National Indian Health Board

TESTIMONY OF THE NATIONAL INDIAN HEALTH BOARD REGARDING H.R. 2662, "RESTORING ACCOUNTABILITY IN THE INDIAN HEALTH SERVICE ACT OF 2017"

BEFORE THE COMMITTEE ON NATURAL RESOURCES, SUBCOMMITTEE ON AMERICAN INDIAN, INSULAR AND ALAKSA NATIVE AFFAIRS

June 21, 2017

Chairman La Malfa, Ranking Member Torres and Members of the Committee:

Thank you for holding this hearing on this very important piece of legislation. My name is Victoria Kitcheyan. I am a member of the Winnebago Tribe of Nebraska and I currently serve as Treasurer of the Winnebago Tribal Council. I also serve as the Great Plains Area Representative of the National Indian Health Board. The National Indian Health Board serves all 567 federally-recognized Tribal nations when it comes to health. This means we serve both Tribes who receive care directly from the Indian Health Service (IHS) and those who operate their health systems through self-governance compacts and contracts.

The federal government has a duty, agreed to long ago and reaffirmed many times by all three branches of government, to provide healthcare to Tribes and their members throughout the country. Yet, the federal government has never lived up to that trust responsibility to provide adequate health services to our nation's indigenous peoples. Historical trauma, poverty, lack of access to healthy foods, loss of culture and many other social, economic and environmental determinants of health as well as lack of a developed public health infrastructure in Indian Country all contribute to the poor state of American Indian and Alaska Native (AI/AN) health. AI/ANs suffer some of the worst health disparities of all Americans. We live 4.5 years less than other Americans. In some states, life expectancy is 20 years less, and in some counties, the disparity is even more severe. With these statistics, it is unconscionable that some IHS-operated facilities continue to deliver a poor quality of care to our people.

We appreciate the commitment of this committee to find lasting change at IHS which has long-faced challenges in the delivery of health care. Legislative efforts to address these issues should be conducted in tandem with increased oversight and scrutiny over the administration of the delivery of care at service units operated by the Indian Health Service. The current legal framework for IHS provides much of the necessary guidelines for the operation of the agency.

While we appreciate the speed at which the House is considering the legislation given the critical situation going on in the Great Plains Region, we need to make sure we get this right. It is true, our people need help. These issues surrounding quality of are cannot go on any longer. However, it is also important that these changes are accompanied by input from all Tribal nations

to ensure the best possible outcome and product. Tribes across the country would have appreciated the time to review any draft legislative language before H.R. 2662 was introduced. NIHB is ready and willing to lead a legislative consultation on this bill and we intend to do so in the coming weeks and months. This step must happen first before anything can be enacted.

IHS Hospital Operations

Quality of care issues at IHS-operated hospitals and facilities are well documented. Since at least 2007, the Winnebago IHS Hospital has been operating with demonstrated deficiencies which should not exist at any hospital in the United States. The Centers for Medicare and Medicaid Services (CMS) deficiencies were so numerous and so life-threatening that in July 2015 the IHS Hospital in Winnebago became what still is, to the best of our knowledge, the only federally operated hospital ever to lose its CMS certification. Other IHS facilities in the Great Plains Region such as Rosebud Hospital and Pine Ridge Hospital have been experiencing similar quality of care issues throughout this time and are also under threat of decertification by CMS. These facilities continue to have quality of care issues, and it is unclear if the actions the agency has taken are substantially improving the situation. This situation is especially troubling considering the challenges that have been identified are not new. In 2010, for example, then Chairman of the Senate Committee on Indian Affairs, Byron Dorgan (D-ND) issued a report detailing issues in the Great Plains Area that sound similar to those still experienced today. As recently as October 2016, the Department of Health and Human Services' Office of the Inspector General published a report that highlighted the longstanding challenges IHS-operated hospitals experience across the system.[1]

Comments on H.R. 2662

Though we continue to express the need for more review and comment by the Tribes, we have some general areas of concern regarding the proposed legislation. There are provisions in the bill that create new programs and functions for the IHS, which will be beneficial if they are actually funded. We want to make sure the legislation does not put forward programs that become in essence unfunded mandates. We urge this Committee to work with the Appropriations Committee to ensure that these provisions are funded so they do not end up just being lip service to Tribal communities. The Indian Health Care Improvement Act was permanently enacted in 2010 and contained many provisions designed to modernize the provision of care, such as the development of new health care delivery demonstration projects and expansion of the types of health professionals available within the Indian health system. Yet many of those provisions remain unimplemented due to lack of adequate funding. We do not want to see the same type of thing happen with this legislation. Congress cannot continue to starve the Indian health system and expect major change.

[1] 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, p.14-15.

About 60 percent of the IHS budget is delivered directly to the Tribes through contracts and compacts. We are concerned that the proposed legislation does not do an adequate job of stating which provisions of the legislation pertain to self-governance Tribes and which do not. The legislation provides a "Savings Clause" that appears to ensure the legislation does not interfere with Tribal contracting or compacting. Yet the provision at 607(e) of the proposed legislation is not clear on what provision or provisions that Savings Clause language pertains. This language does not clearly state that the provision it is contained in does not apply to Tribal health programs. Instead, it just states that it cannot be construed to interfere with Tribes' rights under the Indian Self-Determination and Education Assistance Act (ISDEAA). If enacted, it is entirely possible that IHS or others could interpret the operative position to apply to self-governance Tribes because, in their view, compliance with that provision would not inhibit the authority of a Tribe to exercise its ISDEAA rights. As a result, we think it important that the rule of construction be clarified throughout the bill so as to clearly state that the provision does not apply to Tribal health programs. Similarly, we believe that language should be constructed in such a way that self-governance Tribes *could* opt into some of the provisions if they so choose in the bill such as liability protections for health professional volunteers as described in Section 103.

NIHB understands the intent to make a streamlined system for licensed health care professional credentialing procedures, including volunteers, as outlined in Section 102 and provisions in Section 103 that support liability protections for health professional volunteers at IHS that would allow for health care professionals who volunteer at an IHS service unit to be considered an employee of the IHS in order to receive liability protections.

However, we note that these provisions should not be considered a substitute or final step for increasing available providers to the IHS and Tribes throughout the country. For example, NIHB and a large majority of Tribes support the expansion of the dental therapy model, which was first brought to the United States by Tribes in Alaska in 2004. It is a highly effective way to provide reliable, safe, and quality dental care providers to underserved areas. We urge the Committee to consider models such as these to address the chronic staffing shortages in the Indian health system, rather than exclusively relying on a patchwork of volunteers. Additionally, NIHB supports provisions included in similar legislation introduced in the 114th Congress (H.R. 5406) that would provide tax-exempt status for IHS student loan repayment. Because IHS is paying the necessary taxes on the loan payments to the medical professionals, this provision would allow IHS to fund more medical professionals for loan repayment, thereby increase the amount of practitioners in the IHS system.

Section 105 addresses improvement in hiring practices. While we certainly agree that hiring practices need drastic improvement, we are concerned that some of the proposals in the bill do not adequately involve the Tribes, which has been a central concern with some of the issues in the Great Plains Region. Furthermore, this provision indicates that the Secretary has direct hire authority, but Tribal Preference should not be ignored in this process. This provision of the proposed legislation goes on to note that the Secretary shall notify each Tribe in the service area

prior to the direct hire taking place without further guidance on how or why. While notice is appreciated, Tribes should be able to file objections to any hire, especially if the new hire is somebody who has been recycled through the system previously and has not performed well with other Tribes in the Region, which has been a common practice at IHS. Lastly, this provision provides that the Secretary may seek waivers to Indian preference from each Indian Tribe concerned if certain criteria are met. Tribes are concerned about diminishing Indian preference in the hiring process. Further, consultation on this provision is needed to ensure that IHS receives a more streamlined hiring system, but also that Indian hiring preference is respected across the agency, as is current practice.

We are pleased to see a provision addressing the Timeliness of Care in Section 107. We believe that timeliness of care has been an issue for many years and that additional standards to improve the reporting and tracking of timeliness are necessary. It should be noted that underfunding also contributes to the inadequate and untimely care. There is currently a system in place that, if implemented, correctly tracks these important care initiatives. However, if a region does nothing to implement the current system or inadequate staffing impedes the ability to track these initiatives, then it becomes a major problem. We feel that additional Congressional oversight over this particular area may be necessary. Section 107 also states that regulations and standards to measure the timeliness of the provisions of health care services must be done within 180 days of the enactment of this legislation. We are concerned that 180 days may not be enough time to develop the regulations and standards if proper consultation with the Tribes is used to develop said regulations and standards. Lastly, we request that any data gathered regarding the timeliness of care be provided to the Tribes as well as the Secretary.

NIHB believes that Section 108 regarding training programs in Tribal culture and history is of utmost importance. Meaningful cultural training will help IHS employees as they learn the history and culture of the people they are serving on a daily basis. We think this training should be mandatory and it should not only include medical professionals but also include all IHS employees from headquarters to all staff at the service unit facilities, who have daily interaction with Native American people. It would be even more useful if the training was specifically developed by the Tribes and was tailored specifically for the Tribes in the service area.

Section 110 establishes rules regarding a Tribal consultation policy. We are in complete agreement that a consultation policy should exist and that Tribes should have input into the way services are provided to Tribal communities. However, it is imperative that the consultation policy developed under this section mandate to IHS staff that consultation shall be more than simple lip service or a listening session with the Tribes. It should be viewed as a true partnership and collaborative effort. Tribal input is key to IHS in providing high quality services and must be taken seriously. The problems in the Great Plains Area would have never have risen to the current critical level if there was true consultation and collaboration at every step in this process; and these issues never would have received the attention they have if not for Tribal oversight and actions.

Fiscal accountability is never a bad thing, but the provision in Section 202, subsection (b) that addresses the prioritization of patient care is concerning due to the specific guidelines provided. This section explains that IHS should only use certain dollars for patient care directly and limits their use to essential medical equipment; purchased/ referred care; and staffing. While it is understandable the agency should have more scrutiny over these funds, we worry that the criteria may end up being too constraining. IHS should consult with the Tribes in their service area before making decisions on what can be done with the funds pertaining to this section. With consultation, the money can go to the most needed programs in a particular service area.

Most of Title III of the proposed legislation outlines a series of reports. One report that drew our attention was the Inspector General reports on patient care in Section 304. We agree that reports on the quality of care and patient harm at IHS are necessary. However, we want to draw attention to the fact that many Tribal members end up receiving their care outside of the IHS system through the Purchased/Referred Care program. For example, in South Dakota, approximately 70% of care is referred outside of IHS facilities. It would be useful to also have information on quality of care once a patient has left the IHS facility as part of reporting. Additionally, we believe that any and all reports that come as a result of this legislation be first shared with the Tribes for review and comment before they are made public.

Again we thank the Committee for its genuine interest in trying to alleviate problems within IHS. It is clear that management, recruitment, accountability and transparency are all still issues that need to be addressed at IHS-operated facilities. Real change and the rebuilding of many of the areas in the Great Plains region cannot happen without permanent qualified personnel and the funding necessary to carry out the mission. However, we reiterate our request that additional time be taken to review the legislation with Indian Country before the legislation moves forward in the legislative process. It is critical that we are able to more fully understand the implications of the bill.

Legislation alone will not solve issues in the IHS. Proper training of hospital staff costs money, new equipment costs money, and recruitment under these circumstances is also going to cost money. Correcting this situation is going to require a continuous team effort, additional resources, and consistent Congressional oversight of IHS activity.

Thank you again for allowing me to testify, I will be happy to answer any questions you may have.