therapy. Personal health care services are integrated with Community and Public Health Services, including epidemiology that targets health conditions disproportionately affecting members of the Navajo Nation and San Juan Southern Paiute Tribe such as diabetes, maternal and child health, and communicable diseases including influenza, human immunodeficiency virus/acquired immune deficiency syndrome (HIV/ AIDS), hepatitis, and Covid-19. The federally operated healthcare facilities in the five Navajo Area Service Units serve 67.8 percent of the Area User Population while the Tribally operated healthcare facilities serve 32 percent of the Area User Population. Resources under the H&C budget category are distributed to and supports all healthcare delivery stakeholders in the Navajo Area, including PL 93-638 Indian self-determination contracts and tribal self-governance compacts.

Increased funding for the H&C budget category will support increasing population growth and increasing life expectancy where elders with chronic health conditions will drive the demand for health care. Increased funding will support post COVID-19 infection rehabilitative care. A COVID-19 infection can result in immediate and delayed health and mental health effects, requiring

occupational therapy, physical therapy, respiratory therapy, and other medical therapies, along with behavioral health care. Increased funding will support the need to modernize health Information Technology systems and infrastructure across the Navajo Area. A modern Information Technology will allow full integration of tele- medicine into routine clinical practice. Increased funding will support a robust public health infrastructure of effective response, recovery, and prevention for ongoing COVID-19 pandemic crises and other unforeseeable emerging challenges from infectious disease outbreaks, disasters from climate changes, and environmental hazards from industrial contaminates, etc. Increased funding will develop a centralized epidemiology program which provides uniformity in health data management and reporting, optimize data sharing, and use data analytics for public health, reducing health risks and population-based health planning. The H&C budget category is a catch all budget for hospital and ambulatory health care operations, hence a default to budget when other funds are unavailable to support health care operations.

Past funding increases allowed a proactive response to the COVID-19 pandemic by redirecting existing resources to infection surveillance and contract tracing, support patient isolation and quarantine, purchase more Personal Protective Equipment, medical supplies and medicines, and upgrade and expand several computer and telecommunication technologies to support tele-medicine by ensuring a smooth flow of information and images between providers (internal and external), and support staff tele-work. Past funding increases established COVID-19 testing sites and vaccinations sites. Past funding increases allowed the standing up of the Area's and Service Units' Emergency Management Operation Centers. Past funding increases permitted funds to pay for overtime and hiring of temporary staff (federal and contractors) to fulfill federal permanent hires staff shortages. Past funding allowed the Navajo Area to meet a significant number of the GPRA performance targets and outcomes, however this changed with the onset of COVID-19 where less performance targets were met in 2021 and 2022. The Navajo Area's healthcare delivery system changed focus from chronic health care management and preventive medicine to crises or emergency health management while responding to COVID-19 pandemic. Past funding allowed the implementation and designation of Primary Care Medical Home Model across the Area, along with Trauma-informed Care Approach to behavioral health care. Past funding allowed continue accreditation and certification by The Joint Commission and CMS, respectively. State certifications for Levels III and IV trauma center designations for three hospitals were also supported by past funding increases.

2. LINK TO INDIAN HEALTH CARE IMPROVEMENT ACT PROVISIONS.

- SUBCHAPTER I-INDIAN HEALTH PROFESSIONAL PERSONNEL
  - » 1616b Recruitment activities.
  - » 1616c Tribal recruitment and retention program
  - » Tribal health program administration.
- SUBCHAPTER II-HEALTH SERVICES
  - » 1621c. Diabetes prevention, treatment, and control.
  - » 1621d. Other authority for provision of services.
  - » 1621h. Mental health prevention and treatment services.
  - » 1621k. Coverage of screening mammography.
  - » 1621m. Epidemiology centers.
  - » 1621n. Comprehensive school health education programs.
  - » 1621q. Prevention, control, and elimination of communicable and infectious diseases.
- SUBCHAPTER III-HEALTH FACILITIES
  - » 1638c. Contracts for personal services in Indian Health Service facilities.
  - » 1638e. Other funding, equipment, and supplies for facilities.
- SUBCHAPTER III A-ACCESS TO HEALTH SERVICES
  - » 1647b. Access to federal insurances.
- SUBCHAPTER V-ORGANIZATIONAL IMPROVEMENTS
  - » 1662. Automated management information system.
- SUBCHAPTER VI-MISCELLANEOUS
  - » 1677. Nuclear resources development health hazards.
  - » 1680d. Infant and maternal mortality: fetal alcohol syndrome.
  - » 1680q. Prescription drug monitoring.

3. LINK TO GOVERNMENT PERFORMANCE AND RESULTS ACT PERFORMANCE TARGETS AND OUTCOMES.

During 2021, with COVID-19 pandemic restrictions in place, GPRA performance measures were adversely impacted as it was in 2020. The closure of several health services occurred throughout the Area due to the COVID-19 pandemic, negatively impacting meeting the GPRA performance targets.

Below are the GPRA performance measures results for 2021.
The Navajo Area has met zero of the three Dental measures.

- Dental General Access: Target: 26.60 percent; Navajo Area: 18.25 percent.
- Sealants: Target: 13.80 percent; Navajo Area: 6.10 percent.
- Topical Fluoride: 27.60 percent; Navajo Area: 13.67 percent.

Navajo Area has met one of the five Diabetes care measures.

- Controlled Blood Pressure: Target: 59.10 percent; Navajo Area: 44.50 percent
- Nephropathy Assessment: Target: 45.50 percent; Navajo Area: 41.14 percent.
- Poor Glycemic Control: Target: 16.80 percent; Navajo Area: 21.74 percent.
- Retinopathy exams: Target: 51.40 percent; Navajo Area: 42.12 percent.
- Statin therapy: Target: 49.00 percent; Navajo Area: 52.67 percent.

The Navajo Area has met three of the four Immunizations measures.

- Adult Immunizations – all age-appropriate immunizations: Target: 55.10 percent; Navajo Area: 42.37 percent.
- Childhood Immunizations: Target: 42.80 percent; Navajo Area: 51.68 percent.
- Influenza Vaccinations for Ages 18 and Over: Target: 24.40 percent; Navajo Area: 25.71 percent.
- Influenza Vaccines for Ages Six Month to 17 Years: Target: 26.60 percent; Navajo Area: 27.17 percent.

The Navajo Area has met four of the 14 Prevention measures.

- Cervical PAP Screening: Target: 38.40 percent; Navajo Area: 35.10 percent.
- Childhood Weight Control: Target: 22.60 percent; Navajo Area: 27.38 percent.
- Colorectal Cancer Screening: Target: 32.60 percent; Navajo Area: 30.58 percent.
- Controlling High Blood Pressure (MH): Target: 42.90 percent; Navajo Area: 33.25 percent.
- CVD Statin Therapy: Target 33.30 percent; Navajo Area: 40.71 percent.
- Depression Screening or Mood Disorder 12 – 17 years old: Target: 43.20 percent; Navajo Area: 27.12 percent.
- Depression Screening or Mood Disorder 18 years and older: Target: 49.40 percent; Navajo Area: 38.18 percent.
- Breastfeeding at age two months: Target: 40.00 percent; Navajo Area: 44.39 percent.
- HIV Screening Ever: Target: 32.00 percent; Navajo Area: 44.39 percent.
- IPV/DV Screening: Target: 37.50 percent; Navajo Area: 35.61 percent.
- Mammography Screening: Target: 43.40 percent; Navajo Area: 25.08 percent.
- SBIRT: Target: 14.30 percent; Navajo Area: 9.15 percent.
- Tobacco Cessation Counseling, Aid, or Quit: Target: 34.00 percent; Navajo Area: 15.63 percent.
- Universal Alcohol Screening: Target: 39.00 percent; Navajo Area: 39.19 percent.

4. THE LINK REQUESTS TO INDIAN HEALTH SERVICE STRATEGIC PLAN.

The mission of the IHS is to raise the physical, mental, social, and spiritual health of AI/ANs 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/Alaska Native people;**
   The H&C funds ensure comprehensive, culturally appropriate personal and public health services are available and accessible to patients across the Navajo Area. The Area uses an interdisciplinary approach to delivering health care, using medical and behavioral therapeutics, traditional healing practices, and public and community health methods to achieve and improve positive health outcomes. One of the factors that drives positive health outcomes is a commitment to increasing access to care for the population.

   Continual H&C funds facilitate health services availability, and the Navajo Area strives to ensure services are relevant and effective to allow patients, families,

and communities to gain access to care. The Area has implemented the Primary Care Medical Home model, Primary Care Behavioral Health model, and Trauma-informed Care Approach to support integration of physical and mental health care and combining these models with the Navajo philosophy of healing, well-being, and health, hence developing a culturally appropriate holistic approach to healing and well-being.

2. **To promote excellence and quality through innovation of the Indian health system into an optimally performing organization; and**
The Navajo Area's highest priority is sustaining hospital accreditation and certification by The Joint Commission and CMS, respectively.

   Accreditation is a mark of excellence and quality. The Navajo Area is facing numerous complex challenges including funds shortfalls, competing, nationally, for professional health care workers, aging facilities, and COVID-19 pandemic, and incredibly, the Area continues to be innovative in maintaining hospital accreditation/certification, sustaining State certifications for Levels III and IV trauma center designations, implementing best practices models of Primary Care Medical Home, Primary Care Behavioral Health and Trauma-informed Care Approach, keeping aging facilities repaired for patient care services, and an effective immediate and far reaching response to COVID-19 pandemic. The people who manage the Area's healthcare delivery system and those who deliver health care are to be commended for their dedication and innovative spirit in excelling health care in Navajo.

3. **To strengthen IHS program management and operations.**
Increased H&C funds will continue to strengthen the Navajo Area's healthcare delivery system.

   The strength of a healthcare system requires reliable recurring funds that keep current with advancing information technologies, biomedical equipment technologies, building codes, competitive salaries and benefits, and a robust population health data collection and management system. The strength of an organization involves retaining and recruiting of talented staff into a safe environment and who have access to the latest technologies and clinical practices and processes available in the healthcare industry.

HEALTH EDUCATION

1. **HOW THE RECOMMENDED BUDGET INCREASES SHOULD BE ALLOCATED, I.E., WHY EACH INCREASE IS IMPORTANT AND HOW IT WILL AFFECT CERTAIN PROGRAMS OR INITIATIVES. INCLUDE ANY EFFECTS OF PREVIOUS YEARS INCREASES. INCLUDE ANY DATA THAT HIGHLIGHTS EFFECTS OF PREVIOUS YEARS INCREASES.**

The Navajo Area and Navajo Nation are requesting a funding increase to the Health Education Program major line item account budget category. The Navajo Nation operates and manages the Area's Health Education Program. There are 28 Health Educators serving 110 communities, which is inadequate. The increase in funding will be used to hire more Health Educators and provide public health prevention services and training support. The current funding is inadequate for upgrading and replacing information technology equipment and network systems, training, and augmenting staffing level. Increase funds are needed to support a health education digital environment. With the progression of a digital media environment, the Educators are force by digital consumerism to integrate digital communication tools, accessibility, and management of content into their health education platforms and these digital media requirements are costly to the program. The role of a Health Educator is to promote and support activities directed at promoting healthy lifestyles, community capacity building, and the appropriate use of public health education services targeted to employees, schools, community health education, community health, and patient education. An Educator assists with the development of patient education codes and protocols to simplify the documentation of patient education services provided by health care providers, both paraprofessionals and medical providers.

The Navajo Nation is the largest Indian reservation in the United States, comprising about 16 million acres, or about 25,000 square miles, approximately the size of the state of West Virginia, serving nearly 400,000 tribal members. The Navajo Nation Health Education Program covers a rural geographic area involving 110 Navajo communities across three States. Annually, the Educators provide about 14,187 school health education, 5,119 employee worksite health education, and 4,981 patient health education, for a cumulative total of 70,173 Navajo individuals served. Social media has also provided a literary platform for the dissemination of literature and is an effective communication strategy for rural communities. From Calendar Year 2019 to Calendar Year 2021,

social media engagements have increased by 653 percent totaling 39,446 users reached.

With the declaration of the COVID-19 pandemic as a national emergency, the Health Education Program refocused its staff and operation to combat the pandemic by training and educating on the COVID-19 virus: what it is, how to mitigate and prevent spread of an infection, how to identify signs and symptoms of an infection, how to do self-care through isolation and quarantine, where to obtain a COVID-19 screening test and vaccination, why contract tracing is important in prevention and mitigation, etc. The Tribal Health Educators are in a unique position to communicate in a culturally sensitive manner by tapping into their cultural knowledge, tribal philosophy of health and well-being, and indigenous language. The Educators have developed a realm of COVID-19 knowledge and skills for preparedness, protection, and maintenance of the disease. The Educators also assist the patients and their families in navigating their local health care delivery system and community resources.

Past funding increases were used by the Educators to educate the population about health promotion, risk behaviors, and physical, mental, and social well-being to effect positive population heath status outcomes and decrease health disparities. An Educator is the conduit for conveying knowledge and skills of self-care resources and patients/families acceptance of these resources to restore their health to achieve a state of well-being, and past funding increases have supported this transmission of understanding. In the recent past, prior to the onset of COVID-19 pandemic, the Navajo Area had achieved a significant number of the national GPRA performance targets and outcomes. The Navajo Nation's Health Educators were part of this effort to improve the health status of the Navajo population.

2. LINK TO INDIAN HEALTH CARE IMPROVEMENT ACT PROVISIONS, WHERE APPLICABLE.

- 1616c. Tribal recruitment and retention program.
- 1616f. Tribal culture and history.
- 1616p. Health professional chronic shortage demonstration programs.
- 1621b. Health promotion and disease prevention services.
- 1621c. Diabetes prevention, treatment, and control.
- 1621d. Other authority for provision of services.
- 1621n. Comprehensive school health education programs.
- 1621q. Prevention, control, and elimination of communicable and infectious diseases.

3. LINK GOVERNMENT PERFORMANCE AND RESULTS ACT PERFORMANCE TARGETS AND OUTCOMES.

The Navajo Nation Health Education Program serves the geographic population of the Navajo Area Indian Health Service, and the Health Educators are members of the Area's local IHS Units' health teams. The role of a Health Educator is critical in meeting the Area's GPRA performance targets and outcomes. These health indicators measure the work of providers of health care in relation to effects of their care on the health status of the population. In 2020 and 2021 the Area did not meet a significant number of established national GPRA performance targets due to the COVID-19 pandemic. The pandemic resulted in restricting health care services to core services that treat and care for COVID-19 patients, emergency types of patients, and high-risk patients.

The 2021 Navajo Area's GPRA performance targets and outcomes:

The Navajo Area has met zero of the three Dental measures.

- Dental General Access: Target: 26.60 percent; Navajo Area: 18.25 percent.
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- Topical Fluoride: 27.60 percent; Navajo Area: 13.67 percent.

Navajo Area has met one of the five Diabetes care measures.

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- Nephropathy Assessment: Target: 45.50 percent; Navajo Area: 41.14 percent.
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- Retinopathy Exams: Target: 51.40 percent; Navajo Area: 42.12 percent.
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- Adult Immunizations – All Age-Appropriate Immunizations: Target: 55.10 percent; Navajo Area: 42.37 percent.
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- SBIRT: Target: 14.30 percent; Navajo Area: 9.15 percent.
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The Strategic Plan details how the IHS will achieve its mission through three strategic goals:

1. **Ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian/Alaska Native people;**
   As members of the local health teams, the Health Educators are culturally competent in delivering comprehensive, culturally appropriate personal and public health services, resulting in accessibility to health, medical, and public health information to patients, families, and communities.

2. **To promote excellence and quality through innovation of the Indian health system into an optimally performing organization; and**
   The Health Education Program promotes excellence and quality through innovation, using their training and cultural competencies to effectively deliver health education and information to patients, families, communities, schools, employers, and other community organizations by digital media, face-to-face, and congregated groups. All aspects of wellness, diseases, and health care are facilitated by language and linguistic expression is driven by personal experiences with well-being and sickness, and procedures and treatments, and human compassion shown by heath care workers. The Navajo Nation uses their local radio station for consistent delivery of public health and health information to its listeners by crafting an innovative information platform that translates the intent of public health, health promotion, health risks, and healthy lifestyles into the Navajo language. This uniquely crafted model of communication improves understanding and effects change.

3. **To strengthen IHS program management and operations.**
   Increase funding for the Health Education Program will strengthen IHS program management and operations by adding a supply of Health Educators to the NAIHS healthcare delivery system. The added Educators will further support and enhance relationship-based care, culturally appropriate health information communications, connect networks of community health resources information to support the patients and their families, and maximize the use of digital media platform, which all effect positive population health status outcomes.

INFORMATION TECHNOLOGY & INFRASTRUCTURE

1. HOW THE RECOMMENDED BUDGET INCREASES SHOULD BE ALLOCATED, I.E., WHY EACH INCREASE IS IMPORTANT AND HOW IT WILL AFFECT CERTAIN PROGRAMS OR INITIATIVES. INCLUDE ANY EFFECTS OF PREVIOUS YEARS INCREASES. INCLUDE ANY DATA THAT HIGHLIGHTS EFFECTS OF PREVIOUS YEARS INCREASES.

The Navajo Area is requesting an increase in funding for Information Technology (IT) Infrastructure and its components (network equipment, computers, servers, and software programs requirements). The funding to support the IT Program is located under the Hospitals & Health Clinics (H&C) major line item budget account. There is not a separate designated line item account for IT, hence when there are competing needs and priorities, the advancement, and often the sustainability, of an IT program becomes secondary until a failure or immediate threat occurs. The previous H&C funds increases that were specifically earmarked for IT modernization and maintenance have been used accordingly and successfully. The advancement of medicine and patient care procedures and treatment require the interfacing of medical equipment and electronic health records with the latest information technology and network systems which are critical to the operations of hospitals and ambulatory field clinics in the delivery of safe patient care. The current funding appropriations for the H&C line item account does not meet the needs and should be increased with funds earmarked specifically for the continual advancement and maintenance of IT and IT security.

In 2021, the Navajo Area updated its IT needs assessment and its five-year IT plan. The plan reflects IT needs/priorities and associated annual costs to keep current with changing technology and medicine. An IT modernization effort is an intentional investment to keep pace with the latest health care technology by terminating, stabilizing, upgrading, and replacing equipment and systems. The modernization plan has a strong focus on IT Security compliance and a four-year life cycle replacements of IT equipment, periodic upgrades of software programs and two to three years replacements or upgrades of network systems to keep abreast of advancing security requirements to protect against damages and threats. Over the years, organizational information has become more valuable and vulnerable, therefore accessibility, integrity, and confidentiality of information must be protected. During the COVID-19 pandemic, the Navajo Area has expanded and continues to improve the use of tele-medicine/health and tele-behavioral health technologies to prevent disruption of patient care services, with a significant focus on the high risk and elderly populations. The use of these digital technologies support prevention and mitigation of COVID-19 virus exposure. With the growth of tele-medicine, the healthcare facilities' bandwidth capacities, transmission speeds and accessibility to information require annual quality and risk evaluations and associated costs for upgrades and replacements. In a digital environment, bandwidth and internet are considered crucial. Telemedicine is here to stay, and bandwidth and internet speed and availability are indispensable for medical providers and their patients. The current funding for IT is not sufficient to cover upgrades and enhancements to meet the needs of the Navajo Area healthcare facilities. The Navajo Area's IT Modernization Plan's investments target the next three years in core healthcare infrastructure development and maintenance: Patient Care Medical Home (PCMH) model, cloud computing, and Wide Local Area Network (WLAN), wireless voice and radio services. The IT infrastructure must be able to support the mandatory PCMH initiative, a patient care model that supports access to care, case management, and transition of care. The full development of a robust PCMH model requires a reliable IT infrastructure that links a patient's electronic health records to a network of providers of care for real time and almost real-time medical information accessibility to care for and manage the patient. As the digital environment evolves, the hybrid and cloud services will progress to a comprehensive delivery of computing services over the internet – and health care information computing will be part of this advancement and healthcare facilities will need to be prepared to use this platform as part of their daily business practices. Telemedicine practice will double in the next two years, becoming a mainstay of a provider's clinical practice. With the advent of COVID-19 pandemic and possible future pandemics and endemics, healthcare facilities will need to be well organized and prepared to maximize their WLAN, wireless voice, and radio services with their local partners such as counties, states, Tribes, federal and others, i.e., first responders, emergency disaster teams, schools, police, other medical facilities, etc. Delivery of electronic health information to the point of care and across networks of partners is highly dependent on a reliable IT infrastructure.

The Navajo Area's IT infrastructure needs, annually for Fiscal Years 2023, 2024, 2025, 2026, and 2027.

Summary of Spending	FY2023 Planned Total Costs	FY2024 Planned Total Costs	FY2025 Planned Total Cost	FY2026 Planned Total Cost	FY2027 Planned Total Cost
FTE & Contract Costs Total	$8,717,498.00	$8,979,022.94	$9,248,393.63	$9,490,753.86	$9,688,158.90
Hardware Replacement Total	$8,850,814.00	$12,734,158.00	$7,647,922.00	$8,389,974.00	$8,850,814.00
Software Total	$7,081,647.04	$7,081,647.04	$7,081,647.04	$7,081,647.04	$7,081,647.04
Planned Project Total	$5,062,980.00	$6,962,381.00	$3,965,059.00	$5,106,822.00	$5,062,980.00
Planned Cloud Projects Total	$210,000.00	$0.00	$8,500.00	$0.00	$470,000.00
Total Area IT Spending	**$29,922,939.04**	**$35,757,208.98**	**$27,951,521.67**	**$30,069,196.90**	**$31,153,599.94**

2. LINK TO INDIAN HEALTH CARE IMPROVEMENT ACT PROVISIONS, WHERE APPLICABLE.

- SUBCHAPTER I-INDIAN HEALTH PROFESSIONAL PERSONNEL
  - 1616b Recruitment activities.
  - 1616c Tribal recruitment and retention program
  - Tribal health program administration.
- SUBCHAPTER II-HEALTH SERVICES
  - 1621c. Diabetes prevention, treatment, and control.
  - 1621d. Other authority for provision of services.
  - 1621h. Mental health prevention and treatment services.
  - 1621k. Coverage of screening mammography.
  - 1621m. Epidemiology centers.
  - 1621n. Comprehensive school health education programs.
  - 1621q. Prevention, control, and elimination of communicable and infectious diseases.
- SUBCHAPTER III-HEALTH FACILITIES
  - 1638c. Contracts for personal services in Indian Health Service facilities.
  - 1638e. Other funding, equipment, and supplies for facilities.
- SUBCHAPTER V-ORGANIZATIONAL IMPROVEMENTS
  - 1662. Automated management information system.

3. LINK TO GOVERNMENT PERFORMANCE AND RESULTS ACT PERFORMANCE TARGETS AND OUTCOMES.

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

4. LINK REQUESTS TO INDIAN HEALTH SERVICE STRATEGIC PLAN.

The IT budget priority is in line with the modernization of the federal IT initiatives and with the IHS mission to raise the physical, mental, social, and spiritual health of AI/ANs 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/Alaska Native people;

The modernization of IT infrastructure across the Navajo Area will assure recruitment and retention of staff, availability of the latest technology for patient care and training, and the use of tele-medicine technology in clinical practice. Maximum integration of tele-medicine technology into clinical practice will increase access to care.

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

Obsolete and outdated IT systems will be replaced with current technologies that support organizational excellence and quality, and fosters innovation.

3. To strengthen Indian Health Service program management and operations.

To strengthen IHS programs management and operations, a healthcare facility's IT infrastructure and equipment must be advanced and reliable or trustworthy to

handle the volume and complexity of a digital work environment and protects patient privacy and confidentiality of health records. The technology is seamlessly integrated with appropriate medical and non-clinical equipment, health devices, work on computers, and digital platforms. The technology is user friendly, efficient, and dependable to prevent disruptions to patient flow and health care. A modern Information Technology program is central to health accreditation standards, quality improvement initiatives, population health data management, and cyber security.

MAINTENANCE & IMPROVEMENT

1. **HOW THE RECOMMENDED BUDGET INCREASES SHOULD BE ALLOCATED, I.E., WHY EACH INCREASE IS IMPORTANT AND HOW IT WILL AFFECT CERTAIN PROGRAMS OR INITIATIVES. INCLUDE ANY EFFECTS OF PREVIOUS YEARS INCREASES. INCLUDE ANY DATA THAT HIGHLIGHTS EFFECTS OF PREVIOUS YEARS INCREASES.**

The Navajo Area is requesting an increase to the Maintenance & Improvement (M&I) Program major line item budget account. Previous increases in funds were used to support the operation of health care facilities to accomplish its goal of the delivery of health care. Previous M&I funds increases were used for maintenance, repair, and improvement of physical plant (buildings), utility systems (exterior and interior), clinical equipment (medical and often non-medical, grounds, roads, and parking lots, and building service equipment systems that provide the physical environment for patient care.

Organizing these engineering related services include assessing the structure, utilities, and equipment, designing modifications, preparing engineering drawings and specifications for repairs and improvements, and troubleshooting major components or system failures. The funds are also responsible for the realty, clinical engineering, and facilities environmental programs that support patient care activities.

Furthermore, the IHS maintains government owned/leased buildings whether operated by IHS or Tribal health programs pursuant to contract or compact arrangements executed under the provisions of the Indian Self Determination and Education Assistance Act (P.L. 93-638). IHS also provides funding to tribally owned/leased buildings containing health programs pursuant to contract or compact arrangements executed under the provision of the Indian Self Determination and Education Act (P.L. 93-638).

Increased M&I funds will be used to enhance the M&I Program objectives as follow: providing routine maintenance for facilities, achieving compliance with buildings and grounds accreditation standards of The Joint Commission (TJC) or other applicable accreditation bodies, providing improved facilities for patient care, ensuring that health care facilities meet building codes and standards and ensuring compliance with Executive Orders and public laws relative to building requirements, e.g., energy conservation, seismic, environmental, handicapped accessibility and security. Increased funding is essential to ensure functional health care facilities that meet building/life safety codes, conform to laws and regulations, and satisfy accreditation standards. The M&I appropriation has historically been underfunded. The amount of funding historically provided was adequate to fund at the level of sustainment. Sustainment is activities conducted to keep the buildings in their current condition. This is only to keep the building in their current condition with no replacement or upgrades of building infrastructure. In FY 2020, and FY 2021 the IHS received M&I funding beyond the amount required for sustainment. The Navajo Area requests these levels be maintained, as it is needed to address the Backlog of Essential Maintenance, Alternation, and Repair (BEMAR). This is an IHS required report on the current backlog, which now totals approximately $1,022,369,599.00

The Navajo Area currently has a BEMAR need of $230,384,313.00. Included in this need is $59,494,334.00 of mechanical BEMAR. The current HAVC systems in our health facilities are old and need of replacement. A majority of the HVAC units were installed when each facility was originally built. The Navajo Area healthcare facilities age range from six years to 61 years. The oldest facility being our largest facility, the Gallup Indian Medical Center (GIMC).

The COVID-19 pandemic brought to the forefront the problems with the antiquated undersized equipment. Data shows that improving indoor ventilation can reduce the risk of virus transmission. These systems could not be modified or expanded to meet the American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) requirements for air changes. The increased funding will help reduce the mechanical BEMAR of $59,494,334.00.

The increased in M&I funds will incrementally improve the IHS capability to meet sustainment and repair/

replace/improve existing infrastructure and building equipment for each health facility. This increase will help IHS and Tribal facilities to maintain, improve the condition index, and meet accreditation requirements of these facilities.

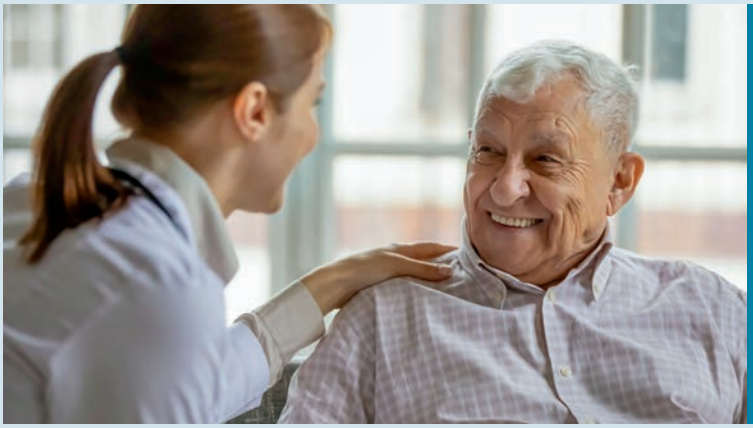
2. LINK TO INDIAN HEALTH CARE IMPROVEMENT ACT PROVISIONS.

- CAPTER 18 – INDIAN HEALTH CARE GENERAL PROVISIONS SEC.
  - » § 1602. Declaration of national Indian health policy.
- SUBCHAPTER II – HEALTH SERVICES
  - » § 1621. Indian Health Care Improvement Fund.
  - » Use of funds.
  - » (J) Maintenance and Improvement.
  - » § 1638a. Tribal management of federally owned quarters.
  - » § 1638f. Indian country modular component facilities demonstration program.
  - » § 1638g. Mobile health stations demonstration program.
- SUBCHAPTER IV – HEALTH SERVICES FOR URBAN INDIANS
  - » § 1656. Other contract and grant requirements.
  - » § 1659. Facilities renovation.
  - » § 1660g. Use of federal government facilities and sources of supply.
- SUBCHAPTER V – ORGANIZATIONAL IMPROVEMENTS
  - » § 1661. Establishment of the Indian Health Service as an agency of the Public Health Service.
- SUBCHAPTER VI - MISCELLANEOUS
  - » § 1674. Leases with Indian Tribes.
  - » § 1680a. Contract health facilities.
  - » § 1680h. Demonstration projects for Tribal management of health care services.

3. LINK TO GOVERNMENT PERFORMANCE AND RESULTS ACT PERFORMANCE TARGETS AND OUTCOMES.

The increase of M&I dollars will allow IHS to keep all existing health care facilities operational and meeting Accreditation standards. Given there are few opportunities to replace healthcare facilities, maintaining current facilities is imperative.

This will allow IHS, Tribes and Tribal organizations to continue to provide health care and to increase and improve the health care of the AI/ANs. This will allow IHS to continue to provide health care and meet the GPRA performance targets and outcomes.



4. LINK REQUESTS TO INDIAN HEALTH SERVICE STRATEGIC PLAN.

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

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

To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible, staff must have a safe place to work. A place where buildings, utility systems, medical equipment, etc. are not constantly breaking down due to aging and lack of parts to make repairs. Funding increase for the M&I Program will support the operation of health care facilities, i.e., maintenance, repair, and improvement of physical plant (buildings), utility systems (exterior and interior), clinical equipment (medical and often non-medical, grounds, roads, and parking lots, and building service equipment systems.

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

To promote excellence and quality through innovation requires daily safe and optimal functioning buildings, utility systems, grounds, roads, and parking lots, and clinical equipment. The Navajo Area's highest priority is assuring that hospitals and clinics are accredited. Accreditation is a display of quality and safe patient care which involves buildings, utilities, medical equipment, and other physical and structural conditions of hospitals and ambulatory clinics. Increased funding of the Maintenance & Improvement Program will not only permit compliance with accreditation standards, but also move towards decreasing the Backlog of Essential Maintenance, Alternation, and Repair (BEMAR) projects. Decreasing the BEMAR projects backlog allows organized M&I projects planning to prevent and mitigate risks involving healthcare buildings, utility systems, clinical equipment, etc. over frequent reactive responses to

break downs of buildings, utility systems, clinical equipment, etc. These break downs repeatedly disrupt and interfere with health care delivery creating frustration and stress of staff and patients. For people to be innovative, they need a safe place to work.

3. To strengthen Indian Health Service program management and operations.

To strengthen IHS program management and operations increased funding for the M&I Program is critical as many of Navajo Area's hospitals and freestanding ambulatory facilities are aged/aging. Many of the existing facilities and building systems are obsolete with an age of 46 years and have long surpassed their useful lives. The age of building systems makes preventative maintenance more intense, increased routine maintenance, and repairs more frequent. Many clinical equipment is aged beyond their useful lives and continue to be used for patient care due to no other alternatives. As the existing health facilities age, associated building equipment and infrastructure also deteriorate to a point of failure. The decreased availability of replacement parts for aged equipment and infrastructure ultimately disrupts the already limited medical service and funds. The constant system failures deplete designated maintenance and improvement funds and requires the use of third-party collections funds that would otherwise be used for direct patient care. The strength of a healthcare system requires reliable buildings, mechanical infrastructure, clinical equipment and so forth, free from breakdowns, disruptions and risks to patient care and staff, and threat to accreditation compliance. The strength of an organization involves retaining and recruiting of staff into a safe environment.

MENTAL HEALTH

1. HOW THE RECOMMENDED BUDGET INCREASES SHOULD BE ALLOCATED, I.E., WHY EACH INCREASE IS IMPORTANT AND HOW IT WILL AFFECT CERTAIN PROGRAMS OR INITIATIVES. INCLUDE ANY EFFECTS OF PREVIOUS YEARS INCREASES. INCLUDE ANY DATA THAT HIGHLIGHTS EFFECTS OF PREVIOUS YEARS INCREASES.

The Navajo Area is requesting a funding increase to the Mental Health major line account category. The COVID-19 pandemic has significantly increased the need for additional Behavioral Health providers for primary care, outpatient mental health and emergency departments. The COVID-19 pandemic has been a catalyst for onsets of new psychosis, increased depression, and suicide rates among AI/ANs. The strategies of social distancing increased isolation and loneliness and is detrimental for individuals with Serious Mental Illness (SMI). Emotional distress related to COVID-19 pandemic leads to relapse of psychotic symptoms and re-hospitalization for acute care.

Acute psychiatric care facilities on the Navajo reservation are non-existent. 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 post-partum 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.

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

1. Realize the prevalence of traumatic events and the widespread impact of trauma;
2. Recognize the signs and symptom of trauma;
3. Respond by integrating knowledge about trauma into policies, procedures; and practices;
4. Seek to actively Resist Re-traumatization. There are often referred to as the "Four R's"."

Inadequate funds lead to insufficient availability of behavioral health workers across the Navajo Nation and San Juan Southern Paiute lands, leading to access to mental health service problems. The continuous breaks in mental health care led to poor patient health outcomes for chronic medical conditions. Services to manage consistent and intensive treatment are needed to engage patients in mental health care and to improve health outcomes. The innovation of tele-medicine 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. LINK TO INDIAN HEALTH CARE IMPROVEMENT ACT PROVISIONS, WHERE APPLICABLE.

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

3. LINK TO GOVERNMENT PERFORMANCE AND RESULTS ACT PERFORMANCE TARGETS AND OUTCOMES.

There are two GPRA measures relevant to the mental health line item budget: 1) Depression Screening and other Mood Disorders for ages 12-17 years old. In 2021, Navajo Area did not meet the national target of 43.20 percent and Navajo Area performance was 27.18 percent and 2) Depression Screening and other Mood Disorders for ages 18 years and older. In 2021, the Navajo Area did not meet the national target of 49.40 percent and Navajo's performance was 38.2 percent. The prior year 2020, the Navajo Area did not meet its two GPRA measures due to COVID-19 pandemic onset. The pandemic caused closure of some health services, including behavioral health care. Though tele-behavioral health technology was activated, many patients could not access computers and/or phones and/or had no local internet connectivity. The pandemic exacerbated access to care issues for patients which in turn impacted the achievement of GPRA measures.

4. LINK REQUESTS TO INDIAN HEALTH SERVICE STRATEGIC PLAN.

In the past increased funding had allowed the Navajo Area to meet its GPRA performance targets for mental health screening for ages 12 and greater and this effort supports the IHS Strategic Plan Mission to raise the physical, mental, social, and spiritual health of AI/ANs 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/ Alaska Native people;**

The implementation of the PCBH model will increase patient access to mental health care for screening, counseling, and intervention therapies/treatments. The COVID-19 pandemic has increased social isolation, emotional distress, and rapid change in activities of daily living skills. The impact of COVID-19 pandemic on patients and the workforce has increased the necessity for additional mental health providers. The trauma associated with the pandemic has compounded the existing historical trauma experience for AI/ANs PCBH will promote comprehensive holistic healthcare, decrease the stigma of mental health, increase access, and early intervention. Training and implementation of evidence based screening and brief interventions for patients presenting with suicide symptoms in the emergency department will enhance access to the appropriate level of care. Suicide surveillance strategies will assist in the migration of suicide rates. Trauma-informed Care Approach will establish a user-friendly hospital environment which will enhance patient confidence and trust. Facilitating Trauma-focused comprehensive treatment interventions will enhance reintegration into the community environment and decrease re-hospitalization for patients with serious mental illness. The collaborative model supports the Navajo philosophy of healing and well-being where the whole person is treated within a network of relationships.

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

Significant innovative efforts have been made to integrate mental health screening and intervention with medical primary care services using the PCBH Model. The Model is a collaborative model that supports population-based care and holistic approach to care. PCBH in collaboration with outpatient mental health services will promote ongoing care for patients with a diagnosis of chronic mental illness to decrease the necessity of long-term care off the Indian reservation and community. PCBH facilitates integration of medical and mental health care with the inclusion of the patient's primary care provider. Primary Care Behavioral aligns with holistic healing which is an integral element among Indigenous practice and beliefs.

Evidence-based interventions will enhance mental health services through the utilization of screening tools and mental health intervention models such as Cognitive-Behavioral Health Therapy. Evidence based practices are established through scientific research to improve mental health outcomes. Comprehensive suicide surveillance will enhance community-based intervention and decrease the rate of acute psychiatric hospitalization located off the Indian reservations. Trauma- Informed Care Approach is being used throughout Navajo Area to promote healing and recovery from the effects of trauma throughout one's life. Trauma-Informed Care is a necessity to enhance

employee and patient satisfaction rates by addressing historical trauma and its impact on current life experiences within relationships, community, and society. Trauma-Informed Care will provide a safe environment to engage in the emotional processing of the COVID-19 pandemic for patients and employees thereby promoting and learning effective coping skills. Trauma-Informed Care is significantly important for Indigenous populations to heal and establish safe environments at home and in the community and society. Trauma-Informed Care will decrease the stigma associated with mental health. Robust development of tele-behavioral health technology and practice throughout the Navajo Area will significantly improve access to care. The increased use of tele-medicine has significantly increased since the COVID-19 pandemic. The challenge of access to services for patients included unreliable transportation, long distance traveling to mental health outpatient clinics, and social-economic limitations. Patients with internet access have been able to mediate these barriers by accessing services through tele-health. Tele-behavioral health is also relied upon for ongoing education and training required for professional staff to maintain current competencies for mental health practices. However, the limited capabilities of internet services have created additional challenges such as slow internet speed, limited network towers, capabilities, and accessibility to specific applications.

3. To strengthen Indian Health Service program management and operations.

To strengthen the Navajo Area's behavioral health program and operation, the following approaches to care, PCBH and Trauma-Informed Care, and the use of a reliable information technology to support the aforementioned best practice models must be fully realized and integrated to achieve excellence with population behavioral health. In addition, staff must be trained to these best practices to achieve the desired outcomes and to ensure technology support for efficient behavioral health practices. The advent of COVID-19 pandemic has forced health care providers to capitalize on digital technology for reaching patients. A significant Information Technology infrastructure development will need to occur on Indian reservations and rural areas of American to improve access to care, including behavioral health care.

REFERENCE:

Agency for Healthcare Research and Quality (AHRQ). (2016). *Trauma-Informed Care.* Retrieved on 01/7/2021 from Website: Trauma-Informed Care | Agency for Healthcare Research and Quality (ahrq.gov)

PUBLIC HEALTH NURSING

HOW THE RECOMMENDED BUDGET INCREASES SHOULD BE ALLOCATED, I.E., WHY EACH INCREASE IS IMPORTANT AND HOW IT WILL AFFECT CERTAIN PROGRAMS OR INITIATIVES. INCLUDE ANY EFFECTS OF PREVIOUS YEARS INCREASES. INCLUDE ANY DATA THAT HIGHLIGHTS EFFECTS OF PREVIOUS YEARS INCREASES.

The Navajo Area is requesting an increase in funding for the Public Health Nursing Program budget category. Increased funding will increase the number of Public Health Nurses in the Navajo communities to carry out skilled nursing care and treatment, community protection work, and emergency readiness work. The Public Health Nursing Program supports registered nurses and ancillary staff in the provision of population-based health care to promote healthier communities through direct nursing services and home visits. Public Health Nursing is a specialty practice that is focused on population health. Skills nursing services and follow up visits are completed for assessment, evaluation, screening, health promotion and/or disease prevention activities for individuals, families, schools, and communities, including well-child examinations, maternal and child health care, and elder care. Public Health Nursing services are provided in the following settings: homes, worksites, educational institutions, and community settings like chapter houses, senior citizen centers, and other congregated sites.

Increased funding will allow hiring of Public Health Technician (Medical) who will serve as front-line health care personnel in support of Public Health Nurses by performing ancillary duties, hence optimizing a Public Health Nurse's education and professional. Technicians permit the availability of a Registered Nurse for more complex nursing duties and strategic planning for population-based health care to meet GPRA performance targets and outcomes. Technicians are dependent upon for adjuvant care and are a vital member of the public health team. In the Navajo communities, there is a continual shortage of Public Health Nurses, and it appears the shortfall will not improve in the near future. For that reason, trained Technicians are vital in strengthening the Public Health Nursing Program and the public health infrastructure.

Increased funding will allow hiring of nursing students into a Public Health Student Intern Program to further their professional development and training in Public Health Nursing. This provides an opportunity not only

for training and development of an individual, but also serves as an excellent recruiting tool to enhance the Indian Health Service and tribal communities and public health workforce.

4. LINK TO INDIAN HEALTH CARE IMPROVEMENT ACT PROVISIONS, WHERE APPLICABLE.

The Fiscal Year 2024 budget request is aligned with the provisions of the IHCIA as follow:

- 1612. Health professions recruitment program for Indians.
- 1616b. Recruitment activities.
- 1616e. Nursing program.
- 1616e–1. Nursing school clinics
- 1616j. Retention bonus.
- 1616k. Nursing residency program.
- 1616l. Community health aide program.
- 1621b. Health promotion and disease prevention services.
- 1621c. Diabetes prevention, treatment, and control.
- 1621d. Other authority for provision of services.
- 1621h. Mental health prevention and treatment services.
- 1621k. Coverage of screening mammography.
- 1621m. Epidemiology centers.
- 1621n. Comprehensive school health education programs.
- 1621q. Prevention, control, and elimination of communicable and infectious diseases.

5. LINK TO GOVERNMENT PERFORMANCE AND RESULTS ACT PERFORMANCE TARGETS AND OUTCOMES.

Promoting population health in the realm of Public Health Nursing is supported by IHS GPRA Performance measures outcomes. During 2021, with COVID-19 pandemic restrictions in place, GPRA performance measures were adversely impacted as it was in 2020.

Below are the 2021 GPRA performance measure results for dental, diabetes, and prevention:

The Navajo Area met zero of the three Dental measures.

- Dental General Access: Target: 26.60 percent; Navajo Area: 18.28 percent.
- Sealants: Target: 13.8 percent; Navajo Area: 6.1 percent.
- Topical Fluoride: 27.6 percent; Navajo Area: 13.69 percent.

Navajo Area met one of the five Diabetes care measures – Statin Therapy.

Statin therapy: Target: 49.0 percent; Navajo Area: 52.66 percent. Four diabetes GPRA measures were not met.

- Controlled Blood Pressure: Target: 59.10 percent; Navajo Area: 44.53 percent
- Nephropathy Assessment: Target: 45.50 percent; Navajo Area: 45.2 percent.
- Poor glycemic Control: Target: 16.80 percent; Navajo Area: 21.76 percent.
- Retinopathy Exams: Target: 51.4 percent; Navajo Area: 42.24 percent.

The Navajo Area met three of the four Immunizations measures.

- Adult Immunizations – all age-appropriate immunizations: Target: 55.1 percent; Navajo Area: 42.44 percent.
- Childhood Immunizations: Target: 42.8 percent; Navajo Area: 51.81 percent
- Influenza Vaccinations for Ages 18 and Over: Target: 24.40 percent; Navajo Area: 25.87 percent.
- The GPRA Measure for Influenza Vaccines for Ages six Month to 17 Years was not met: Target: 26.60 percent; Navajo Area: 27.3 percent.

The Navajo Area met three of the Prevention measures.

- CVD Statin Therapy: Target 33.30 percent; Navajo Area: 40.71 percent.
- Breastfeeding at Age Two Months: Target: 40.0 percent; Navajo Area: 44.32 percent.
- HIV Screening Ever: Target: 32.0 percent; Navajo Area: 44.39 percent.

The GPRA measures that were not met in 2021 were: Mammography Screening: Target: 43.40 percent; Navajo Area: 25.21 percent.

- Cervical PAP Screening: Target: 38.40 percent; Navajo Area: 35.09 percent.
- Childhood Weight Control: Target: 22.60 percent; Navajo Area: 27.46 percent.
- Colorectal Cancer Screening: Target: 32.60 percent; Navajo Area: 30.64 percent. Controlling High Blood Pressure (MH): Target: 42.90 percent; Navajo Area: 38.05 percent.

6. LINK REQUESTS TO INDIAN HEALTH SERVICE STRATEGIC PLAN.

The Public Health Nursing Program promotes specialty registered nursing care in a home setting, provides public health awareness and protection, and supports reducing health disparities. These responsibilities are in alignment with the mission of the IHS which is to raise the physical, mental, social, and spiritual health of AI/ANs 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/Alaska Native people;**

Using culturally appropriate personal and public health services, Public Health Nurses promote public-community awareness for health promotion and disease prevention, conduct educational and clinical care outreach to reduce health risks, and provide surveillance and mitigation of contagious disease outbreaks. The Public Health Nurses in the Navajo Area are part of patients' medical homes, the Primary Care Medical Home Model. Public Health Nurses team up with their local CHR to coordinate a network of nursing care and services delivered in the patients' homes and draw on community resources to support the patients.

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

The Public Health Nurses promote excellence and quality care by using evidenced-based practices to render clinical nursing care and public health and preventive care. Innovations include integrating the Navajo philosophy of wellness and health into western medical practices to allow a holistic approach to caring and treating of an individual patient. This cultural competency approach to healing and well-being allows admissions of kinships or networks of relationships and an individual's community of shared beliefs, values, practices, and general fraternity to aid in healing and promoting well-being.

3. **To strengthen Indian Health Service program management and operations.**

Increased funding for the Public Health Nursing Program will strengthen IHS program management and operations by adding a supply of Public Health Nurses, Public Health Technicians, and Public Health Nurse Interns to the NAIHS healthcare delivery system. The addition of professional nurses and ancillary health workers will alleviate the threat of disruption in patient care and community protection, thereby strengthening the public health infrastructure.

URBAN INDIAN HEALTH FACILITIES

1. HOW THE RECOMMENDED BUDGET INCREASES SHOULD BE ALLOCATED, I.E., WHY EACH INCREASE IS IMPORTANT AND HOW IT WILL AFFECT CERTAIN PROGRAMS OR INITIATIVES. INCLUDE ANY EFFECTS OF PREVIOUS YEARS INCREASES. INCLUDE ANY DATA THAT HIGHLIGHTS EFFECTS OF PREVIOUS YEARS INCREASES.

The Native Americans for Community Action, Inc. (NACA), located in Flagstaff, AZ, is one of 41 Urban Indian Health Programs (UIHP) serving the Urban Indian population. Urban Indians refer to AI/AN individuals who are not living on a reservation, either permanently or temporarily, often because of the federal government's forced relocation policy or lack of economic opportunity. According to the 1990 United States Census, 62 percent of all AI/ANs reside off-reservation. The 1994 Census identified 1.3 million or 58 percent residing in urban areas. NACA was established as a 501C (3) nonprofit organization in 1971. NACA provides services to approximately 6,000 AI/ANs. These services include Primary Health Care, Behavioral Health, Health Promotion, Suicide Prevention, Alcohol/Substance Abuse Prevention, Workforce Investment, and others. Social services offered include rent, utility, funeral assistance, etc. NACA also has an economic development program called the Overlook program where AI/AN artist's sell their arts and crafts to tourists through an agreement with the United States Forest Service (USFS) and as a result produces revenues for both NACA and the artisans.

Currently, NACA leases space for their programs in a central shopping center plaza comprised of 16 suites. Any facility improvements are financed by NACA including all the recent Covid-19 renovations that needed to be completed.

Infrastructure is a problem not only faced by NACA but other UIHPs as well. Many UIHPs are housed in outdated facilities, do not own the facilities, and encounter liability issues. If NACA could utilize IHS funding it receives for Leasehold Improvements, then it could better manage its limited resources and capital on other necessary items. NACA's financial position could improve if

leasehold capital projects could be completed using IHS funding, this in turn would allow the organization to build its financial reserves for a possible property ownership in the future. This is a benefit not only to NACA but just ownership in general.

Currently, there is no UIHP line item for leasehold improvements. The current structure does not allow for growth and improvements, unless the facility is JCAHO accredited, which is difficult to do when there is an older facility out of compliance. For the 70 percent of the AI/ANs who reside in an urban setting, this is not advantageous or economical. Many of the IHS service areas have identified facility construction as one of the top funding issues, from Alaska's "Small Ambulatory Grants Program (SAP) to Nashville Area's recommendations for increased funding for both Maintenance and Improvements and construction funding to support critical maintenance and construction needs.

Approximately 5 percent of the United States annual health expenditures are investments in health care facility construction. In 2018, that $158-billion-dollar investment in health care facility constructions equaled $574 per capita, compared with IHS health care facility (non-Urban Centers) construction appropriation of $77 million, equally $35 per AI/AN capita. The nation invests over 10 times the amount per capita that it appropriates to IHS facility construction. Equipment replacement is another infrastructure expense for NACA. NACA must balance the needs for available capital for leasehold improvements and necessary medical equipment.

2. LINK TO INDIAN HEALTH CARE IMPROVEMENT ACT PROVISIONS, WHERE APPLICABLE.

Regarding the IHCIA provisions, IHCIA does not contain provisions for facility construction funding for UIHPs. Per Title 25 U.S.C, Chapter 18, Subchapter IV. Sec 1659; Facilities Renovation; "The Secretary may make funds available to grant recipients for minor renovations to facilities, or construction or expansion of facilities in meeting or maintaining the JCAHO for Accreditation standards." The ability to make leasehold improvements will enhance and ensure maintenance of accreditation and greatly improve the chances of attaining accreditation for those UIHPs seeking accreditation. One of NACA's goals is to obtain AAAHC accreditation. One of the obstacles has been ensuring the facility meets accreditation standards. For example, in 2019, NACA finally was able to modify its entrance/exit to the health center to become ADA compliant. UIHPs with multiple locations also incur additional basic operating costs, electrical, HVAC and other expenses associated with administering multiple locations. Having leasehold improvement funding will ensure that UIHP facilities meet accreditation standards as well as utilize operating funds much more efficiently.

Access to and continuity of health care and other critical services for AI/ANs will be improved by having adequately sized and equipped facilities. Some of the UIHPs have outgrown their space and lack the resources to expand to meet demand for services, while some have facilities in need of major renovations and repair. For other UIHPs, gentrification has displaced Urban Indian communities to other neighborhoods leading to transportation challenges for AI/AN 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 percent of the 5.2 million AI/ANs reside in urban areas. Historically however, less than 1 percent of the funding provided by the federal government for health care services for AI/AN goes to funding for services at UIHP facilities.

The urban Indian population experiences greater rates of substance abuse, chronic disease, infant mortality, and suicide as compared to all ethnicities from the same Metropolitan Statistical Areas (MSAs). UIHPs have an important role in the safety net and attract a disproportionate share of those without any other resources. In the IHS Office of Urban Indian Health Programs (UIHPs) Strategic Plan for 2019-2023, the number one goal is "To support currently IHS-funded UIHPs in their efforts to address the key challenges they identified for improving and expanding their capacity to provide access to quality, culturally competent health services for urban Indians." This goal is in line with the IHCIA provisions as set forth in the amended version.

Regarding IHS priorities, investment in the necessary resources and infrastructure to sustain urban programs is one of the most essential priorities. Investing in leasehold improvements and capital improvement programs will positively impact the recruitment and retention of a dedicated workforce and allow for improved patient care and quality measures as well as foster local partnerships through contractual arrangements for health

care delivery. The proposed funding allocations will have a tremendous impact on the ability of Urban Indian Health Programs to enhance and surpass current levels of healthcare by increasing appropriations required to meet the health care and other needs of the AI/AN population residing in urban areas. Services that are only available at IHS tertiary facilities need to be reallocated to where the majority of the patient population resides. Moving diagnostic and screening services closer to the urban centers will allow more AI/ANs to take advantage of preventative services and care that is otherwise difficult to obtain.

3. LINK TO GOVERNMENT PERFORMANCE AND RESULTS ACT PERFORMANCE TARGETS AND OUTCOMES.

The allowance for Urban Indian Health Programs to utilize their IHS funding for leasehold improvements, facility renovations, and capital improvements will have a significant impact towards elevating and reaching GPRA measures. With improvements in clinical operational design and facility investment and expansion, barriers for urban AI/AN patients can be addressed and the investment in the future of UIHPs will contribute to achieving the IHS mission of raising the physical, mental, social, and spiritual health of AI/ANs to the highest degree.

4. LINK REQUESTS TO INDIAN HEALTH SERVICE STRATEGIC PLAN.

Investment in the necessary resources to strengthen the infrastructure of Urban Indian health programs through facility renovation, expansion, and overall capital improvements will benefit the individuals served by UIHPs through the recruitment and retention of a dedicated workforce, improved patient care and quality of care, and strengthening of local partnerships through contracted arrangements for health care delivery.

The proposed funding allocations for UIHPs in the FY 2024 budget will have a tremendous impact on the ability of UIHPs to enhance and surpass current levels of healthcare by allowing funding required to take care of 70 percent of the AI/AN population in urban areas.

WATER & SANITATION

1. 1. HOW THE RECOMMENDED BUDGET INCREASES SHOULD BE ALLOCATED, I.E., WHY EACH INCREASE IS IMPORTANT AND HOW IT WILL AFFECT CERTAIN PROGRAMS OR INITIATIVES. INCLUDE ANY EFFECTS OF PREVIOUS YEARS INCREASES. INCLUDE ANY DATA THAT HIGHLIGHTS EFFECTS OF PREVIOUS YEARS INCREASES.

The Navajo Nation and the San Juan Southern Paiute Tribe have more than 3,500 existing homes lacking funding for adequate water and sewer facilities. The total water and sewer economically feasible unmet need is nearly $137 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. Decreased disease rates reduce medical costs. Therefore, increased funding to address this severe backlog in sanitation facilities is requested. The increase in funds will reduce the backlog and will also address the need for sanitation facilities for eligible new homes being purchased and constructed annually.

The Navajo Area includes service to the Navajo Nation and San Juan Southern Paiute Tribe. Past Water and Sanitation Program funds increases have been used for the provision of sanitation facilities as an extension of primary health care delivery. During FYs 2021, 14,311 existing homes and new and like new homes in the Navajo Area received new or improved water, wastewater, and solid waste facilities. 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. LINK TO INDIAN HEALTH CARE IMPROVEMENT ACT PROVISIONS, WHERE APPLICABLE.

Provision of safe water and sanitary waste disposal facilities is referenced in 25 U.S.C. § 1632.

3. LINK TO GOVERNMENT PERFORMANCE AND RESULTS ACT PERFORMANCE TARGETS AND OUTCOMES.

The FY 2021 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 14,311 homes. Increased water and sewer (P.L. 86-121) funding will allow IHS to provide facilities to more homes thus improving the quality of health care services.

While 1 percent of the United States general population lacks access to safe water, 9 percent of Indian homes lack access to safe water. There is a large national backlog of needed sanitation facilities construction projects in Indian Country. With inflation, new environmental requirements, and population growth, the current sanitation appropriations are not reducing the backlog. In addition to providing safe sanitation facilities to existing homes, IHS also provides sanitation facilities to new homes.

4. LINK REQUESTS TO INDIAN HEALTH SERVICE 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 2021, Navajo Area's project duration was 4.57 years, which exceeded the national goal of less than 4.0 years.

Appendix I

Oklahoma City Area Budget Narrative

INDIAN HEALTH SERVICE
FISCAL YEAR 2024 OKLAHOMA CITY AREA BUDGET INSTRUCTIONS
BUDGET RECOMMENDATION NARRATIVE

On November 10, 2021, the Oklahoma City Area Indian Health Service (IHS) convened a meeting with Oklahoma City Area (OCA) Tribal leaders and representatives from IHS, Tribal, and Urban (I/T/U) health systems to discuss the fiscal year (FY) 2024 Budget Formulation process and development of budget recommendations for the National Budget work session.

Two OCA budget formulation representatives were selected. The primary representative is President Terri Parton, Wichita and Affiliated Tribes, and the alternate is Second Chief Del Beaver, Muscogee Nation. Technical representatives are Melissa Gower, Chickasaw Nation; Melanie Fourkiller, Choctaw Nation; Terra Branson-Thomas, Muscogee Nation; Rhonda Beaver, Muscogee Nation; Kasie Nichols, Citizen Potawatomi Nation; Nicholas Barton, Southern Plains Tribal Health Board, and Scott Miller, Sac and Fox Nation; and Ron Grinnell, Iowa Nation.

PROFILE OF THE OKLAHOMA CITY AREA

The OCAIHS serves the states of Oklahoma, Kansas, a portion of Texas, and Richardson County, Nebraska. Forty-three Tribes are represented within the Area with 38 in Oklahoma, four in Kansas, and one in Texas. In FY 2021, the OCA user population was 405,015 the largest user population in IHS. The OCA is the lowest funded IHS Area per capita. The I/T/U health systems within the Area manage eight hospitals, 60 health centers (which includes five health clinics in urban locations) and one regional youth alcohol and substance abuse treatment center. The large number of Tribal health care facilities and programs is a strong reflection of the partnership and cooperation within the OCA to fulfill the existing health care needs of our community.

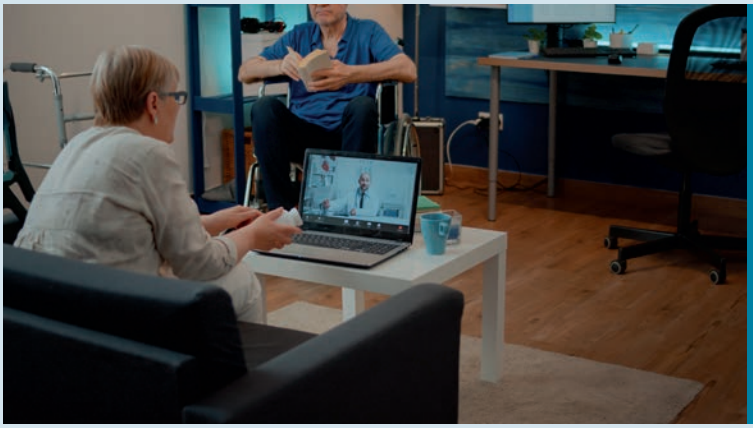
According to the 2019 American Community Survey Five-year report, there are 927,946 American Indians/Alaska Natives (AI/ANs) alone or in combination with one or more other races in the OCA. This represents the potential users for our Area's I/T/U health system that reside within the service area. The 2020 American Community Survey reports and Census 2020 reports by Race and State were not available per the United States Census due to impacts of Covid-19. The estimated release date is March 2022.

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 10 Ranked 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 COVID-19 (U07.1)	3 COVID-19 (U07.1)
4 Accidents (unintentional injuries)	4 Accidents (unintentional injuries)
5 Chronic lower respiratory diseases	5 Chronic lower respiratory diseases
6 Diabetes Mellitus (E10-E14)	6 Cerebrovascular diseases
7 Cerebrovascular diseases (I60-I69)	7 Alzheimer's disease (G30)
8 Chronic liver disease cirrhosis (K70,K73-74)	8 Diabetes Mellitus (E10-E14)
9 Alzheimer's disease (G30)	9 Intentional self-harm, suicide (X60-X84,Y87.0)
10 Intentional self-harm, suicide (X60-X84,Y87.0)	10 Chronic liver disease cirrhosis (K70,K73-74)

Source: Oklahoma State Department of Health (OSDH), Center for Health Statistics, Health Care Information, Vital Statistics 2020, on Oklahoma Statistics on Health Available for Everyone (OK2SHARE). Ranking Based on Age Adjusted Death Rate.



BUDGET RECOMMENDATIONS

1. INDIAN HEALTH CARE IMPROVEMENT FUND (HOSPITALS & HEALTH SERVICES)

IHS faces significant funding disparities when compared to other federal health care programs. The historic allocations of resources appropriated to IHS have created significant inconsistencies throughout the system. Over the years, allocation methodologies have created a disparity of available resources by line items when reflected in a per capita amount. While youth trauma, suicide, and substance abuse treatment are 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 two diabetes or bipolar disorder. In short, quality health services remain a priority for all Tribal citizens. The OCA has historically had the lowest funding per capita amongst the Areas in overall IHS funding, in FY 2021 the OCA per capita amount is $2,228.

The Indian Health Care Improvement Act (IHCIA) established the Indian Health Care Improvement Fund (IHCIF) to eliminate the deficiencies and inequities in health status and health resources in Indian Country. Despite significant AI/AN health disparities and a legislative mechanism to address resource deficiencies and inequities, only $258.8 million has been distributed to IHS Service Units, Indian Tribes, or Tribal organizations through the IHCIF via the Level of Need (LNF) formula since adopted in 2001. While Tribes are appreciative of the 2018 allocation of $72.28 million, the IHCIF was not allotted additional funding in FY 2019, FY 2020, or FY 2021. 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 ICHIF. Unfortunately, gains in parity also have been negated by rescissions and sequestration. All areas of IHS are underfunded; however, the most underfunded units require immediate attention.

In FY 2024, 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, IHS drafted the final report and requested workgroup input, however, to date IHS has not released a report. The OCA strongly suggests IHS, and the workgroup complete the report and forward to the IHS Director so a final determination can be made. OCA specifically requests the following:

- Complete the final report with recommendations on the new allocation methodology for the IHCIF; and
- Through Tribal consultation, the IHS Director adopt the recommendations on the new allocation methodology for better articulation of the IHCIF in the future; and
- Communicate with all Tribes the new allocation methodology for the IHCIF; and
- Update the data in the IHCIF allocation methodology and release to all Tribes annually; and
- Identify and train new permanent statistical/technical staff as point of contact for future IHCIF need calculations; and
- Reduce per capita disparities for the most underfunded as the top priority to promote greater equity in health care funding.

Any major increases in funding for the Indian Health system should be distributed through the IHCIF formula to ensure all increases are equitable and fair which will ensure greater access to high quality, culturally appropriate care, and services across the I/T/U system for the ever-increasing user population.

2. MAINTENANCE & 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 United States 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 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 2024 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

Purchased Referred Care (PRC) 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 $308.92 per person for FY 2021. 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 2021, the numbers of PRC denied cases were 25,134 and deferred cases totaled 47,587 for those facilities reporting. Of the deferred cases, over 92 percent were for acute and chronic care. In FY 2021, OCA Catastrophic Health Emergency Fund (CHEF) reimbursed cases was approximately $3.8 million. Furthermore, in the five years (2014-2018), the OCA averaged over 18 percent of funded CHEF cases nationally but was funded at only at 11 percent on average for the PRC program when compared to all other IHS Areas combined.

Again, the OCA does not have adequate funding for specialists, such as cardiologists, oncologists, and specialized surgeons, readily available. OCA does not have tertiary hospitals and must utilize PRC to provide that aspect of specialty care. The cost of providing such services is disproportionately burdensome on all PRC resources. The existence of IHS/Tribal hospitals in OCA does not mean there are specialty services available, which must be purchased, nor timely access to direct services, due to waiting times for appointments.

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

Due to the lack of PRC resources available per patient, IHS-eligible individuals are routinely denied access to needed care until the situation is grave enough to threaten life or limb. Routinely denied and deferred services consist of orthopedic diagnostics and treatment, which often prevents AI/ANs from being in the workplace. Other services, such as sophisticated diagnostic procedures, are also often denied or deferred due to medical priority.

The OCA recommends continuing increased funds for PRC by making it a high national priority. The OCA also recommends that distribution continue to be primarily based upon the patient population to be served with PRC.

Although the positive impact of Medicaid expansion has been profound on a national level, IHS has noted that Oklahoma City Area remains one of the few IHS Areas that still only fund Priority Level one 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. In its 2019 report, numbered GAO-19-612, the Government Accountability Office (GAO) 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 one) to funding nearly all types of care covered by the PRC program.

Prioritization of PRC directly contributes to access to care described in Goal one of the IHS Strategic Plan, which states:

Access: Many facilities operated by 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.1

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 & HEALTH CLINICS, INCLUDING HEALTH INFORMATION TECHNOLOGY

Hospitals & Health Clinics (H&HC) in the OCA funds essential personal health services for a user population of 405,015 AI/ANs including medical and general surgical inpatient care, routine and emergency ambulatory care, and medical support services including laboratory, pharmacy, nutrition, diagnostic imaging, physical therapy, and health information management. The IHS system of care is unique in that personal health care services are integrated with community health services. In addition, the program includes public and community health initiatives targeting health conditions disproportionately affecting AI/ANs such as diabetes, maternal and child health disparities, unintentional injuries and communicable diseases including influenza, HIV/AIDS, and hepatitis. Data collection, analysis, and interpretation is done through Department of Health and Human Service (HHS) and IHS (2019) IHS Strategic Plan. Retrieved from partnerships with area epidemiology centers throughout IHS service areas leading to the identification of health conditions as well as promoting interventions.

https://www.ihs.gov/sites/strategicplan/themes/responsive2017/display_objects/documents/IHS_Strategic_Plan_FY%202019-2023.pdf

The increase is critically needed to help fund increasing staffing costs, primarily in rural America. IHS has seen a drastic surge in population over the last 10 years without a sufficient increase in funding to support the added population. The OCA saw a 24.1 percent increase in User Population from 2010-2021, as reflected in the table.

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*(l)* leases. 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, IHS has seen an increase of almost 10 percent in pharmaceutical expenditures. OCA must continue to provide life-saving medications used to treat heart failure and diabetes, even though drug costs continue to rise. H&HC funding must increase to meet this critical need.

Finally, screening and early detection efforts, which are known to be lifesaving through preventative and managed care, have not historically been funded. Within the OCA, there is an increased need to focus on early detection of cancer, diabetes, and heart disease as well as communicable diseases like HIV and Hepatitis C, so intervention at an early stage can prevent other chronic conditions from co-occurring or in some cases, cure the disease altogether.

5. HEALTH INFORMATION TECHNOLOGY

The Roadmap Report developed by HHS laid out several priorities and plans, including establishment of a Project Management Office and governance structure, acquisition planning, Health Information Technology (HIT) selection and procurement, implementation planning, and testing. While recent reports have not been driven by this report, 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 (EHR) 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 EHR patient portal and telemedicine) public health emergencies and initiatives have historically primarily been funded through the H&HC budget. Due to the complexity of HIT and the need to transition, store, and improve legacy systems, OCA continues to recommend that a new separate line item is essential.

6. URBAN FACILITIES

Although 78 percent of AI/ANs reside in urban areas, the IHS funding allocation for Urban Indian Health only reflects close to 1 percent of the total annual IHS budget. The Urban Indian Health budget request is at $749 million for FY 2024 for essential funding to support and sustain the capacity demand on programs, to support ongoing chronic effects of the COVID-19 pandemic, and to address the systemic gap in social determinants of health. In addition, Urban Indian Organizations (UIOs) do not receive funding from other line items which the other facets of the IHS system receive, such as the facilities line item budget. Since 1988, $13.3 billion in facilities funding has been allocated to IHS, however, UIOs are not eligible for the IHS Facilities or Sanitation line items and zero of the 41 UIOs are on the IHS Facilities Priority List or are eligible to be on the list. In FY 2021, IHS received over $900 million in facilities funds that UIOs are not eligible for and the recently passed Infrastructure Investment and Jobs Act includes $3.5 billion for the IHS sanitation facilities construction program, which excludes UIOs. It is critical that all three parts of the I/T/U (IHS, Tribal Health Program, UIO) system receive adequate facility funding to better serve the AI/AN population.

UIOs are also ineligible for other payment options that reduce costs for the other facets of the IHS system – including 100 percent Federal Medical Assistance Percentage (FMAP). Historically, in the I/T/U system, only UIOs have been excluded from the 100 percent FMAP rate. Because services provided at UIOs have not been reimbursed by the federal government at 100 percent, UIOs receive less third-party funds, limiting their ability to collect additional reimbursement dollars that can be used to provide additional services or serve additional patients. The American Rescue Plan Act temporarily authorized 100 percent FMAP for services at UIOs for two years, however, permanently authorizing this rate is crucial for UIOs to better provide services to urban Indians.

There is a total of 41 UIOs spanning across 22 states, including five UIOs in the Oklahoma City Area: Hunter Health in Wichita, KS; Kansas City Indian Center in Kansas City, MO; Urban Inter-Tribal Center of Texas in Dallas, TX; Indian Health Care Resource Center in Tulsa, OK; and Oklahoma City Indian Clinic in Oklahoma City, OK. These UIOs are operating pursuant to a grant or contract under Title V of the Indian Health Care Improvement Act and embody the third prong of the Indian health care delivery – I/T/U system. Because UIOs receive substantially less funding from the IHS budget, they are often faced with the harsh reality of obtaining supplemental sources of funding to provide more services to more AI/ANs living in urban areas.

It is recommended we prioritize urban Indian health funding as a part of our Tribal health priorities to advocate that Congress increase the budget to appropriate funding levels for all AI/ANs.

Appendix J

Phoenix Area Budget Narrative

INDIAN HEALTH SERVICE
FISCAL YEAR 2024 PHOENIX AREA
BUDGET INSTRUCTIONS
BUDGET RECOMMENDATION NARRATIVE

The Annual Phoenix Area Indian Health Service (PAIHS) Budget Formulation process was conducted virtually over three-hour meetings on November 17, 2021, December 2, 2021, and December 17, 2021. The outcome of the sessions was an agreement on a full funding recommendation for the fiscal year (FY) 2024 Indian Health Service (IHS) budget at $51.3 billion per the instructions of the IHS National Tribal Budget Formulation Workgroup.

SESSION I – 11/17/21

At this meeting, Dr. Charles Reidhead, Director of the PAIHS, welcomed the Tribal leaders, Tribal Health Directors, and Urban Indian Organization (UIO) officials and provided an Area update. Chairman Rupert Steele gave the opening prayer. Ms. Carol Chicharello, the Executive Officer, facilitated the meeting. Dena Wilson, M.D., Chief Medical Officer, PAIHS, gave a presentation on the Phoenix Area Health Status. It included detail on demographics, leading causes of American Indian/Alaska Native (AI/AN) mortality in the Phoenix Area and by state, medical service trends, and Government Performance Results Act (GPRA) results. Reported and discussed was the IHS national and Phoenix Area Covid-19 information on daily and cumulative positive test results in 2020 by month and the positivity rate (seven-day rolling averages) in 2020.

A principal focus of the meeting was to provide the FY 20224 timeline, instructions, and required deliverables. Ms. Angela Lindsay and Ms. Arikah Kiyanni-McClary, Area Finance staff, provided information on the current IHS budget and the status of the FY 2022 and FY 2023 Budget Requests. At this meeting, last year's FY 2023 Phoenix Area and National recommendations were presented. Updates were provided on activities under the PAIHS Office of Health Programs, Purchased Referred Care, and the Indian Health Care Improvement Fund Workgroup. PAIHS Finance staff reviewed the FY 2024 spreadsheet and informed the participants that the formulation process will involve building on the FY 2023 Phoenix Area national budget recommendation of $48 billion to develop a budget at the $51 billion level. Attendees were informed that the Inter-Tribal Council of Arizona, Inc., PAIHS contractor, will complete deliverables (two through four) for the budget formulation process. Area staff announced that nominations for the Area Representatives would be accepted from each Tribe via letter or email. After nominations close, a voting process will occur via email.

SESSION II – 12/2/21

Ms. Carol Chicharello facilitated the meeting, and Councilmember Delia Carlyle of the Ak-Chin Indian Community gave the opening prayer. At this meeting, updates were provided by the PAIHS Office of Environmental Health and Engineering (OEHE) and the Phoenix Indian Medical Center (PIMC). PAIHS contractor Alida Montiel, on behalf of the Inter-Tribal Council of Arizona, Inc., facilitated the discussion on "hot issues" and requested that the Tribes/UIOs complete the form provided to list their respective hot issues or submit them to her via email. The bulk of the meeting was to discuss 1) Summary of FY 2023 National Recommendations, 2) Overview of Budget Worksheet, and 3) Significance of Full Funding Amount and Current Services and Binding Obligations. The Tribes were able to begin to identify priority line Items and recommendations for FY 2024.

SESSION III – 12/17/21

Ms. Carol Chicharello facilitated the meeting and held a moment of silent prayer. She provided a recap of meetings one and two and noted that an updated zip drive with all the budget formulation presentations and meeting documents had been emailed to Tribal leaders, Tribal health, and urban Indian officials for the meeting. It was reported Tribes had nominated three individuals to serve as the Phoenix Area Representatives for this year's budget formulation process and that the results of the confidential voting process were closed, but it was announced that two nominees received the most votes. They are Amber Torres, Chairman of the Walker River Paiute Tribe, and Jessica Rudolfo, Tribal Health Director of the White Mountain Apache Tribe. ITCA staff reported on the hot

issues submissions, and questions from previous meetings were clarified. These pertained to how the $337.5 million proposed amount for 105*(l)* was determined if traditional healing practices were authorized in the Indian Health Care Improvement Act, the methodologies to determine fixed costs and binding obligations, and examples of mandatory programs.

The principal focus of the meeting was for the Tribes to complete their recommendations that were incorporated on the spreadsheet and submitted to IHS Headquarters by PAIHS today. The final Tribal/UIO recommendations are as follows:

RECOMMENDATION I:

Tribes and UIOs in the PAIHS FY 2024 Budget formulation process concur with and recommend a total budget of $51.3 billion. The additional $1.16 billion includes a $310.2 million *program increase* and specific adjustments over the Phoenix Area's FY 2023 Tribal budget recommendation in the following line items:

- **Hospitals & Clinics:** Electronic Health Record/ Telehealth +$285 million
- **Mental Health** +$10 million (Due to elimination of the "Community Health" line item).
- **Dental Health** +$10 million
- **Community Health Representatives** +$5 million (Due to elimination of the "Community Health" line item)
- **Maintenance & Improvement** – PIMC Labor/Delivery +$13.2 million
- **Direct Operations** – Self-Governance +$5 million
- **Direct Operations** - Section 105*(l)* Lease Cost Agreements +$250,000
- **Binding Obligations** - Section 105*(l)* Lease Cost Agreements +$5 million

RECOMMENDATION II:

- Priority funding was determined based on the highest percentage changes over the FY 2021 IHS.
- Enacted Budget in many line items that Tribes/UIOs noted have become especially critical when addressing the COVID-19 pandemic across all levels of the Indian health care system. Further, these services and infrastructure need to connect to provisions of the Indian Health Care Improvement Act (IHCIA) (25 U.S.C. Chapter 18), passed into law in 1976 and permanently reauthorized in 2010. It contains a declaration of national Indian health policy that states it is the policy of the nation in fulfillment of its special trust responsibilities and legal obligations to Indians— (1) to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to affect that policy. It was a notable achievement that cannot be ignored as the law guides the delivery of health care services by IHS, Tribes, and Urban Indian Organizations.

PRIORITY 1

Mental Health +$514 million – The program increase of $514 million, of which the major portion is to address the IHCIA unfunded mandates, includes $10 million for Community Health Representatives (CHR) capacity building and expansion of CHAP Behavioral Health Aides in the lower 48 states.

The IHCIA provisions aligned with this priority include:

- SUBCHAPTER V–A—BEHAVIORAL HEALTH PROGRAMS (§ 1665 et al.) PART B—INDIAN YOUTH SUICIDE PREVENTION (§ 1667 et al.)
  - » § 1680u. Traditional health care practices
  - » § 1616l (d). Nationalization of the Community Health Aide Program

PRIORITY 2

Health Education +$71.2 million – The program increase of $71.2 million will elevate the chronic static funding in this line item to address a wide range of health education initiatives that will help close the gaps in health care disparities across Indian Country.

The IHCIA provisions aligned with this priority include:

- » § 1621n. Comprehensive school health education programs
- » 1621q. Prevention, control, and elimination of communicable and infectious diseases

PRIORITY 3

Equipment +$154 million – The program increase of $154 million was identified in FY 2023 and remains a top concern in FY 2024 to provide extra support for smaller Tribes.

The IHCIA provision aligned with this priority includes:

- » § 1621c. (d) Dialysis programs
- » § 1638e. Other funding, equipment, and supplies for facilities

PRIORITY 4

Hospitals & Clinics +$9.95 billion – The major increase of $9.95 billion includes several Phoenix Area priorities noted in last year's FY 2023 recommendation that we seek to advance in FY 2024 under H&C:

- +$7.75 billion for the H&C program increase
- +$1.5 billion for Elder Health
- +$570 million for Health Information Technology Modernization/Broadband
- +$42 million for Telehealth
- +$30 million for Traditional Healing
- +$15 million for Extra Support for Small Tribes
- +$12 million for Rocky Mountain Spotted Fever (RMSF) epidemic affecting Tribes, especially in the Southwest.
- +$5 million for CHR (Public Health Emergency Response)

The IHCIA provisions aligned with this priority include:

- » § 1616. Community Health Representative Program.
- SUBCHAPTER II—HEALTH SERVICES (§1621. Et al.)
  - » § 1660h. Health information technology
  - » § 1680l. Shared services for long-term care

PRIORITY 5

Community Health Representatives +$233 million - The program increase of $233 million addresses long-term static funding in Tribal/Urban CHR services, including salary enhancement and CHAP Community Health Aide program implementation in the lower 48 states.

The IHCIA provisions aligned with this priority include:

- » § 1616. Community Health Representative Program
- » § 1616l (d). Nationalization of the Community Health Aide Program
- » § 1621q. Prevention, control, and elimination of communicable and infectious diseases
- » § 1660f. Title 1 – Subtitle E. Health Services for Urban Indians – CHR

PRIORITY 6

Health Care Facilities Construction +$18.8 billion - The program increase identified in FY23 remains a top concern in FY24. $18.8 billion would fund the following:

- +$2.02 billion for the Current HCFC Priority List
- +$2 billion for Urban Indian facility renovation
- +$14.5 billion for the new National IHCIA new construction system
- +$360 million for Long Term Care facilities (IHCIA)

The IHCIA provisions aligned with this priority include:

- SUBCHAPTER III—HEALTH FACILITIES (§1631 et al.)

PRIORITY 7

Maintenance & Improvement +$1.15 billion - The program increase identified in FY 2023 remains a top concern in FY 2024. $1.15 billion will provide necessary upgrades to IHS/Tribal health care facilities to maintain quality in older facilities. Designated amounts are identified for the following:

- +$1.12 billion for Backlog of Essential Maintenance, Alteration, and Repair (BEMAR)
- +$12 million for Long Term Care/Assisted Living/ Hospice Facilities
- +$10 million for Small Tribes
- +$13.2 million for PIMC Obstetric Labor & Delivery Department

The IHCIA provisions aligned with this priority include:

- » § 1621. Indian Health Care Improvement Fund
- » § 1680a. Contract health facilities

The Indian Health Facilities Act of 1957 (Public Law 85-151) pertains to this line item.

PRIORITY 8

Urban Health +$92.6 million - The program increase of $92.6 million identified in FY 2023 remains a top concern in FY 2024. This line item has remained static for too long. Services must be aligned and enhanced across the Indian health care system.

The IHCIA provisions aligned with this priority include:

- SUBCHAPTER IV—HEALTH SERVICES FOR URBAN INDIANS §1651. et. al.

PRIORITY 9

Dental Health +$414 million - The program increase of $414 million identified in FY 2023, plus an additional $10 million for Dental Therapy identified in FY 2024, reflects that oral health care remains a top concern. These are essential health care services that impact the whole health of our population.

The IHCIA provisions aligned with this priority include:

- § 1616l. Community health aide program
- § 1621. Indian Health Care Improvement Fund (§ 1621 et al.)

PRIORITY 10

Alcohol/Substance Abuse +$706 million - The program increase of $706 million identified in FY 2023 remains a top concern in FY 2024. The increase is needed to implement the Comprehensive Behavioral Health Prevention and Treatment Program authorized by the Indian Health Care Improvement Act (25 U.S.C. §1665c) in 2010.

The IHCIA provisions aligned with this priority include:

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

Appendix K

Portland Area Budget Narrative

INDIAN HEALTH SERVICE
FISCAL YEAR 2024 PORTLAND
AREA BUDGET INSTRUCTIONS
BUDGET RECOMMENDATION NARRATIVE

Tribal Representatives

- Nickolaus Lewis, Lummi Nation, Secretary, Primary Representative, Northwest Portland Area Indian Health Board (NPAIHB) Chair
- Andy Joseph, Jr., The Confederated Tribes of the Colville Reservation Chairman, Alternate Representative, NPAIHB Delegate

Technical Representative: Northwest Portland Area Indian Health Board

- Laura Platero, Executive Director
- Elizabeth J. Coronado, Senior Policy Advisor

Indian Health Service Representatives

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

CONSULTATION

Portland Area Indian Health Service (IHS) held a virtual consultative meeting on November 16, 2021, with the NPAIHB and the Area's 43 Tribes. Following a thorough discussion of the Area Tribal health care needs, the Portland Area IHS national fiscal year (FY) 2024 budget recommendations were established, as highlighted below.

SUMMARY OF FY 2024 BUDGET RECOMMENDATIONS

The national budget mark for FY 2024 is a full funding request of $51 billion. Except for funding a regional specialty referral center, Portland Area Tribes do not support additional funding in Health Care Facilities Construction (HCFC) due to decades of non-funding for the 43 Tribes in Portland. Portland Area Tribes recommend that the Health Care Facilities Construction Priority System be reformed to ensure equity across areas in new health care facility construction and staffing.

Portland Area National Budget Recommendation Summary
(Dollars in Thousands)

Budget Line Item	PAO FY24 National Budget Recommendation Total	PAO FY24 National Recommendation Percentage by Budget Line Item
Purchased/Referred Care	$29,501,347	57.85 percent
Hospitals and Health Clinics	$5,594,291	10.97 percent
Alcohol & Substance Abuse	$3,075,075	6.03 percent
Mental Health	$2,973,083	5.83 percent
Maintenance & Improvement	$2,310,131	4.53 percent
Urban Health	$1,820,567	3.57 percent
Indian Health Professions	$1,677,777	3.29 percent
Dental Services	$764,944	1.50 percent
Electronic Health Record System (New)	$713,948	1.40 percent
Sanitation Facilities Constr.	$698,649	1.37 percent
Equipment	$566,059	1.11 percent
Comm. Health Reps	$331,476	0.65 percent
Public Health Nursing	$290,679	0.57 percent
Facility & Environment Health Supply	$275,380	0.54 percent
Health Education	$244,782	0.48 percent
Direct Operations	$114,742	0.23 percent
Health Care Fac. Constr.	$35,697	0.07 percent
Self-Governance	$7,649	0.01 percent
Total	**$50,996,276**	**100.00 percent**

CURRENT SERVICES

FUND PAY COSTS, INFLATION, AND POPULATION GROWTH

IHS-funded programs have absorbed significant inflationary cost increases over the past twenty years. Tribal and Federal 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 (CSC) indefinite appropriations to ensure full funding required to support contracted or compacted programs.

BUDGET LINE ALLOCATION JUSTIFICATION

PURCHASED/REFERRED CARE

Portland Area IHS recommends allocating $29.5 billion or 57.85 percent of the total FY 2024 budget to the Purchased/Referred Care (PRC) budget line item. Portland Area IHS does not have hospitals or specialty care centers. Thirty percent 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).

HOSPITALS & CLINICS

Portland Area IHS recommends allocating $5.6 billion or 10.97 percent of the total FY 2024 budget to the Hospitals & Clinics (H&C) budget line item. The budget will partly support the Community Health Aide program expansion, Affordable Care Act (ACA), Indian Health Care Improvement Act (IHCIA), long-term care, restore pay act increases, regional specialty referral center, and Tribal epidemiology centers.

Community Health Aide Program Expansion:

Portland Area Tribes support increased funding for the Community Health Aide Program (CHAP) expansion, authorized in the IHCIA under Section 1111; and increased funding for the Community Health Representative (CHR) budget line, authorized under IHCIA Section 165. Portland Area Tribes have led the way in CHAP expansion in the lower 48. Portland Area IHS is the first to establish a program and Certification Board.

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

The ACA includes amendments and permanent reauthorization of the IHCIA. 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. Funding is required to implement the ACA further and carry out new IHCIA authorities.

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 an additional need for facilities and infrastructure to comprehensively support these programs, which can be cost-prohibitive. Portland Area recommends developing long-term care programs with staffing. Carrying out home and community-based services 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.

Restore Pay Act Increases:

Restore past years' unfunded pay costs resulting from a federal moratorium on Pay Act increases. Competitive compensation is required for the IHS and Tribes to retain employees. Reductions under sequestration in FY 2013 have not been fully restored, further eroding the agency's purchasing power. Nationally, there is increased competition to recruit and retain qualified and competent providers, creating an increased need for recruitment and retention pay and additional market pay to attract applicants.

Regional Specialty Referral Center:

Portland Area IHS requests funding for a Regional Specialty Referral Center under IHCIA, Section 134, Indian Health Care Delivery Demonstration Projects. The Area also requests 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.

Tribal Epidemiology Centers:
Within the IHS, there are 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, managing disease prevention and control programs, respond to public health emergencies, and coordinate activities with other public health authorities.

ALCOHOL/SUBSTANCE ABUSE AND MENTAL HEALTH
Portland Area IHS recommends allocating $3 billion or 6.03 percent of the total FY 2024 budget to the Alcohol and Substance Abuse budget line item and $2.9 billion or 5.83 percent to the Mental Health budget line item.

Behavioral Health:
The provisions of IHCIA allow for expansions to the behavioral health programs, which have not received substantial funding since enacted. Funding increases would be used to implement IHCIA Section 702 to expand behavioral health care for prevention and treatment and Section 704 to provide more comprehensive care through detox, psychiatric hospitalization, and community-based education and rehabilitation programs. The Area would also like IHCIA Section 705 funded to expand the use and dissemination of a Mental Health Technician Program to serve patients and 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 mental health and inpatient care.

MAINTENANCE & IMPROVEMENT AND SANITATION FACILITIES CONSTRUCTION
Portland Area IHS recommends allocating $2.3 billion or 4.53 percent of the total FY 2024 budget to the Maintenance and Improvement budget line and $698 million or 1.37 percent to Sanitation Facilities Construction. Portland Area recognizes that past years' budgets have not included increases necessary to address the ongoing backlog of facilities infrastructure.

URBAN HEALTH
In part, Portland Area IHS recommends allocating $1.8 billion or 3.57 percent of the total FY 2024 budget to the Urban Indian Health budget line item to allow Urban Indian Organizations to purchase insurance for their users.

INDIAN HEALTH PROFESSIONS
Portland Area IHS recommends allocating $1.6 billion or 3.29 percent of the total FY 2024 budget to the Indian Health Professions budget. Increased funding for Indian Health Professions for the IHS Scholarship Program and Loan Repayment Program would support workforce development and recruitment and retention efforts in the Northwest. This will be especially important now that CHAP Providers are eligible for the Loan Repayment Program.

Workforce Development:
IHCIA Sections 127, 165, 193, 705, 710, 712, 713, and 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). Funding increases are needed to address chronic and pervasive health care provider shortages.

ELECTRONIC HEALTH RECORDS
Portland Area IHS recommends allocating $713 million or 1.40 percent of the total FY 2024 budget to the Electronic Health Record Systems budget line.

Health Information Technology (HIT) Modernization:
The resource and Patient Management System (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 dependent on core coding from the VA. Substantial IT infrastructure and software investment is needed to maintain RPMS or transition to another system. 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.

ENVIRONMENTAL HEALTH SUPPORT

Portland Area IHS recommends allocating $275 million or .54 percent of the total FY 2024 budget to the Environmental Health (EH) program.

Public Health:

The Environmental Health (EH) Program addresses environmental determinants of health in Al/AN communities 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.

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 than non-Hispanic Whites (NHW) in the region, with more considerable disparities observed for lung, colorectal, and liver cancers (1.5, 2.6, and 3.2 times higher for AI/AN). One factor contributing to these disparities is limited access to cancer screening. In 2020, less than 30 percent of Portland Area IHS patients received age-appropriate breast, cervical and colorectal cancer screenings.

BEHAVIORAL HEALTH

Mental Health and Suicide Prevention:

According to the 2014 trends in Indian Health, AI/ANs have a 60 percent greater chance of suicide than other United States races. Suicide is the seventh leading cause of death among AI/ANs in the Portland Area and accounts for 4 percent of all deaths among AI/ANs. Suicide mortality rates for AI/ANs are 60 percent higher than non-AI/ANs in the region. AI/AN suicide mortality in ages 10-29 is two to three times greater than that for non- AI/ANs. AI/ANs in the Northwest are more likely to report depression or poor mental health than non-Hispanic Whites. Over 30 percent of adult AI/ANs in the Northwest report having been diagnosed with depression. AI/ANs 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.

The COVID-19 pandemic has exacerbated the burden of mental illnesses and suicide among Northwest AI/AN communities. Emergency department visits for suicide ideation and attempts increased between 2019 and 2020. Most suicide-related emergency department visits among AI/ANs occur among younger people ages 10-29.

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/ANs, and almost 2.5 times more likely to die from a drug overdose than non-AI/ANs. Opioids are involved in nearly 70 percent of AI/AN overdose deaths, and methamphetamine is involved in over 30 percent of AI/AN overdose deaths in the Northwest. During the first year of the COVID-19 pandemic, emergency department visits for overdoses increased sharply among young AI/AN people less than 17 years of age.

Intimate Partner Violence and Sexual Assault:

According to the United States Department of Justice, AI/AN women are 2.5 times more likely to be raped or sexually assaulted than women in the United States in general. 34.1 percent of AI/AN women will be raped during their lifetime. In the Northwest, AI/AN people are 40-70 percent more likely than White people to seek care at an emergency room for sexual violence. It is widely accepted that these statistics do not accurately portray the extent of the sexual violence against AI/AN women.

Trauma:

Up to 74 percent of AI/AN youth have experienced at least one traumatic event during childhood. AI/ANs are two to three times more likely to meet Post Traumatic Stress Disorder (PTSD) criteria than the United States adult population. AI/ANs have a 2.5 times greater risk than the national average of experiencing physical, emotional, and sexual abuse. AI/AN communities experience a layering effect of these conditions and historical trauma.

DIABETES

In the Portland Area, approximately 15 percent of AI/AN adults report being 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 but also have high rates of complications and uncontrolled diabetes and a higher mortality rate due to diabetes.

INJURY PREVENTION

Unintentional injuries are the leading cause of death for AI/ANs from age one 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 percent), falls (29 percent), accidental poisoning/overdose (27 percent), and accidental drowning (3 percent).

CARDIOVASCULAR, HEART DISEASE, AND STROKE

The prevalence of cardiovascular disease (CVD) risk factors among AI/ANs is significant, with 63.7 percent of AI/AN men and 61.4 percent of AI/AN women having one or more CVD risk factors. In the Northwest, approximately 8 percent 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 than 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 have increased in Portland Area, and the proportion of patients with these diseases benefit from treatment with greater percentages of 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 about 29 percent of AI/AN adults are overweight or obese.

Approximately 25 percent of AI/AN adults in the Northwest are current cigarette smokers. In 2018, 38 percent of AI/AN twelfth 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 percent of AI/AN adults in Oregon report being current e-cigarette users.

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 United States. More than one out of three AI/AN children (37 percent) have untreated decay between 1 and 5 years of age. Almost 40 percent of AI/AN two-year-olds have experienced tooth decay, indicating the need for early prevention efforts.

Nationally, 66 percent of adolescent (ages 13-15) IHS patients have experienced tooth decay, and 53 percent have untreated tooth decay. AI/AN dental patients are more than twice as likely to have untreated tooth decay compared to the general United States 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 unique to the elderly population require developing 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 IHCIA 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 considering 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 in the general United States 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 three 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 fourth leading cause of death among AI/ANs in the Northwest. AI/ANs are four times more likely to die from chronic liver disease and cirrhosis than the general population. Many deaths are attributed to liver cirrhosis 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 two to four and a half times the risk of dying from hepatitis C compared to non-Hispanic Whites.

OTHER COMMUNICABLE DISEASES

In 2016, 8.7 percent of AI/AN hospitalizations were due to infectious causes, compared to 6.4 percent for non-AI/ANs. AI/ANs are 1.6 times more likely to die from influenza and pneumonia than 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 to chlamydia infections and are diagnosed at over three times the rate of their male counterparts. In 2017, Northwest AI/ANs were three 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 than 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 nationwide in the Northwest. 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 and hospitalization rates, respectively, 1.6 and 3.3 times higher than non-Hispanic Whites. COVID-19 deaths are estimated to be 2.2 times higher for AI/AN people than non-Hispanic Whites. In the Northwest, the ongoing pandemic appears to exacerbate the burden of mental health and substance use disorders among AI/AN people. The pandemic has exposed the need for continued investment in 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 percent (compared to 1.5 percent in women in the United States population). Overall, AI/ANs experience higher rates of rheumatic diseases and 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 IHS, NPAIB, and Tribes.

The Portland Area IHS budget request demonstrates a commitment to maintaining health programs by funding current services. The Portland Area IHS recommendations are funding initiatives to address the health disparities that exist 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.

Appendix L

Tucson Area Budget Narrative

INDIAN HEALTH SERVICE
FISCAL YEAR 2024 TUCSON AREA
BUDGET INSTRUCTIONS
BUDGET RECOMMENDATION NARRATIVE

The Tucson Area is submitting a National Budget Increase as requested by the Tribal Budget Formulation Workgroup at the 1.71 percent level over the fiscal year (FY) 2023 National Budget Recommendations to achieve National Needs Based Funding amount of $50.1 billion by FY 2024. The Tucson Area Office (TAO), Tohono O'odham Nation (TON), Pascua Yaqui Tribe (PYT), and the Tucson Indian Center (TIC) recommend 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 the Indian Health Service (IHS).

The Tucson Area budget priorities are aligned with the FY 2023 National Budget when fully funded; these include and are not limited to: Purchased/Referred Care, Hospital & Health Clinics, Health Care Facilities Construction, New/Replacement Equipment, Mental Health, Community Health Based Programs, Alcohol & Substance Abuse, Public Health, Urban Program Services and Facilities, Long-Term Care/Assisted Services and Sanitation Facilities Construction.

We recommend grant-funded programs become permanent funding for Tribes as part of the reauthorization and remove the competitive grants and awards as 106(a) funding, such as Special Diabetes Prevention for Indians (SDPI), Methamphetamine and Suicide Prevention Initiative (MSPI), Domestic Violence Prevention Initiative (DVPI), and Cancer Prevention.

The Tucson Area is submitting a National Budget at the 1.71 percent increase over the FY 2023 National Budget Recommendations and strongly recommends the IHS budget allocation be changed from discretionary appropriations to mandatory entitlements and Advance Appropriations.

TOP BUDGET PRIORITIES AND INCREASES

1. PURCHASED/REFERRED CARE

Purchased/Referred Care (PRC) Services continue 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 costs difficult to project based on the fluctuation of health insurance rates. In addition, the designation of Arizona as a statewide PRCDA would also significantly impact PRC expenditures. 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 to pay for services provided to newly eligible PRC patients and new staff to address the additional workload. Federal and state agencies need 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.

Long-term care for recovery related to COVID-19 is unknown and is predicted to have a major impact on PRC in the future.

2. HOSPITALS & HEALTH CLINICS (H&HC) DENTAL EQUIPMENT

The Tucson Area recommends preserving, protecting, and expanding new services under the new provisions of the Indian Health Care Improvement Act (IHCIA). With a fully funded budget, access to quality health care would be possible and would provide funding to support expanding services in the IHCIA (for example, sections 112, 123, and 124), which were authorized without appropriations. During the COVID-19 pandemic, routine health screening and vaccination rates for children and adults decreased significantly.

The number one health priority continues to be preventing and treating Type 2 Diabetes and promoting 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.

Staffing continues to be a concern in providing quality healthcare.

The lack of State reimbursement in Adult Dental Services causes the Tribes to supplement all non-emergency dental costs. Caps on dental services and benefits are limited to emergency services only. Dental equipment is costly and requires frequent replacement. With the supply chain challenges, PPE and sterilization supplies are difficult to acquire due to demand and price increases.

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

3. HEALTH CARE FACILITIES CONSTRUCTION

The Tucson Area continues to strongly support funding for new health care facilities 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 the 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 for the Tohono O'odham Nation to develop a Program Justification Document (PJD) to determine the cost of replacing San Xavier and Santa Rosa Health Centers over 65 years old and not on the IHS Health Care Facilities Planned Construction Budget priority list. Outdated facilities prevent our members from receiving the care they need and deserve.

4. NEW/REPLACEMENT EQUIPMENT

Tucson Area recommends funds for new and replacement equipment to provide quality medical service to diagnose and treat certain medical illnesses. The biomedical 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 a 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 installing, operating, and maintaining new bio-medical equipment. New technology does not readily interface with the RPMS system. IT infrastructure is costly and requires constant upgrades due to technological medical and dental care advances. These funds would be used to purchase IT hardware and software such as servers, software licensure, wireless and local area network connectivity, communication systems, and upgrading the data infrastructure for mobile health care units.

5. MENTAL HEALTH

Additional funding is necessary to address the mental health needs for treating and expanding services. With the recent impacts of COVID-19, there is a need to expand Public Health services to respond to the vast increase of mental health issues.

Telehealth services have never been so critical to meet the increased cases of mental health care treatment and awareness/education to family and community.

Mental Health Support Services, such as 24-hour Helplines and transportation to crisis centers, have been impacted due to limited resources and licensed personnel. The additional increase would fund the new provisions in the IHCIA (Sections. 707, 708, 710, and 712), such as Comprehensive Behavioral Health and Treatment Programs, Fetal Alcohol Spectrum Disorders Programs, and 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 serve the population better and provide adequate behavioral health training and community educational programs.

Recent behavioral health funding increases have only been allocated through limited time-sensitive competitive grants. We recommend the funding become a permanent fund for Tribes and remove the competitive grant process. There are time constraints in the grant process to award funding, creating a barrier to addressing behavioral health crises and interventions. Due to limited services available, many individuals cannot receive timely services for mental illness or emotional disorders and may self-treat by using or abusing alcohol or drugs. American Indians and Alaska Natives fall victim to violent crime at more than double the rate of all other United States citizens, and at least 70 percent of violent victimization experienced by American Indian/Alaskan Natives (AI/ANs) is committed by non-Native and usually while they are drinking. Nearly one-third of all AI/AN victims of

violence are between 18 and 24, and about one violent crime occurs for every four persons of this age.

According to the CDC, the following factors increase the risk for numerous public health and social issues: young age, low income, low academic achievement, unemployment as well as a numerous other factors. The State of Arizona Chapter 14 Title 13 Criminal Code recognizes that adolescents can be charged for an array of sexual misconduct yet do not have adequate services available. In the State of Arizona, there are no facilities to specifically address the needs of high-risk youth behavioral issues, which require costly out-of-state treatment.

We 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 create 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

Community Health Representatives (CHR) provide an array of community-based services that target hard-to-reach medically underserved populations. The 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 critical gaps to address the population's health needs in rural areas.

The Tucson Area recommends additional funds to support and expand CHR programs. CHRs are instrumental in providing preventative health screening services, wound care, community health education, delivery of medications, food handler training, home visits, and advocates for all health promotion and outreach. Without the fundamental services CHRs provide, AI/ANs right to quality healthcare would suffer, and most individuals would be unable to access their healthcare system.

Tribal communities appreciate the CHR program beyond the basic services of transport, delivery, and home visits. They value the delivery of these services in a culturally competent manner. Since the pandemic CHRs have been critical to the COVID-19 response team, CHRs are more likely to be trusted community members. The CHR model continues to work for Tucson Area Tribes because

it is rooted in the understanding that CHRs 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 past years. These actions by the Administration are unacceptable.

7. ALCOHOL & SUBSTANCE ABUSE

Tucson Area recommends expanding current services and funding new programs related to Behavioral Health under the IHCIA (Section 127). The high prevalence of Alcohol & Substance Abuse (ASA) related to the opioid epidemic, which contributes to suicides and violence within the communities, has also been magnified by the COVID-19 pandemic. Funding will expand the scope of treatment, establish group homes and inpatient treatment facilities, and increase clinicians and case managers.

Drug overdose deaths from opioid misuse are of significant concern to tribal communities. The rates and patterns of use in Native American communities are often due to substance availability, finances, the presence of substance-misusing peers, and attitudes toward substance misuse.

8. EXPAND URBAN PROGRAM

The Tucson Urban American Indian Population has grown significantly over the years. The health disparities within this population continue 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, including primary care, behavioral health, and community health programs that desperately need to meet the population's needs (IHCIA Section 164). It is also important for safety, accessibility, etc., to note that current funding does not support all necessary building improvements to maintain and expand services.

9. LONG TERM CARE/ASSISTED LIVING SERVICES

The Tucson Area requests new funding to implement Long Term Care and Assisted Living Services (IHCIA Section 124). The existing services in 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 an assisted living facility by January 2022. 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.

10. SANITATION FACILITIES CONSTRUCTION

The Tucson Area requests additional SFC funding to continue meeting existing and future needs for essential water and sewer needs in consultation with Indian communities.

The Tohono O'odham Nation is the second largest reservation in the United States in geographical size, with a land base of 2.8 million acres (4,460 square miles), approximately the State of Connecticut. The Tohono O'odham Nation operates 33 existing water systems and 24 sewer systems to serve 3,400 homes. Most communities are in remote rural areas with challenges in providing access to clean water and sanitation facilities. Currently, 33 homes lack access to safe water or adequate sewer. These 33 homes are identified on the FY 2022 Sanitation Deficiency System (SDS) list as having no indoor plumbing or proper sewer.

IHS funded five of 34 eligible projects in FY 2020 and 4 of 14 eligible projects in FY 2021. For FY 2022, 13 eligible projects reside on the SDS list, along with 51 ineligible projects which do not currently qualify for IHS funding. Ineligible projects do not meet IHS funding criteria due to a lack of an eligible need (for example, projects to address future needs, replacement of adequate facilities, or projects to address efficiency upgrades, etc.)

The 2021 Infrastructure Investment and Jobs Act (Pub. L. 117-58) is expected to provide $3.5 billion for the SFC program over five years (FY 2022-FY 2026). These funds are expected to address most of the backlog of nationwide projects, as listed on the FY 2021 SDS list.

The Tohono O'odham Nation and the Pascua Yaqui Tribe have robust housing programs, with the Tribes constructing approximately 60-80 homes over the past three fiscal years (FY 2019-FY 2021). Homes that are constructed with other than the Housing and Urban Development (HUD) funding are eligible for SFC housing assistance to pay for the eligible costs of water and sewer connections and related facilities. The need for single-family homes rather than multigenerational homes is more of a necessity now with the current COVID-19 pandemic. The pandemic has hit Tribal communities the hardest due to a lack of housing, including homelessness which has always been an issue. The pandemic has escalated this housing crisis, and it's been a real challenge to isolate and quarantine with limited living space.