Oglala Sioux Tribe

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Testimony of

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Committee on Indian Affairs

On

"Reexamining the Substandard Quality
of Indian Health Care in the Great Plains"

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Good afternoon, Mr. Chairman and Members of the Committee. My name is Sonia Little Hawk-Weston, and I serve as the Chairwoman of the Tribal Council's Health and Human Services Committee for the Oglala Sioux Tribe. The Oglala Sioux Tribe is the largest tribe of the Great Sioux Nation, with more than 47,000 tribal members. Our Reservation, the Pine Ridge Reservation, spans more than 2.8 million acres, making it larger than the States of Delaware and Rhode Island combined.

I am pleased to be here today to testify on the state of Indian health care in the Great Plains Area, and specifically on the Pine Ridge Reservation, as the lack of adequate health care is one of the greatest challenges facing our Reservation community. It is also an issue requiring federal attention and action on behalf of the United States. In the Sioux Treaty of 1868 (known as the Fort Laramie Treaty) the Great Sioux Nation and the United States agreed on a *quid pro quo*: by terms of the Treaty, the United States promised to provide certain benefits and annuities to the Sioux Bands each year, including health care services, in exchange for the right to occupy vast areas of Sioux territory. Accordingly, it is our position that the obligation of the federal government to provide adequate health care services to the Oglala Sioux people, who are some of the poorest and most disenfranchised in the Nation, is not only a moral responsibility, but a legal one.

In 2010, this body held a similar hearing, exploring the urgent need to reform the Indian Health Service in what was then referred to as the Aberdeen Area, prompted by years of complaints of mismanagement and substandard care. The hearing followed up on a formal investigation of the Aberdeen Area, which resulted in a Report of Committee Chairman Byron

Dorgan confirming and documenting the deplorable condition of the Area's health care services to Indians.[1]

I am here today to testify that, while some efforts have been made to improve the administration and delivery of health care in the Great Plains Region, much work remains. The Oglala Sioux Tribe is concerned that the IHS Great Plains Area still struggles with poor management and lack of accountability, and that many of the problems identified in the 2010 Hearing and Report continue, to a greater or lesser extent, today.

We need administrators in the Great Plains Area to focus on ensuring patient care, a stable, well-managed work environment and recruitment of permanent medical staff. The IHS also needs to bring on more staff for third party collections and for paying referred claims in a timely manner. In 2013, the GAO disagreed with IHS's position that it could not divert resources to hire more contract health services (now called purchased and referred care) staff. We need to be far-sighted, not short-sighted in the approach to fix the problems in health care delivery in the Great Plains Area. We look forward to working with this Committee and the Administration to make sure this happens.

This testimony discusses some of the specific ongoing problems we face.

Quality of Care and Accreditation/Certification

Substandard quality of care and the resulting threat of loss of accreditation and certification are ongoing issues for the IHS facilities at Pine Ridge. Chairman Dorgan's 2010 Report concluded that the Pine Ridge Service Unit Hospital was one of six facilities in the Great Plains Area experiencing accreditation problems and/or Emergency Medical Treatment and Labor Act (EMTALA) violations. The Report specifically cited a 2010 the Centers for Medicare and Medicaid Services (CMS) report finding that Pine Ridge Hospital "received a number of EMTALA complaints in 2009 and 2010, which centered on insufficient care in its Emergency Department."[2]

Clearly, insufficient progress has been made over the last five years to address these violations. In letters dated November 24th and 25th, 2015, the CMS stated that based on recent surveys the Pine Ridge Hospital is in violation of several Medicare Conditions of Participation for Hospitals and the EMTALA. As a result, the Hospital is at risk of termination of its provider agreement and loss of its right to participate in the Medicare program. The loss of Medicare reimbursements would have significant financial consequences for the Pine Ridge Service Unit, which takes in substantial amounts in third party collections. The Service Unit's third party collections for FY2015, as of December 2015, were approximately $8.4 million, with about $6.5 million at Pine Ridge Hospital. The Service Unit's hospital and clinics federal appropriations amount was just over $15 million for FY2015. If the Service Unit lost its ability to participate in the Medicare program, it would be forced to operate on base funding alone. This would pose

[1] In Critical Condition: The Urgent Need to Reform the Indian Health Service's Aberdeen Area, Report of Chairman Byron L. Dorgan to the Committee on Indian Affairs, 111th Cong. (Dec. 28, 2010) ("2010 Report").
[2] 2010 Report at 23.

drastic budget problems to an already woefully underfunded facility; the Hospital simply *could not operate* on its base budget alone.

Of course, apart from the funding issues, the survey findings underscore that the Hospital continues to fail to meet basic federal standards for competency and quality of care. CMS uncovered numerous violations in its surveys, conducted last October, including but not limited to the following:

- The Hospital's governing body "failed to ensure that medical staff was accountable for the quality of care provided to patients" and abided by Hospital policies and regulatory requirements, resulting in the Hospital's "inability to ensure the provision of quality health care in a safe environment."
- The Hospital failed to ensure that patient privacy and safety requirements were met. Among other things, the survey team discovered unsecured scalpels, needles, and syringes readily accessible to patients, including prisoners, and visitors in the Hospital, including an unlocked syringe cart near a patient entrance and unlocked cupboards in exam rooms where patients and family members were left alone. The survey also found that the Hospital left prisoners and individuals at risk for suicide unattended, contrary to Hospital policy, thus endangering staff, patients, and visitors in the Hospital.
- The Hospital failed to ensure confidentiality of patient records, as computer monitors with patient data were visible to patients and visitors, and medical records were found left on the countertop in an unsecured room.
- The Hospital has "failed to develop, implement, and maintain an effective, ongoing, hospital wide [Quality Assessment and Performance Improvement] program" with "plans of action and measurable goals" as required by the Conditions of Participation. The Hospital has no plan in place to address patient complaints and grievances or patient pain management. Members of the Hospital's Quality Management Oversight Committee do not consistently show up for Committee meetings, and several meetings have been cancelled altogether due to poor attendance. In short, the Hospital is failing to adequately monitor quality of care and implement performance improvement measures.
- Medical records were found to be incomplete or inaccurate, and many contained information on the wrong patient. In one case, a female patient was informed that she had multiple illnesses, including liver disease and hepatitis C, which she did not in fact have. That information related to a male patient, and was wrongfully included in the female patient's chart. Hospital staff admitted this was a common problem. The survey also revealed instances of "pre-signed" records, later filled out by Hospital staff.
- Hospital failed to provide medical screening exam that was, within reasonable clinical confidence, sufficient to determine whether an Emergency Medical Condition existed. The survey cited that the Hospital discharged a person with a displaced fracture in the head after the preliminary report of the CT scan was read as negative. The CT scan report, however, was timed after the patient was discharged. This patient was ultimately retrieved after discharge and airlifted to an off-Reservation

facility for treatment. This patient's care was not presented for review through the Quality Assessment Performance and Improvement Committee.

- Certain drugs were found to be stored in an improper environment, and expired infant formula was kept in supply and not discarded. In addition, the Hospital "failed to ensure all drugs and biologicals were kept in a secure and locked area."
- Among other broken equipment, the dish machine in the hospital kitchen, used to wash and sanitize cookware, has been broken since 2013.
- The Hospital has "failed to ensure that there was an active infection control program that monitored, investigated, controlled, and/or prevented or decreased the opportunities for the spread of infections." The hospital also failed to "ensure adequate processing of contaminated reusable medical instruments and the proper use of mechanical sterilizers," several of which were broken. In some instances, dirty instruments were found sitting uncovered at various locations throughout the Hospital. There were no gowns or masks readily available in the isolation room in the ER. The survey thus concluded that the Hospital "failed to ensure infection control policies specific to each department… This included the training [for] and monitoring [of] the procedure for handling of dirty or soiled reusable instruments and the use of sterilizers to ensure those infection control measures were being followed to prevent or decrease the opportunities for the spread of infections."

The survey also revealed that the Hospital had failed to implement an earlier Plan of Correction submitted to CMS after a July 16, 2015 survey that discovered EMTALA deficiencies. In fact, the EMTALA survey conducted in October was a follow-up to the July 16 survey, and revealed ongoing deficiencies even though the Hospital had alleged compliance as of August 26, 2015. The October survey found that the Hospital did not have a functioning and effective Quality Assessment and Performance Improvement committee, which the Hospital had represented would be utilized to implement its Plan of Correction, and that no committee meeting had been held since April, 2015.

Though CMS has accepted new Plans of Correction submitted by IHS following the November 24th and November 25th letters, past experience gives the Tribe little reason to believe that these plans will be fully and competently implemented or will result in lasting, meaningful reform. For example, we understand that the Service Unit has made the decision to borrow over $1 million from the Kyle Health Center to pay for contracts for outpatient and ER providers at the Hospital in order to comply with the Plans of Correction. Now that these violations have been uncovered, the solution must not be to divert funding from one under-resourced part of the Service Unit to another in a last-ditch effort to avoid de-certification. We never should have arrived at this point. Simply put, the IHS should not be operating the Pine Ridge Hospital in a manner that threatens its accreditation or CMS certification.

Unfortunately, the Oglala Sioux people do not need CMS to tell them that IHS is operating the Pine Ridge Hospital in an unsatisfactory—even dangerous—manner. The Oglala Sioux Tribal Council and the Office of the President have heard ongoing complaints from tribal members about the quality of care on our Reservation, including frequent complaints of misdiagnosis and mis-prescribed medications. In one case, a tribal member suffering severe back pain was told several times that a complete hysterectomy was needed and the member was

preparing for the procedure. In the meantime, the member was seen at a non-IHS hospital off the Reservation, where the member was diagnosed with a herniated disc in the spine and advised that in fact no hysterectomy was needed and that it would have been malpractice for any doctor to perform one. Another tribal member went to the Hospital complaining of chest pains, and was diagnosed and treated for acid reflux. Hours later, at home, this tribal member suffered a massive heart attack and passed away. Another tribal member visited the hospital repeatedly complaining of health problems, and was repeatedly told nothing was wrong, until the person was finally diagnosed with cancer. A few weeks later, this tribal member passed away. Stories like these undermine our confidence that the IHS is able to provide competent, quality care to our tribal members on our Reservation.

Access to Care Issues

Access to necessary medical services is also a serious problem for Oglala Sioux tribal members. Oftentimes, the IHS cannot or does not provide the kinds of services that tribal patients need. But because of limited funding for purchased and referred care, previously referred to as contract health services, IHS often refuses to pay when patients are referred to non-IHS providers unless the issue is life-threatening. Those that do go to these referred appointments oftentimes cannot pay and they end up looking to the Tribe for financial help. We have stacks of IHS denial letters and bills for medical services that our tribal members have received and shared with the Tribal Council. In one collection, we have files shared with us by our members that contain approximately 212 claims submitted by 147 different claimants and worth over $1.2 million. Several IHS denials state that although the care is a Priority 1 due to lack of contract health funds IHS is unable to approve the referral. IHS's numbers show that it has denied 4,830 referrals since April 2015. In December 2015, IHS reports 539 referrals denied.

Many patients simply choose not to go to their medical appointments when they know the IHS will not pay. As a result, these patients ultimately do not receive the medical care they need. This pattern leads to a lack of preventive care, the development of chronic conditions, and the overall deterioration of health on our Reservation.

We hear from our tribal members on a regular basis about their access to care problems and the impact of receiving IHS denials of referred care. Many times if only the person received preventive care, the needed specialized treatment or necessary medications, health conditions would not have progressed to a chronic or catastrophic state. In one instance, a tribal member with a painful joint problem was referred to a specialist in Rapid City for an assessment. The specialist told the tribal member that surgery was needed to alleviate the pain. When the tribal member attempted to schedule the surgery, the IHS refused to cover it, saying they had agreed to cover an assessment but not a surgery. But what good is an assessment if the patient cannot pursue the recommended course of treatment? In another instance, a tribal member fell and called the Hospital Emergency Room but was told it was full. At a service clinic, this patient was advised that a bone was broken and was referred to a specialist in Rapid City. The specialist notified this member that surgery was needed, but the IHS would not pay for the surgery or the visits to the specialist, so the member could not return for the surgery. Consequently, this tribal member suffered with severe pain.

Another tribal member who did undergo critical surgeries following a car accident, and was later hit with bills totaling approximately $250,000 because the IHS refused to pay. Fortunately, this tribal member was able to hire a lawyer to help deal with the situation. However, many tribal members, who receive direct bills often for staggering amounts, cannot bring on lawyers, and are plagued by debt collection actions and credit score downgrades. IHS regularly denies purchased and referred care based on procedural requirements even though IHS does not provide education to members about what those requirements are. As just one example, a member recently shared a collection agency letter with our Council showing that the member is being pursued for payment of more than $72,000 in medical bills. Our members cannot pay that amount.

The costs of transportation to referred care is also a very serious problem for our tribal members and the Tribe, itself. Many tribal members who are referred to Rapid City or elsewhere for medical treatment simply do not have the means to cover the costs of transportation, even if the services would be covered by the IHS or other insurance. When these patients are minors or need to be accompanied by family or caregivers for other reasons, the costs of travel are even more prohibitive.

The Tribe supplements transportation costs out of its general fund when it can. In the past decade, the Tribe has spent just short of $3.5 million in medical emergency assistance for its tribal members. About $2.9 million was spent from 2010 through 2015. These transportation costs are a significant amount of money that the Tribe badly needs for other initiatives such as community development, economic development, and other projects for improving Reservation life, all of which are needed in our efforts to overcome our poverty conditions and poor health outcomes on our Reservation. In Oglala Lakota County, on the western side of the Pine Ridge Reservation, more than 52% of our people live below the poverty line and the average per capita income is only $9,226. According to the U.S. Census Bureau, Oglala Lakota County is the third poorest county in the United States. The unemployment rate on our Reservation is well over 70% and our high school dropout rate exceeds 60%. These statistics directly impact the health of our tribal members and need to be addressed. Last year, upon tribal request, the IHS reimbursed a portion of the funding the Tribe diverted to cover medical transportation costs for our members. Nevertheless, the Tribe should not have to front these costs and lose the ability to use its general fund monies for other purposes to benefit the Tribe. Unfortunately, the portion of monies that was reimbursed went right back out the door to cover costs of additional medical emergency assistance needs.

We are also concerned with the costs incurred by the frequent use of airlifts or life-flights to facilities off the Reservation for specialized care. Since the Pine Ridge Hospital often lacks the care needed, airlifts to other facilities are not unusual. The IHS covers the cost of the airlift if the patient is determined to be Priority 1. Airlifts can cost approximately $20,000 per trip. Clearly, these trips result in a significant amount of money being paid out from the Pine Ridge Service Unit's already strapped budget. Furthermore and significantly, if it is determined that the patient is not Priority 1, the patient, ultimately, is billed for the airlift, and if the patient does not have Medicaid, Medicare or private insurance to look to, this massive bill falls to the patient.

In terms of on-Reservation access to care, the Pine Ridge Hospital lacks the space, staff, and equipment to meet demand. The Pine Ridge Service Unit had documented a need for fetal monitoring systems, telemetry systems, surgery lights, a nurse call system, and dental chairs and equipment, among other equipment needs estimated to cost approximately $5.5 million for FY 2016. In fact, the equipment needs are so dire that the Hospital waits for one of its IV Service Unit Pumps to finally stop working so they can take parts from it to fix another one. There are not enough supplies for the IV pumps, and new ones that are needed would cost an estimated $677,790. This is a critical piece of equipment that could mean the difference between life or death in a patient emergency.

These unmet needs lead to an inability of our local facilities to address a variety of illnesses locally, and contribute to backlog and long wait times for medical staff to see patients. The Pine Ridge Hospital is notorious for its long wait times, and it is generally understood that if you need to see a doctor at a Reservation facility you should clear your schedule for the day, as your minimum wait time is likely to be five hours or more. One tribal member waited five hours at the Emergency Room without being seen by medical staff even though the member presented with severe pain. Ultimately, this member left unseen and went to an emergency room off the Reservation where the member was told surgery was needed the next day due to a protruding broken bone. Seriously ill patients cannot withstand these wait times, and nobody should have to. Some have remarked of the Reservation clinics that, "if you are not sick when you go in, you are when you leave" because of the wait times. Additionally, the Emergency Room is backlogged with patients coming to receive primary care services because there is such a long wait time to see outpatient providers.

Our Tribal Council pushed hard to have a Tribal Liaison position created between the Tribal Council and the Pine Ridge Service Unit so that there would be an open line of communication between the two entities. The position was to provide an avenue for our efforts as Tribal Council to promote the interests and welfare of our members when they receive health care from the Pine Ridge Service Unit. There is a grievance process at the Hospital for patients to file complaints about their care. The Tribal Liaison reports to our Council's Health and Human Services Committee. However, when we ask questions to determine if grievances and complaints are being addressed, we are told that because of HIPAA they cannot answer our questions. We are, therefore, left in the dark about whether our members' grievances are in fact being addressed. Our tribal members, however, rely on our Health and Human Services Committee and the Council overall to get answers and ensure all is functioning as it should at the Service Unit. We, of course, want strict adherence to HIPAA, but we want to make sure it is not used as a general shield to not answer any questions about the grievance process. We need to develop a plan to ensure our Tribal Liaison position is being as effective as it should be and was envisioned to be; such plan should include HIPAA training on what information can and cannot be shared.

Inadequate Facilities

As I have mentioned, the Pine Ridge Hospital struggles with inadequate space to serve its user population. The IHS Service Unit profile states that the active user population exceeded the designed user population in 2000, and that the Service Unit currently services a user population

of 51,227, in a space that is already undersized to serve the Health Systems Planning estimated user population of 22,000 patients.

The Hospital has used curtains and ad-hoc partial walls to improvise exam space, but this approach obviously risks breach of patient confidentiality. The single trauma room is inadequate and the Service Unit reports a need for additional space for the emergency department, outpatient, behavioral health, contracted specialty services, physical therapy, occupational therapy, respiratory therapy, dental, administration, and support services.

Further, the Hospital has no psychiatric unit, and lacks any appropriate facilities to handle psychiatric patients. The Hospital employs one psychiatrist and one psychiatric nurse. Yet, multiple individuals with immediate psychiatric needs—some of them suicidal or homicidal—come into the hospital on a daily basis. Medical staff on duty, who are not necessarily trained in psychiatric medicine, must be diverted from their assigned duties to supervise these patients until they can be transferred to an appropriate facility off-Reservation. This disrupts services to other patients in the Hospital and puts Hospital staff, patients, and visitors at risk of harm.

Need to Recruit, Retain, and House Qualified Staff

I recently heard of a clinical psychologist, brought in to help with suicide prevention and other behavioral health issues, who worked for *one day* before quitting. It is common for providers to only stay as long as the duration of their temporary contract. Once their contract is up, they move on. As a result, there is a lack of trust between patients and providers, and patients constantly have to start over from square one as new physicians cycle through. Further, the position vacancy rates at our facilities hover around twenty percent.

If we want to have any hope of a positive outcome in the Indian health care system, we need permanent physicians who will stay, become part of the community, and get to know their patients. The Pine Ridge Hospital Unit needs to recruit, hire and retain skilled medical staff. That is not happening, for several reasons.

One major factor is the critical shortage of housing in Pine Ridge and the surrounding areas. Medical and Hospital staff simply have nowhere to live. The housing shortage affects every facility in the Pine Ridge Service Unit:

- The Pine Ridge Hospital has **450 positions**, but only **104 housing units**.
- The Kyle Health Center has **86 positions**, but only **20 housing units**.
- The Wanblee Health Center has **35 positions**, but only **5 housing units**.
- The LaCreek District Clinic has **6 positions**, but **0 housing units**.

There are very limited housing options available within 60 miles of the Hospital or within a reasonable distance of our other facilities, due to our isolated location. Pine Ridge also lacks a local motel or other temporary housing for contracted providers and visiting professionals.

Limited funding for medical staff, facilities, and equipment is, of course, another challenge in recruitment and retention. In addition to an overall lack of funds for competitive salaries, IHS employees are impacted by the uncertainty of continuing resolutions and the threat

of government shutdowns when Congress fails to enact a timely budget. The lack of funding for basic and necessary equipment and the inadequate facilities are also unappealing to prospective medical staff, as these inadequacies make their jobs much harder.

Significantly, however, work environment is also related to recruitment and retention. Competent, professional medical personnel want to work in a well-managed facility where high-quality patient care is a priority and where staff are rewarded for good performance. The CMS survey findings clearly demonstrate, at the very least, that the Pine Ridge Hospital is not being effectively managed and is not prioritizing improvement in patient care. This kind of environment is demoralizing and discourages the kind of professionals we need to address our urgent health care needs from applying or remaining on the Reservation.

In addition to qualified medical staff, we need trained, expert hospital administrators and administrative staff. Administrators must prioritize recruitment and a stable, well-managed work environment. Further, the administrative staff should be trained and proficient in third party billing to enable aggressive pursuit of third party collections, so no available health care funding is left on the table. We were told that for the past three months, third party collections are only at 25% of the goals for our hospitals and clinics.

Administrative Leave

Senator Dorgan's 2010 Report found that the IHS used transfers, reassignments, details or lengthy administrative leave to deal with employees who had a record of misconduct or poor performance. We have heard that these practices, and the "recycling" of problem employees, continue to persist throughout the Great Plains Area. We remain concerned about the use of these practices and would like this issue to be examined and analyzed for its effect on the provision of quality health care for our members.

Administration and Accountability

The Great Plains Area Office should be accountable to, and work in partnership with, the Tribes it serves. The Oglala Sioux Tribe would like information clearly detailing the budget received by the Area Office and how that budget is then allocated and spent. It is clear that the levels of funding actually reaching our local facilities are grossly inadequate; **the Pine Ridge Service Unit estimates it operates at 50% of need.** But the Tribe lacks the information necessary to evaluate whether the Area Office is appropriately managing its funding to ensure that the greatest amount of funds possible are used for direct patient services. The Tribe would like to see greater transparency, accountability, meaningful partnership and consultation in the allocation of funding for the Pine Ridge Service Unit. In addition, when the Area Office is listing and filling job vacancies, the Tribe would like to be notified and involved with candidate selection and interviews. Finally, the Tribe would like statistics and information about patient lawsuits against the IHS, including the cost to the IHS of defending and settling such lawsuits.

Use of Third Party Revenues

Third party resources are an increasingly important component of IHS funding, but the Oglala Sioux Tribe is concerned that these resources are not being effectively managed or utilized by the IHS to improve patient care.

In August of 2015, the IHS used third party collections to pay an administrative settlement of a union grievance in arbitration. The settlement had two categories: $60 million for back pay and back pay-related costs (such as payroll taxes), and $20 million for administrative costs and attorneys' fees. Fifty million of the $60 million amount was paid from third party collections and $10 million from expired appropriations. The $20 million was paid from then current FY 2015 appropriations.

Under federal law, third party collections are primarily to be used "to achieve or maintain compliance with applicable conditions and requirements" of the Medicaid and Medicare programs. If there are amounts collected in excess of what is needed for this purpose, such collections shall be used "subject to consultation with the Indian tribes being served by the service unit ..., for reducing the health resource deficiencies (as determined in section 1621(c) of this title) of such Indian tribes."[3] We are, therefore, greatly concerned by the fact that there was such a large amount of third party collections readily available to the IHS that was not being used for maintaining compliance or for reducing health resource deficiencies. We request that Congress look into this matter.

Use of Telehealth

Efforts are currently underway to utilize telehealth capabilities for behavioral health on the Pine Ridge Reservation pursuant to a Health Resources and Services Administration (HRSA) grant, but the Oglala Sioux Tribe believes that this technology should be used in a wider variety of circumstances by the IHS. The use of telehealth technology could be a powerful tool in addressing some of our most pressing concerns related to the prohibitive cost and other burdens of patient travel, as well as misdiagnosis and improper treatment, resulting from our remote location and the lack of certain medical services and expertise at the Pine Ridge Service Unit. Telehealth would provide access to experts while saving unnecessary patient travel costs to Rapid City and elsewhere.

Importantly, we understand for telehealth to work in all aspects of the Hospital, the Hospital needs to be completely wired. At present, we do not have the technological capabilities as only 50% of the Hospital is wired. For technology purposes, we also need one central system. Presently, we have three systems which causes problems in communications within the Hospital.

Respiratory Health Services

We need accessible respiratory care services on the Reservation. Currently, our members who need respiratory care services are sent to Minneapolis, Denver or Omaha. If those members are able to be weaned off of such care, they return home. However, if they are not able to be

[3] 25 U.S.C. § 1641(c)(1)(B).

weaned off the care, they stay far from home and often end up passing away in these unfamiliar locales. The CMS survey discovered that the Pine Ridge Hospital had contracted a single respiratory therapist to provide respiratory services, but had failed to approve respiratory care policies and procedures for the Hospital. The Tribe would like these services available on the Reservation so our members can stay near their homes and their family members can have them nearby.

Youth Suicide Crisis

On February 17, 2015, the Tribal President issued a proclamation declaring a state of emergency on the Pine Ridge Reservation due to the high incidence of youth suicide. This is a critical problem that continues to plague our Tribe. According to IHS's numbers, an average of 30 persons with suicidal ideation with plan and intent visit the Pine Ridge Emergency Room per month, with one month recording as high as 58 persons.

We appreciate the help of this Committee in highlighting this most important issue. Our Tribe testified at the Committee's June 2015 hearing. We are grateful that Congress provided additional appropriations for methamphetamine and suicide prevention and treatment in the Omnibus. We also appreciate the attention of the Administration toward combating youth suicide on our Reservation and its focus on Native youth. Federal agencies came together to focus on this epidemic. We, however, need a sustained, intense effort.

Our mission has to be to provide our youth with hope and this can only happen by improving the quality of life on our Reservation and raising our people out of the oppressive poverty conditions they currently endure. This requires a comprehensive approach. Behavioral and mental health care must be a priority as well as education and youth engagement. But we also must address housing conditions, community infrastructure and economic development. It is only then that hope will not be elusive when our youth contemplate their futures.

An immediate need is to address the lack of adequate psychiatric care at the Pine Ridge Hospital. As stated above, the Hospital has no psychiatric unit, and lacks any appropriate facilities to handle psychiatric patients. These patients require specialized care for their own safety and the safety of others, but as it stands, they are forced to wait hours just to be seen by the one psychiatrist or by other hospital staff who may not have the specialized training to help them. In the past, the IHS permitted volunteers to come into the Service Unit facilities to sit with psychiatric patients, so at least they would not be left alone; however, the IHS has been forced to disallow that practice unless specifically requested by family members. Oftentimes, however, the families of these patients have limited means of transportation to even visit their loved ones in the Hospital and cannot get to the Hospital to provide the required request. As mentioned above, the Hospital currently diverts staff to supervise these patients which takes staff away from their other duties. We need to quickly implement a plan to address this issue.

Another immediate need is to get our safe houses operational. We have three existing safe houses that provide safe spaces where youth can be secure outside of their homes, but they are currently not running due to lack of funding for staffing and operations.

Dental Care Services Needs

We need more dentists to adequately provide dental care for our members. We also need capability for specialized dental care on our Reservation to avoid members having to travel to Rapid City or elsewhere for specialty services such as oral surgery. Finally, we need improved dental care. The general practice our members receive is to have their teeth pulled rather than treatments and procedures to save the tooth.

Conclusion

The recent CMS survey findings confirm the experience of our tribal members that not enough progress has been made by the IHS to improve Indian health care service delivery on the Pine Ridge Reservation. We hope that the survey findings and this hearing will pressure further reform, but we remain wary of a temporary fix. It would not be acceptable for the IHS to shore up the deficiencies identified by CMS only by diverting resources or attention to the detriment of other areas of the Pine Ridge Service Unit in a desperate attempt to maintain certification. Rather, in light of the longstanding and pervasive nature of IHS substandard quality of health care in the Great Plains Area, a root and branch approach is needed to achieve lasting reform.

Clearly, additional funding is needed. We need to make sure our Service Unit is fully funded. However, we need more than dollars. We also need to make sure that the Pine Ridge Service Unit is managed in such a way that patient care undoubtedly comes first, noncompliance issues are non-existent and the Unit is an attractive place to work for the best and brightest in the medical and hospital administration fields. Our facilities also need to have the capability to provide specialty care, at least in some specific areas, to cut down on the excessive and expensive travel our members must endure for health care services. We need to rectify the colossal issue of IHS referral denials and the financial problems associated with them.

All we want is quality health care for our people without the inordinately burdensome and oftentimes horrific struggles they currently suffer to receive any health care at all. Certainly, this should not be an unachievable goal in the United States of America, especially when the United States of America bears treaty and trust responsibilities to our people.

Thank you for the opportunity to testify.