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In Critical Condition: The Urgent Need to Reform Indian Health Service's Aberdeen Area" Hearing
Senate Committee on Indian Affairs
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Testimony Provided
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Introduction

Mr. Chairman and other Members of the Committee:

I am pleased to be here and want to thank you for your hard work to ensure that the appropriate authority and funding for healthcare services is available to meet the needs of the 17 Tribal Nations of the Great Plains. I am Ron His Horse Is Thunder, Executive Director of the Great Plains Tribal Chairman's Health Board an association of 17 Sovereign Indian Tribes in the four-state region of SD, ND, NE and IA. I am an enrolled member of the Standing Rock Sioux Tribe, The Great Plains Region, aka Aberdeen Area Indian Health Care has 18 I.H.S. and Tribally managed service units.

We are the largest Land based area served of all the Regions with land holdings of Reservation Trust Land of over 11 Million acres. There are 17 Federally Recognized Tribes with an estimated enrolled membership of 150,000. To serve the healthcare needs of the Great Plains there are 7 I.H.S. Hospitals, 9 Health Centers operated by I.H.S. and 5 Tribally operated Health Centers. There are 7 Health Stations under I.H.S. and 7 Tribal Health Stations. There is one Residential Treatment Center and 2 Urban Health Clinics. The Tribes of the Great Plains are greatly underserved by the I.H.S. and other federal agencies with the I.H.S. Budget decreasing in FY 2008 over the FY 2007 amount. This is in spite of increased populations and need. The GPTCA/AATCHB is committed to a strengthening comprehensive public healthcare and direct healthcare systems for our enrolled members.

Health Data and Overview

As documented in many Reports, the Tribes in the Great Plains region suffer from among the worst health disparities in the Nation, including several-fold greater rates of death from numerous causes, including diabetes, alcoholism, suicide and infant mortality. For example, the National Infant Mortality Rate is about 6.9 per 1,000 live births, and it is over 13.1 per 1,000 live births in the Aberdeen Area of the Indian Health Service—more than double the National rate. The life expectancy for our Area is 66.8 years—more than 10 years less than the National life expectancy, and the lowest in the Indian Health Service (IHS) population. Leading causes of death in our Area include heart disease, unintentional injuries, diabetes, liver disease and cancer incidents as a whole has increased. In most cases in the Northern Plains cancer is diagnosed in the late stages, which makes it harder to diagnose and treat as well as poor access to early screening. While these numbers are heartbreaking to us, as Tribal leaders, these causes of death are preventable in most cases. They, therefore, represent an opportunity to intervene and to improve the health of our people. Additional challenges we face, and which add to our health disparities, include high rates of poverty, lwer levels of educational attainment, and high rates of unemployment.

All of these social factors are embedded within a healthcare system that is severely underfunded. As you have heard before, per capita expenditures

for healthcare under the Indian Health Service is significantly lower than other federally funded systems. In FY 2005, IHS was funded at $2,130 per person per year. This is compared to per capita expenditures for Medicare beneficiaries at over $7,600, Veterans Administration at over $5,200, Medicaid at over $5,000 and the Bureau of Prisons at nearly $4,000. Obviously, our system is severely underfunded. It is important to note that as Tribal members, we are the only population in the United States that is born with a legal right to healthcare. Tribes view the Indian Health Service as being the largest pre-paid health plan in history.

Great Plains Indian Health Hearing Objectives

Mr. Chairman, Members of the Committee, this hearing provides a significant opportunity to (1) identify Indian Health Service (IHS) administrative areas of concern, (2) submit Tribal comments on detrimental effects of IHS administrative weaknesses, (3) suggest possible constructive action, and (4) express urgency for congressional support for strengthening agency operations in light of recently enacted Indian health reforms.

You, and others of this Committee, have been very instrumental in promoting needed Indian health legislative provisions in the recently enacted Affordable Care Act (ACA). Our Tribal leaders are grateful for your efforts to secure passage of the Indian Health Care Improvement

Act reauthorization as part of the ACA, as well as Tribal specific language in the national ACA provisions.

However, as you may realize, if these new authorities are overlaid on agency operations and staff protocols that are weak or impaired, these new provisions' benefits are immediately lessened.

Secondly, our Great Plains Tribes are Direct Service Tribes, whose partnerships with the IHS should be strengthened, without our Tribes resorting to Indian Self Determination Act (aka "638") compacting. If there were greater transparency, in the IHS Area's administrative decision-making process, and greater joint IHS-Tribal program decision-making, this improved partnering could act to ensure accountability and deter certain mismanagement conduct. Such Joint Venturing will be vital in this new era of Health Reform implementation.

Most importantly, when there is agency mismanagement of programs or resources, it is our tribal patients and communities who suffer. When there is inequity in resource allocations, preferential treatment or delayed decision-making, it is our tribal members' whose health is immediately harmed.

I will, today, provide some broad areas of agency program operation concern and, then a few examples of the consequences of poor performance, whether through neglect or mismanagement.

Indian Health Service (IHS) Aberdeen Area

Staffing. Our Area has been plagued by inadequate staffing, due to poor recruitment, rural and climate conditions, difficult facility and equipment conditions. Staffing that is obtained is often poorly trained and not prepared for the difficult conditions in their facility postings. Our Area suffers from insufficient funds for both recruitment and retention bonuses. We are in need of quality health professionals for chronic, behavioral or preventive health care services, which services can act to forestall more critical or acute care and costs.

Business Office. This function is critical to ensuring that we maximize all funding and reimbursements for patient care. This office will also be especially important in the new health reform endeavors. However, our direct service staff are often poorly trained, resulting in the untimely processing of billing and collection and missed appeal deadlines for disputed Medicaid reimbursement denials. It is our understanding that if our Area were to appeal initial Medicaid denials for coverage, we could likely recover up to 50% or more of disputed claims. These are Service Unit claims for reimbursement that run afoul

of technical deficiencies that could be corrected with a more thorough documentation or clarification.

What will happen if this trend continues, under the new Affordable Care Act (ACA) or the new VA-IHS coverage authorities and reimbursement protocols? Answer: lost income due to deficient staff training and lack of performance accountability; AND continuing tribal health disparities that were supposed to be alleviated by these new authorities.

Human Resources (HR). HR office problems contribute to poor health services on many levels. HR staff, who are asked to prioritize assistance to one Service Unit over another, adjust quickly to inequitable staffing allocations and assistance. HR staff, who are not held to fast timelines for filling vacancies, contribute to (1) rising Contract Health Services' (CHS) costs, (2) delayed patient treatments, and (3) higher morbidity and mortality levels. HR staff, who do not help Management use appropriate Employee Performance Management criteria and evaluation, contribute to discouraged and dispirited staff. Such demoralized or unfairly targeted staff can delay or improperly fulfill their responsibilities.

Budget Formulation. Area Office budget formula inadequacies, such as insufficient or outdated patient workload data, can cause Service Unit

to Service Unit, or Area to Area funding inequities. Area staff who do not ensure that data is current or uniform make it very difficult to secure needed funding increases. Area Staff who do not understand these various budget formulas or the national formula distribution factors place our Area at a disadvantage in any national program resource allocation.

Area leadership is important in fighting for Area increases. Area Leadership cannot arbitrarily withhold monies from one Service Unit, though, to assist another Service Unit. Decisions to withhold Service Unit allocations cannot be made behind closed doors, nor to favor one community at expense of another [E.g. One SU with serious shortfall was only aided by taking monies away from only one other SU, when such shortfall could have been overcome by taking a little from each SU. Decision not satisfactorily explained to affected Tribe.]

Pharmaceutical. Our Area has insufficient supplies and relies on older medication type. There seems to be an unwillingness to secure new medications (for heart, diabetes, skin graft treatment for diabetes related sores). This outdated pharmacy schedule (inventory) becomes a costly problem, both financially and patient health-wise. If older type medicines are inadequate, then patient is sent to a private provider who recommends more up to date drugs. Yet, these medicines are

often not covered under Contract Health Service (CHS) referrals. Patients are often unable to pay for these meds and, so, do without. Again, this interrupts ongoing care and results in patient moving into an acute care stage when his/her health deteriorates.

A modern pharmaceutical is not only important to our Tribal patients, but it will be critical for a more seamless melding between the IHS and any Affordable Care Act (ACA) coverage and reimbursement activities. It seems that a modern pharmaceutical, such as enjoyed by rest of the U.S., can only come to Indian country if it chooses to "638" compact. This is not the right mind set for improving our federal health care delivery system. Area Management should be advocating for proper drug supplies and treatment, and not be satisfied with status quo.

Patient Transportation. There is simply not enough Emergency Medical Transport (EMT) or Community Health Representative (CHR) funding for this purpose. We have patients who are discouraged from seeking care because they have no way to travel to this care, aware of the long waits on arrival at a clinic or hospital; then need to walk many miles home after seeking such care. Our EMT vehicles must cope with rugged conditions and weather, and Medicaid or other funding is not adequate to rising gas, vehicle maintenance or replacement. Budget planning and funding on this front is critical.

IHS staff are losing their compassion when they allow elderly patients to walk, wait and walk long distance again, after securing minimal care. At Sioux Sanitarium, one Health Board staff did decide to take action when she learned of such an instance. She drove out to find an elderly patient who had left the clinic to walk home on a long, dark road. Yet, how many others did not have this help? In another instance, staff at the Sioux Sanitation facility told a disabled patient to take the city bus in for his appointment. This statement was made knowing that the patient's neurological disorder (myasenthia gravis) was so disabling that he could not drive or stand to wait for a bus. There appears to be no budget being developed for patient transportation purposes, resulting in patients not receiving care until their condition has gone critical. Such poor planning and callous patient treatment increases preventable deaths or leads to other health crisis.

Contract Health Services (CHS). Our Tribal Leaders have previously addressed the current CHS formula , and which we believe unfairly favors certain regions. The current formula directs an immediate and significant percent of new CHS funds (up to 20%) to Areas that do not contain inpatient facilities. These Areas then participate in the national allocation on the remaining funds, giving them two shots at the same budget.

We all recognize that Indian health funding has been, until this Administration, squeezed painfully shut. This includes the CHS program. While a Tribal community may have an inpatient facility, this does not mean that this Tribe is not equally reliant on CHS for inpatient care services. First, such inpatient care facilities are, as we have noted, poorly staffed and equipped. Secondly, such staffing and equipment as exist are very basic. Thirdly, our large populations which helped justify the need for an inpatient care facility, also means that we have an equally large need for specialty or other care not available in our under- funded sites (heart, physical therapy, OB/GYN, etc.).

This CHS formula is a prime example of the many inter-connecting problems afflicting the Area's effective program management, and of this vital program in particular. If CHS program staff do not do a thorough job on documenting patient workloads, new budget and increases are difficult to obtain. If CHS staff do not do a thorough job on documenting denials or timely processing appeals, a false picture of the true CHS need is presented. Likewise, if CHS staff does not share with the Budget Formulation and Clinical Care team, the types of patient care being sought from private providers, funding for in-house staffing and equipment are difficult to come by too.

Poorly trained staff, demoralized staff, or overburdened staff, in CHS or other programs, contributes directly to the amount of patient care is available to our communities.

Conclusion

Mr. Chairman, and other Members of this Committee, as you have seen, any mismanagement costs lives. Any mismanagement, whether staffing inequities, employee performance problems, budget and data deficiencies, billing and reimbursement weakness, or patient access difficulties, all lead down the same path of poor Indian patient health care.

We ask that the Committee work with us to devise Direct Service Tribal and IHS partnerships, appropriate to our circumstances. We support improved transparency and joint Tribal-IHS decision-making to improve accountability and better Tribal awareness. There is an urgent need for these activities to be accompanied by needed resources, so that we are able to carry our weight in the new ACA structure and with the new Indian Health Care Improvement Act reauthorization authorities.

Thank you for this opportunity and we look forward to working with you and others on the committee on strengthening our health care services.