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S. 1797, S. 1895 AND H.R. 1688

HEARING

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S. 1797, S. 1895 AND H.R. 1688

WEDNESDAY, JULY 21, 2021

U.S. SENATE,
COMMITTEE ON INDIAN AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 2:30 p.m. in room 628, Dirksen Senate Office Building, Hon. Brian Schatz, Chairman of the Committee, presiding.

OPENING STATEMENT OF HON. BRIAN SCHATZ, U.S. SENATOR FROM HAWAII

The CHAIRMAN. Good afternoon. During today's legislative hearing, we will consider three bills, S. 1797, the Urban Indian Health Providers Facilities Improvement Act, S. 1895, the Indian Health Service Sanitation Facilities Construction Enhancement Act, and H.R. 1688, the Native American Child Protection Act.

The Federal Government has a special trust responsibility to ensure the general welfare of Native communities. That includes providing adequate health care to Native people, supplying tribal communities with clean, safe drinking water and protecting Native children. But for too long, Congress has underfunded Native-serving programs and ignored Native needs on the ground.

The bills before this Committee today work toward righting these past injustices. The bipartisan Urban Indian Health Providers Facilities Improvement Act, cosponsored by Senators Lankford, Smith, and Moran, will remove a statutory funding use limitation and empower Urban Indian organizations to make needed healthcare facilities enhancements.

UIOs provide care to Native Americans in urban areas. But according to the National Council of Urban Indian Health, at least 74 percent of these facilities have critical, unmet facility infrastructure needs. S. 1797 would stretch Federal dollars for UIOs to use on facilities renovations, construction and expansion.

The next bill, Senator Luján's Indian Health Service Sanitations Facilities Construction Enhancement Act, will support tribal sanitation infrastructure development, an urgent priority across Indian Country. Indeed, the Indian Health Service has identified 110,000 American Indian and Alaska Native homes in need of some form of sanitation facility improvement, including more than 50,000 homes without access to sanitation facilities.

Finally, the House passed Native American Child Protection Act will reauthorize and modernize existing programs that help to ensure the health, safety and well-being of Native children, incor-

porate culturally appropriate treatment and services into these programs, and encourage tribal partnerships with UIOs and States to address family violence and child abuse.

Before I turn to Vice Chair Murkowski, I would like to welcome and extend my thanks to our witnesses for joining us today. Vice Chair Murkowski?

STATEMENT OF HON. LISA MURKOWSKI,
U.S. SENATOR FROM ALASKA

Senator MURKOWSKI. Thank you, Mr. Chairman. I appreciate the fact that at this first legislative hearing that the Committee has held this year that it encompasses these very important topics that we are speaking of today regarding the health and protection of Native children.

The Chairman has outlined the details of these three measures before us. S. 1797, again, the Urban Indian Health Providers Facilities Improvement Act will be significant as we look to make renovations, construct or expand health facilities used by UIOs to provide care of urban Indian patients. Many UIOs have reported their infrastructure needs have increased greatly due to the coronavirus pandemic. I think it is going to be important for the Committee to hear how any potential infrastructure needs could be used to alleviate some of these needs.

S. 1895, the Indian Health Services Sanitation Facilities Construction Enhancement Act—that is too long of a title—introduced by Senator Luján, with Senator Heinrich, Senator Sinema, is focused on addressing the water and sanitation infrastructure needs. The Committee has been very active in this initiative. Since the start of the pandemic, certainly, we have held some hearings and roundtables to determine how we can work to reduce the tribal sanitation facilities construction backlogs.

I have heard from Alaska Native leaders that their communities are without access to basic water and sewage infrastructure. It makes it pretty hard when you are dealing with a pandemic when you cannot meet the basic health guidelines of washing your hands.

We have had some very good testimony within the Committee from tribes and tribal consortia about the need to address the sanitation facilities backlog. We have made good improvements in sanitation infrastructure in rural Alaska. But still about 20 percent of rural Native homes still lack in-home piped water. Thirty-two of 190 Native communities are still unserved, lacking access to in-home water and sewer. So when we say unserved, we mean nothing. Nothing.

We know that the need is great. But we do have good news in this area with regard to how tribal health organizations have really worked creatively to address some of these needs. Just recently, the Committee staff sitting here in this room met with the Alaska Native Tribal Health Consortium. They were shown various examples of innovative uses of coronavirus relief funds. ANTHC is installing 100 mini-pass units. They are doing this in Kivalina, Newtok, there are seven other communities.

But this is effectively a way to help wash hands when you are in a home that doesn't have any running water. It is a small unit, it pumps the clean water from this overhead tank and then down

into a faucet for a person to use. The waste water then runs below the sink, it goes into a bucket. What we would do without our Home Depot buckets? Then that is later hauled out and removed.

So obviously this is not a permanent fix. But it shows that there is a level of innovation. We are trying to address some of the unique situations and circumstances in the needs of these underserved and unserved communities.

When you look at the need out there, it is pretty significant. More than $3 billion needed across the Nation for sanitation construction projects. So much of that in Alaska. We have been looking at this issue extensively within the infrastructure negotiations that I have been part of for these many weeks. Many of the priorities that we have heard here in this Committee from tribes across the Country with regard to water and sanitation infrastructure, broadband tribal energy, these are many of the pieces that we are trying to advance in this bipartisan proposal.

The last bill, H.R. 1688, the Native American Child Protection Act, again, very important to make sure that we are modernizing our programs to better address abuses against Native children. We did have a report that was issued by the Administration for Children and Families in fiscal year 2019, but when you look at the data, when you look at the statistics and you realize that American Indian and Alaska Native children had the highest rates of victimization, 14.8 per 1,000 children when compared to other races and ethnicity, in Alaska, almost half of the over 3,000 reported victims were American Indian or Alaska Native children, unacceptable. Just unacceptable in every sense.

I spoke on the Floor yesterday. We had a bill before us. This was the VOCA fix, focused on the Victims Compensation Fund and how we are able to ensure that that fund is there to meet needs. I had a VOCA roundtable in Alaska in June. We heard from many in the victim service provider community. What we heard about what is happening with far too many of our particularly Native children when it comes to violence against the children, severity of the abuse that we have seen recently, advocacy groups are telling us that they are seeing more cases of child torture and other egregious, actually heinous forms of abuse against children.

So at today's hearing, I hope that we can shed more light on this issue and how H.R. 1688 will help to work to reduce the levels of abuse and neglect of Native children. I am also going to be very interested to hear how this bill complements the work of what we have done with the Alyce Spotted Bear and Walter Soboleff Commission on Native Children, where part of that mission is to focus on child abuse, violence, and crimes.

Good bills before the Committee today. We are looking forward to comments from the witnesses.

Senator Schatz has excused himself to go participate in the first vote that is underway. So I am going to introduce the panel. Before I do, I will turn to you, Senator Lankford, or anybody, any members that might be participating telephonically, although I don't think we are participating telephonically.

Senator Lankford, if you would like to make a statement before we turn to witnesses?

STATEMENT OF HON. JAMES LANKFORD,
U.S. SENATOR FROM OKLAHOMA

Senator LANKFORD. Thank you. I would actually like to be able to help introduce one of the witnesses who is here, who I am a little proud of as well. If I can give just a brief statement.

Oklahoma UIOs serve the second largest population next to California and are a critical part of the Indian health system. Leaders like Robyn Sunday-Allen and Carmelita Skeeter from Tulsa are why the Oklahoma Indian urban clinics are really the gold standards for health care and clinic operations.

I was proud to sponsor and help pass into law the Coverage for Urban Indian Health Providers Act with Senator Smith. As this Committee knows, I just swiftly acted to implement the law on March 22nd, which could be record time for them to implement it, and to bring all the UIOs under the Federal Tort Claims Act. However, we strongly believe, and I strongly believe that more must be done to achieve parity for the UIOs within the Indian Health System umbrella.

According to the National Council of Urban Indian Health, 70 percent of American Indians and Alaska Natives live in urban and suburban areas. However, UIOs only receive a fraction of the cost per patient compared to the rest of the Indian Health system, and have little flexibility for their 501 facility dollars.

To ensure greater parity and flexibility, I was proud to introduce the Urban Indian Health Providers Facilities Improvement Act with Senators Padilla, Moran, Smith, and Feinstein. The legislation will give UIOs the ability to use their facility dollars for renovations as needed and remove the outdated limits on accreditation. That is coming up today. I am pleased it is on the docket for today.

To speak to the bill, I am proud to introduce a fellow Oklahoman, Robyn Sunday-Allen, who I mentioned before. Robyn is a member of the Cherokee Nation, National Council of Urban Indian Health Vice President, and the Chief Executive Officer of the Oklahoma City clinic. She knows the clinic from the ground up, because she started out as a registered nurse, transitioning to director of nursing and then chief operating officer, and finally CEO in 2009. I know her testimony today comes from her years of experience and dedicated service. I am thankful to have such a strong leader to represent our State and Indian Country today before the Committee today. I know she will do an excellent job with her testimony.

With that, I yield back.

Senator MURKOWSKI. [Presiding.] Thank you, Senator Lankford.

Senator Smith, we have just done opening statements. I don't know if you would like to make a comment before we turn to the introduction of witnesses.

Senator SMITH. No, I just am ready and looking forward to hearing from our witnesses. Thank you.

Senator MURKOWSKI. I think we are as well. Thank you, and thank you, Senator Lankford.

The panel today is with us all virtually. It will be led off by Mr. Randy Grinnell. He is the Deputy Director for Management Oper-

ations at IHS. Ms. Heidi Todacheene, Senior Advisor, Office of the Assistant Secretary of Indian Affairs here in Washington, D.C.

We have the Honorable Jonathan Nez, who is the President of the Navajo Nation, in Arizona, the Honorable Gil Vigil, who is the President for the National Indian Child Welfare Association in Portland, Oregon, and as Senator Lankford has just introduced, Ms. Robyn Sunday-Allen. We welcome her as well.

If we can begin with testimony from each of our witnesses. We would ask you to keep your statements to about five minutes or less. Your full statements will be incorporated as part of the record.

Mr. Grinnell, if you would like to lead off, please.

STATEMENT OF RANDY GRINNELL, M.P.H., DEPUTY DIRECTOR FOR MANAGEMENT OPERATIONS, INDIAN HEALTH SERVICE, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. GRINNELL. Good afternoon, Chairman Schatz and Vice Chair Murkowski and members of the Committee. Thank you for the opportunity to testify on the bills, S. 1895, S. 1797, and H.R. 1688.

S. 1895 is a bill to require additional funding through the IHS Sanitation Facilities Construction Program in planning design, construction, modernization, improvement, and renovation of water, sewer, and solid waste sanitation facilities that are funded by IHS. IHS has caried out the program since 1959 using funds appropriated to provide water and waste disposal facilities for eligible American Indian and Alaska Native homes and communities.

About 112,000 eligible homes tracked by IHS need some form of sanitation facility improvements. Many are very remote and may have limited access to health care, which increases the importance of improving environmental conditions.

In fiscal year 2020, for the IHS SFC program, the total sanitation facility need reported to the Sanitation Deficiency System was $3.09 billion. In 2020, IHS appropriated $197 million to address deficiencies. They funded projects to provide services to over 37,000 eligible homes and completed construction on 260 projects with an average project duration of 3.9 years.

Also, 373 construction projects were funded with a construction cost of $220 million using IHS and contributed funds. These sanitation facilities will benefit over 143,000 American Indian and Alaska Native people, and help avoid over 235,000 inpatient and outpatient visits.

Since fiscal year 2016, the SFC program funding has increased by nearly 100 percent without any increase in staffing. Without these staffing increases, the program is being strained to accomplish the required statutory obligations.

S. 1797, the Urban Indian Health Providers Facilities Improvement Act, would amend the Indian Health Care Improvement Act to extend the funding authority for renovating, construction, and expanding Urban Indian Organization facilities. Because of the language in current Federal law, IHS cannot award funds to a UIO to make minor renovations, construct, or expand facilities unless the UIO is doing to meet or maintain accreditation specifically from The Joint Commission. Only one out of the 41 UIOs maintains Joint Commission accreditation. Expanding the current authority to be consistent with the authority of other government contractors

would allow UIOs to make renovations, construct or expand facilities to improve the safety and quality of care provided to urban Indian patients.

H.R. 1688, the Native American Child Protection Act, would amend the Indian Child Protection and Family Violence Prevention Act and require the Secretary of HHS, acting through IHS, to establish the Indian Child Abuse Treatment Grant Program. IHS does not believe Congress has ever appropriated funding for this program.

The bill would amend current Federal law to expand the scope of this grant program to treatment programs for Indians who have been victims of child abuse or neglect. The bill would also allow UIOs to partner with Indian tribes and inter-tribal consortia in submitting grant applications. H.R. 1688 would also amend current Federal law to require IHS to encourage the use of culturally appropriate treatment services and programs and providing grants under this program.

IHS has an important role in improving the lives of Native youth. It is critical to identify and respond to child maltreatment for the health and well-being of children. A comprehensive approach is required that integrates health care and a community response. IHS's efforts include early intervention, assessment, and education to build resiliency among children and youth and to promote family engagement. This proposed legislation would expand access to child advocacy, center services, often not available in tribal communities. These include pediatric forensic exam services, mental health care providers with advanced training in child trauma, and culturally appropriate services for pediatric patients.

We look forward to continuing our work with Congress on these bills. We welcome the opportunity to provide technical assistance as requested.

Thank you again for the opportunity to speak with you today. I am happy to answer any questions you may have.

Thank you.

[The prepared statement of Mr. Grinnell follows:]

PREPARED STATEMENT OF RANDY GRINNELL, M.P.H., DEPUTY DIRECTOR FOR MANAGEMENT OPERATIONS, INDIAN HEALTH SERVICE, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Good afternoon Chairman Schatz, Vice Chairman Murkowski, and Members of the Committee. Thank you for the opportunity to testify on the bills S. 1895, a bill to require the Secretary of Health and Human Services to award additional funding through the Sanitation Facilities Construction Program of the Indian Health Service, S. 1797, Urban Indian Health Providers Facilities Improvement Act, and H.R. 1688, Native American Child Protection Act.

The Indian Health Service (IHS) is an agency within the Department of Health and Human Services (HHS) and our mission is to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level. This mission is carried out in partnership with American Indian and Alaska Native Tribal communities through a network of over 687 Federal and Tribal health facilities and 41 Urban Indian Organizations (UIOs) that are located across 37 states and provide health care services to approximately 2.6 million American Indian and Alaska Native people annually.

S. 1895

S. 1895, is a bill to require additional funding through the IHS Sanitation Facilities Construction (SFC) Program for the planning, design, construction, modernization, improvement, and renovation of water, sewer, and solid waste sanitation facili-

ties that are funded by the IHS. According to the bill, funding awards will be prioritized in accordance with the IHS Sanitation Deficiency System. The bill authorizes $3 billion in appropriated funds for Fiscal Year (FY) 2022, which will remain available until expended. Of the appropriated funds, $350 million shall be used for additional staffing support.

The IHS SFC Program is an integral component of IHS disease prevention activities. IHS has carried out the program since 1959 using funds appropriated to provide water and waste disposal facilities for eligible American Indian and Alaska Native homes and communities. As a result, infant mortality rates and mortality rates for gastroenteritis and other environmentally-related diseases have declined. Research supported by the Centers for Disease Control and Prevention states populations in regions with a lower proportion of homes with water service, reflect significantly higher hospitalization rates for pneumonia, influenza, and respiratory syncytial virus. Researchers associated the increasing illnesses with the restricted access to clean water for hand washing and hygiene. [1] The SFC Program works collaboratively with Tribes to assure all American Indian and Alaska Native homes and communities are provided with safe and adequate water supply and waste disposal facilities as soon as possible.

In FY 2020, IHS funded projects to provide service to 37,771 American Indian and Alaska Native homes. IHS also completed construction on 260 projects with an average project duration of 3.9 years. However, at the end of FY 2020 about 7,140, or 1.8 percent, of all American Indian and Alaska Native homes tracked by IHS lacked water supply or wastewater disposal facilities. About 112,082, or approximately 28 percent, of American Indian and Alaska Native homes tracked by IHS needed some form of sanitation facilities improvements. Many of these homes without service are very remote and may have limited access to health care, which increases the importance of improving environmental conditions.

The total sanitation facility need reported through Sanitation Deficiency System (SDS) has increased approximately $0.52 billion, or 20.2 percent, from $2.57 billion to $3.09 billion from FY 2019 to FY 2020. In FY 2020, the IHS was appropriated $197 million to address sanitation deficiencies and support provision of sanitation facilities to eligible American Indian and Alaska Native homes and communities. The magnitude of the sanitation facility needs increase is due to the IHS implementing a revised prioritization system to indicate the level of project planning. A "tier" system was introduced with the publication of the 2019 SDS Guidelines document. Projects considered "ready to fund" are assigned Tier 1, while projects considered "engineering assessed" are assigned Tier 2. Projects considered Tier 3 are those that are only "preliminarily assessed." Previously many of these projects were not reported to Congress. In FY 2020, there was a total of $0.67 billion in Tier 3 projects, resulting in an increase in the total sanitation facility need reported through SDS.

During FY 2020, 373 construction projects to address water supply and wastewater disposal needs were funded with a construction cost of $220 million using IHS and contributed funds. Once constructed, these sanitation facilities will benefit an estimated 143,000 American Indian and Alaska Native people and help avoid over 235,000 inpatient and outpatient visits related to respiratory, skin and soft tissue, and gastro enteric disease over 30 years. The health care cost savings for these visits alone are estimated to be over $259 million. Every $1 spent on water and sewer infrastructure will save $1.18 in avoided direct health care cost.

Adequate staffing resources are needed to ensure SFC projects are designed and constructed within the SFC Program's national average project duration of 4 years. Since FY 2016, the SFC project funding has increased by nearly 100 percent without any increase in staffing resources. Without associated increases in staffing resources, the IHS SFC Program is being strained to accomplish the required program statutory obligations of sanitation deficiency needs reporting, project design, planning, and provision of technical assistance, and as such we fully expect our project durations to increase beyond 5–6 years. Under the President's proposed FY 2022 Budget, the IHS SFC project funds will increase by roughly 60 percent. In addition to the proposed increases in IHS appropriated funds, an assumption is made that the amount of project funds to be directed towards the IHS through appropriations and contributions from other funding sources would double over the FY 2020 levels to $547 million in future fiscal years. The FY 2022 Budget also proposes an increase

[1] Thomas W. Hennessy, Troy Ritter, Robert C. Holman, Dana L. Bruden, Krista L. Yorita, Lisa Bulkow, James E. Cheek, Rosalyn J. Singleton, and Jeff Smith. The Relationship Between In-Home Water Service and the Risk of Respiratory Tract, Skin, and Gastrointestinal Tract Infections Among Rural Alaska Natives. American Journal of Public Health: November 2008, Vol. 98, No. 11, pp. 2072–2078.

of $36 million for the Facilities and Environmental Health Support program to support additional staff to implement the proposed funding increases for SFC, Health Care Facilities Construction, Maintenance & Improvements, and Equipment.

S. 1797

S. 1797, Urban Indian Health Providers Facilities Improvement Act, would amend the Indian Health Care Improvement Act (IHCIA), at 25 U.S.C. § 1659, to expand the funding authority for renovating, constructing, and expanding urban Indian organization (UIO) facilities. The bill would delete from existing law the requirement that UIOs may only use IHS funding for renovation, construction, or expansion of facilities to meet or maintain specific accreditation standards.

Current federal law at 25 U.S.C. § 1659 permits the IHS to make funds available to UIOs with contracts or grants with IHS under Title V of the IHCIA to make minor renovations to facilities or construction or expansion of facilities, including leased facilities, but only to assist UIOs in meeting or maintaining accreditation standards of The Joint Commission (TJC). Because of the specificity of the language in Section 1659, the IHS cannot award funds to an UIO to make minor renovations, construct or expand facilities, unless the UIO is doing so to meet or maintain accreditation specifically from TJC.

The IHS enters into limited, competing contracts and grants with 41 501(c)(3) non-profit organizations to provide health care and referral services for Urban Indians throughout the United States. An UIO is defined by 25 U.S.C. § 1603(29) as a nonprofit corporate body situated in an urban center, governed by an Urban Indian controlled board of directors, and providing for the maximum participation of all interested Indian groups and individuals, which body is capable of legally cooperating with other public and private entities for the purpose of performing the activities described in 25 U.S.C. § 1653(a). UIOs provide unique access to culturally appropriate and quality health care for Urban Indians.

Currently, UIOs seek and maintain accreditation from several health care accreditation organizations, including TJC, Accreditation Association for Ambulatory Healthcare (AAAHC), and Commission on Accreditation of Rehabilitation Facilities (CARF). Some UIOs have also achieved recognition as Patient Centered Medical Homes (PCMH), with additional UIOs currently working towards PCMH recognition, as well as AAAHC accreditation. In addition, some UIOs must meet standards from the Centers for Medicare & Medicaid Services and/or their respective state departments of health.

Currently, only 1 out of the 41 UIOs maintain TJC accreditation. Expanding the current authority to be consistent with the authority for other government contractors, rather than limiting it under Section 1659 to only TJC accreditation, would allow UIOs to make renovations, construction, or expansion of facilities necessary to improve the safety and quality of care provided to Urban Indian patients.

A large proportion of Urban Indians live in or near the poverty level and thus face multiple barriers to accessing high quality, culturally relevant health care services in urban centers. They must overcome additional barriers to receiving appropriate care such as lack of culturally appropriate care, lack of respect, lack of visibility, transportation issues, and communication obstacles that often interfere with the delivery of high-quality health care to Urban Indians. Providing UIOs with broader authority, similar to other FAR contractors, to improve their health care facilities will assist in providing the high quality, safe, and culturally relevant health care for the Urban Indian population.

H.R. 1688

H.R. 1688, Native American Child Protection Act, would amend the Indian Child Protection and Family Violence Prevention Act (25 U.S.C. 3201 et. seq.) (the Act), a statute that, among other provisions, required the Secretary of Health and Human Services, acting through IHS and in cooperation with the Bureau of Indian Affairs of the Department of the Interior (Bureau), to establish the Indian Child Abuse Treatment Grant Program (Program). IHS does not believe Congress has ever appropriated funding to carry out the Program.

H.R. 1688 would replace references to the "Secretary of Health and Human Services" with references to IHS. The bill would amend section 409 of the Act (25 U.S.C. 3208) to expand the scope of the Program. Current law requires that Program grants be provided for the establishment on Indian reservations of treatment programs for Indians who have been victims of child sexual abuse. The bill would expand the scope to treatment programs for Indians who have been victims of child abuse or neglect. The bill would also allow urban Indian organizations to partner with Indian tribes and intertribal consortia in submitting grant applications.

Additionally, H.R. 1688 would amend section 409 of the Act (25 U.S.C. 3208) to require IHS to encourage the use of "culturally appropriate treatment services and programs" in providing grants under the Program. The bill would require IHS to submit a report to Congress, within two years, on the award of Program grants. The report would contain a description of treatment and services for which grantees have used Program funds, and other information that IHS requires. The bill would authorize $30 million per year for fiscal years 2022 through 2027 to carry out the Program.

Finally, H.R. 1688 would amend section 410 of the Act (25 U.S.C. 3209), which currently requires the Secretary of the Interior to establish an Indian Child Resource and Family Services Center within each area office of the Bureau, with staffing for the Centers to be provided in a Memorandum of Agreement with the Secretary of Health and Human Services. The bill would remove references to the Secretary of Health and Human Services, eliminate the requirement for the Memorandum of Agreement, and require the Secretary of the Interior to establish one National Indian Child Resource and Family Services Center.

The IHS has an important role in improving the lives of native youth. Child maltreatment, a term that encompasses all forms of abuse and neglect, is associated with injuries, delayed physical growth, neurological damage, and death, and is linked with psychological and emotional problems such as aggression, depression, anxiety, low self-esteem, and post-traumatic stress disorder as well as an increased risk for the development of health problems later in life. It is critical to identify and respond to child maltreatment for the health and well-being of children, and it requires a comprehensive approach that integrates health care within a collaborative community response. IHS' efforts include early intervention, screening, assessment, education, and community-based programming to build resiliency among children and youth and to promote family engagement.

One program that focuses on domestic violence prevention is the IHS Domestic Violence Prevention Initiative (DVPI). Through this nationally coordinated grant and Federal award program, mandated through statute, IHS funds $11.2 million annually to 83 tribes, tribal organizations, urban Indian organizations, and Federal programs. The DVPI promotes the development of evidence-based and practice-based models that represent culturally appropriate prevention and treatment approaches to domestic and sexual violence from a community-driven context. The DVPI expands outreach and increases awareness by funding projects that provide victim advocacy, intervention, case coordination, policy development, community response teams, sexual assault examiner programs, and community and school education programs.

From 2010–2015, the DVPI resulted in over 78,500 direct service encounters including crisis intervention, victim advocacy, case management, and counseling services. More than 45,000 referrals were made for domestic violence services, culturally-based services, and clinical behavioral health services. In addition, a total of 688 forensic evidence collection kits were submitted to federal, state, and tribal law enforcement.

While the successful administration of the DVPI has assisted our agency in addressing violence, the program largely assists young adults experiencing intimate partner violence. Although child abuse and neglect often overlaps with intimate partner violence, the program does not specifically focus on treatment and recovery of child abuse and neglect victims. This proposed legislation would expand access to child advocacy center services that are often not available within tribal communities such as pediatric forensic examination services, mental health care providers with advanced training in child trauma, and culturally appropriate activities and services geared toward pediatric patients.

We look forward to continuing our work with Congress on these bills and welcome the opportunity to provide technical assistance as requested by the Committee or its Members. We are committed to working closely with our stakeholders and understand the importance of working with partners to address the needs of American Indians and Alaska Natives. Thank you again for the opportunity to speak with you today.

Senator MURKOWSKI. Thank you, Mr. Grinnell.

Ms. Todacheene, welcome.

STATEMENT OF HEIDI TODACHEENE, SENIOR ADVISOR, OFFICE OF THE ASSISTANT SECRETARY—INDIAN AFFAIRS, DEPARTMENT OF THE INTERIOR

Ms. TODACHEENE. Good afternoon, Vice Chair Murkowski and members of the Committee.

My name is Heidi Todacheene, and I am a member of the Navajo Nation and Senior Advisor of the Office of the Assistant Secretary for Indian Affairs at the U.S. Department of the Interior.

Thank you for the opportunity to provide testimony today on the Native American Child Protection act. The proposed legislation would amend the previously enacted Indian Child Protection and Family Violence Prevention Act, a statute that required the Bureau of Indian Affairs in collaboration with the Department of Health and Human Services, to establish an Indian Child Abuse Treatment Grant Program, National Resource and Family Services Center, and Child Protection and Family Violence Prevention Program.

Originally, after the bill's enactment in 1990, Congress did not fully fund the grant programs included in the bill and left tribes without resources to implement child preventive services and abuse programs and neglect services in their communities. They subsequently expired in 1997.

To date, the two grant programs included under the Native American Child Protection Act are the only tribally specific prevention programs for American Indian and Alaska Native children who are now at risk of being abused or have been abused.

As you know, there is a continuing need for tribes to build their capacity for these critical preventive and tribal treatment service programs. The Department supports this updated bipartisan legislation to authorize these programs and to develop tribal capacity for preventive services in Indian Country. This is necessary to safeguard indigenous children and strengthen communities, which has been historically overlooked by the Federal Government.

If the bill is enacted, it will modernize and reauthorize programs including the Indian Child Abuse Treatment Grant Program, the National Indian Resource Service Center, and the Indian Child Protection and Family Violence Prevention Program. The Department supports all of these programs to empower tribal communities to provide culturally appropriate tribal welfare services for their communities and provide the building blocks for currently non-existent preventive services for American Indian and Alaska Native children and families.

In furtherance of this work, this bill establishes the National Indian Child Resource and Family Services Center through the Bureau to consolidate resources for tribal capacity, for technical assistance and training, and improving coordination for effective intergovernmental work to help identify, prevent, investigate, and treat child abuse, neglect, and family violence cases.

To carry these activities out, the Department will be charged with establishing an advisory board consisting of 12 members from Indian tribes, tribal organizations and Urban Indian organizations with relevant expertise in the subjects under the provisions of the Indian Self-Determination Act. Additionally, the Department applauds the scope of funding and language included under the Indian Child Prevention and Family Violence Prevention Program.

As written the text includes accountability and tribal consultation requirements, which is a cornerstone of President Biden's work to promote robust and meaningful consultation with tribal nations in furtherance of the well-established responsibility of the Federal Government to honor its government-to-government relationship with tribes and uphold its trust and treaty obligations.

The bill does this through the Department's development of appropriate caseload standards, staffing requirements and the establishment of a base support funding formula developed in consultation with tribes. This consultation will help guide the Bureau to help account for specific factors such as locations of high rates of reported child abuse and will ensure tribal communities' needs are appropriately met.

If enacted and funded as originally intended, the $92 million authorization included in this legislation will finally give tribes preventive social services long overdue, programmatic funding, and support these efforts. Because all communities, regardless of where you come from, should have access to basic safety resources, especially for children.

In sum, the Department supports the Native American Child Prevention Act, and applauds the bill's inclusion of tribal consultation requirements and advancement of culturally appropriate services and self-determination provisions.

Vice Chair Murkowski, and members of the Committee, I thank you again for this opportunity to provide testimony today. I look forward to answering any questions that you may have.

Thank you.

[The prepared statement of Ms. Todacheene follows:]

PREPARED STATEMENT OF HEIDI TODACHEENE, SENIOR ADVISOR, OFFICE OF THE ASSISTANT SECRETARY—INDIAN AFFAIRS, DEPARTMENT OF THE INTERIOR

Good afternoon Chairman Schatz, Vice Chairman Murkowski, and Members of the Committee. My name is Heidi Todacheene, and I am a member of the Navajo Nation in New Mexico and Senior Advisor in Office of the Assistant Secretary for Indian Affairs at the U.S. Department of the Interior.

Thank you for the opportunity to provide testimony on behalf of Indian Affairs on H.R. 1688, the *Native American Child Protection Act.*

The Department of Interior supports H.R. 1688, the bipartisan *Native American Child Protection Act*, which amends the *Indian Child Protection and Family Violence Prevention Act* (Act) (25 U.S.C. §§3201 *et. seq.*). The proposed legislation would amend the Act, a statute that, among other provisions, required the Bureau of Indian Affairs (the Bureau) of the Department of the Interior, to establish Indian Child Resource and Family Services Centers within each area office of the Bureau in collaboration with the Department of Health and Human Services and to administer the Indian Child Protection and Family Violence Prevention Program. Congress has not appropriated funding to the Bureau to carry out the Centers or the Program since the Act's enactment in 1990.

Today, there continues to be a critical need for violence prevention and treatment services for tribal communities, and the Department supports this bill to reauthorize and amend the Act to work towards the fundamental need for preventative services in Indian Country to make critical improvements such as to the Indian Child Abuse Treatment Grant Program, establishment of a new National Indian Resource Service Center through the Department, and reauthorization of the Indian Child Protection and Family Violence Prevention Program to prevent tribal child abuse and neglect.

Significance of the Proposed Legislation

Congress has acknowledged that there is "no resource that is more vital to the continued existence and integrity of Indian tribes than their children."[1] This proposed legislation will empower Tribes to provide programs and services necessary to safeguard their children and strengthen their families. The proposed legislation embodies the well-being of American Indian/Alaska Native (AI/AN) children and families by preserving family relationships and increasing the capacity of tribes to provide for their children and families' needs.

A. Encouraging Use of Culturally Appropriate Treatment and Programs

H.R. 1688 inserts criteria for grant awards under the Act to encourage use of culturally appropriate treatment services and programs that respond to the unique cultural values, customs, and traditions of applicant Indian Tribes. Indian Affairs supports this criterion for grant awards, and notes alignment with Indian Affairs' efforts to promote multi-disciplinary work in tribal communities to prevent family violence and substance abuse.

B. Requires Establishment of a National Indian Child Resource and Family Services Center

H.R. 1688 amends the Act (section 410, *codified* at 25 U.S.C. § 3209) to require the Secretary of the Interior to establish a National Indian Child Resource and Family Services Center (the Center) within one year of enactment. It requires the Bureau to submit a report to Congress within two years after enactment of the bill. Per H.R. 1688, the Center's scope of responsibilities would include development of training and technical assistance materials on the prevention, identification, investigation, and treatment of incidents of family violence, child abuse and child neglect for distribution to Indian tribes, to Tribal organizations and urban Indian organizations.

This legislation requires the Center to develop model intergovernmental agreements between Tribes and States, and other materials that provide examples of how Federal, State, and Tribal governments can develop effective relationships and provide for maximum cooperation in the furtherance of prevention, investigation, treatment, and prosecution of incidents of family violence and child abuse and child neglect involving Indian children and families.

The bill also includes the establishment of a 12-member Advisory Board appointed by the Secretary of the Interior. These members will consist of representatives from Indian tribes, Tribal organizations, and urban Indian organizations with expertise in child abuse and child neglect.

H.R. 1688 allows the Center to operate subject to the provisions of the Indian Self-Determination and Education Assistance Act and authorizes Congress to appropriate $3.0 million per year for fiscal years 2022 through 2027 for the operation of the Center and associated activities.

Interior supports the establishment of the National Indian Child Resource and Family Services Center. The Center will enhance the activities the Bureau is currently implementing through efforts to promote multi-disciplinary work in tribal communities to prevent family violence and substance abuse.

C. Includes Tribal Consultation and Keeps Interior Accountable

The bill requires the Secretary of the Interior to develop caseload standards and staffing requirements in consultation with Indian tribes within one year after the bill's enactment. It also requires the Bureau to submit to Congress a report on the award of grants under Section 411 of the Act within two years of enactment of H.R. 1688. The report shall include a description of treatment and services for which grantees have used funds awarded under Section 411 of the Act.

D. Expands the Scope of the Act

H.R. 1688 expands the scope for which funds provided under the Indian Child Protection and Family Violence Prevention Program (Section 411, *codified* at 25 U.S.C. § 3210), can be used to include three new provisions: (1) the development of agreements between Tribes, States, or private agencies on the coordination of child abuse and neglect prevention, investigation, and treatment services; (2) child protective services operational costs including transportation, risk and protective factors, assessments, family engagement and kinship navigator services, and relative searches, criminal background checks for prospective placements, and home studies; and (3) the development of a Tribal child protection or multidisciplinary team to assist in the prevention and investigation of child abuse and neglect.

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[1] 25 U.S.C. § 1901(3).

Indian Affairs applauds the bill's inclusion of culturally appropriate actions in Section 411 of the Act. Interior is focused on multi-disciplinary work in tribal communities to prevent family violence and substance abuse.

H.R. 1688 authorizes Congress to appropriate $60.0 million per year for fiscal years 2022 through 2027 for Interior to implement Section 411, the Indian Child Protection and Family Violence Prevention Program, of the Act.

Conclusion

Chairman Schatz, Vice Chairman Murkowski, Members of the Committee, thank you for the opportunity to provide testimony today. I look forward to answering any questions that you may have.

The CHAIRMAN. [Presiding] Thank you very much.

Next, we have the Honorable Jonathan Nez, President of the Navajo Nation, Window Rock, Arizona.

STATEMENT OF HON. JONATHAN NEZ, PRESIDENT, NAVAJO NATION

Mr. NEZ. Ya'at'eeh, hello, and greetings from the Navajo Nation, Chairman Schatz, Vice Chair Lisa Murkowski, and members of the Committee. Thank you for the opportunity to speak to you about water infrastructure issues on the Navajo Nation and the need for funding opportunities through S. 1895, The Indian Health Service Sanitation Facilities Construction Enhancement Act.

My name is Jonathan Nez, and I am the President of the Navajo Nation.

The Navajo Nation has nearly 400,000 enrolled members, the majority of whom live within our homelands. The Navajo Nation has over 27,000 square miles of land that extends into the States of Arizona, New Mexico, and Utah.

Sadly, an alarming number of homes on the Navajo Nation have insufficient and decrepit water delivery and sewage disposal systems. Water is a fundamental need. It provides life, growth, and protection.

Some families were able to wash their hands as recommended by the CDC during the ongoing pandemic. One major contributing factor in the spread of COVID–19 on the Navajo Nation was limited access to water. Therefore, we urge Congress to ensure the Federal Government upholds its trust and treaty obligations by protecting and ensuring the deliver of water and sanitation in Indian Country.

For our Navajo people, the need is tremendous. As of December, 2020, IHS estimates the need for existing homes at $535 million. The Navajo Nation estimates the total need for current domestic and municipal water and sewages projects at $2.4 billion, more than $4 billion when you consider funding for critical water infrastructure, such as the Navajo-Gallup Water Supply Project, the Navajo Indian Irrigation Project, and the Navajo-Utah Water Rights Settlement Act.

The Navajo Nation has between 9,000 to 16,000 homes without any running water or sewage disposal. Six thousand of those homes have no IHS funding because the agency considers those projects infeasible. The Navajo Nation IHS area has more level 4 and level 5 households than any of the other areas or regions in the Country.

Roughly 40 percent of Navajo households are multi-generational, with extended families all living under one roof, increasing the need for safe, reliable water delivery and sanitary sewage disposal.

Multi-generational households was another contributing factor during the COVID–19 pandemic, that impeded safe practices that reduce the risk of transmission.

The IHS office of the Navajo area is chronically understaffed with 80 positions the Navajo region is currently struggling to fill.

To put it simply, the Navajo Nation supports S. 1895, investing in water infrastructure in tribal communities is just the beginning. IHS also needs to make internal changes to fully and adequately meet the needs of Indian Country. For example, the areas with the most need, such as the sparsely populated western portion of the Navajo Nation may never be addressed under current rules, because the IHS deems any project that exceeds a threshold of $107,500 as economically infeasible and ineligible for funding. In other words, the Navajo area IHS might only spend $166 million on the feasible project, instead of $535 million to cover feasible and infeasible projects which represent our total estimated need.

Additional changes need to occur within the Bureau of Indian Affairs to expedite rights-of-way so infrastructure projects are not delayed. The IHS SDS list does factor future growth of our communities.

We are grateful to the members of this Committee for considering making meaningful investment in Indian Country. Although significant administrative hurdles remain, the bill currently under consideration, S. 1895, would provide the resources needed to make significant progress toward addressing the current water and sanitation needs of the Navajo Nation and across Indian Country. These types of investments are long overdue, and this legislation is perhaps the most important legislation, along with other infrastructure measures, that will leave a permanent and lasting imprint in our communities and save lives.

Today I represent our Navajo elders, children, and families who struggle without safe and reliable water. By passing S. 1895, Congress is honoring Indian treaties, including our Navajo treaty of 1868, and upholding the Federal trust responsibility.

Thank you for the opportunity to testify, and I am happy to answer any questions.

[The prepared statement of Mr. Nez follows:]

PREPARED STATEMENT OF HON. JONATHAN NEZ, PRESIDENT, NAVAJO NATION

Ya'at'eeh (Hello) Chairman Schatz, Vice-Chairman Murkowski, and Members of the Committee. Thank you for the opportunity to speak to you about water infrastructure issues on the Navajo Nation and the need for funding opportunities through the Indian Health Service Sanitation facilities Construction Enhancement Act, S.1895. My name is Jonathan Nez and I am the President of the Navajo Nation.

The Navajo Nation, known as Diné, is the largest American Indian tribe in the United States, with 399,494 enrolled tribal members as of February 1, 2021. Over half of the Navajo people reside on a land mass of over 27,000 square miles that extends into the states of Arizona, New Mexico, and Utah. If the Navajo Nation was a state, it would rank 41st in size, behind South Carolina and just before West Virginia.

The Navajo Nation is committed to improving the standard of living on the reservation. Access to land, water, and electricity for families, government programs, public institutions, and businesses are critical to a better quality of life—equitable to that of most American communities. Recognizing that water is integral to human health and economic development, the Navajo Nation has placed water development as one of its highest priorities.

I. The Navajo Nation's Water System and IHS' SDS Listing

The development of potable water delivery and sewage disposal systems on the Navajo Nation are among the most pressing issues we need to address to help our people. This fact is shown in particular by data collected by the Indian Health Service (IHS) as part of its obligations under the Indian Health Care Improvement Act:

> The Indian Health Care Improvement Act (IHCIA) requires the Indian Health Service (IHS) to identify the universe of sanitation facilities needs for existing American Indian and Alaska Native (AI/AN) homes by documenting deficiencies and proposing projects to address their needs. These projects prevent communicable diseases by providing new and existing homes with services such as water wells, onsite wastewater disposal systems, or connections to community water supplies and wastewater disposal systems. These projects can also include provision of new or upgraded water supply or waste disposal systems. [1]

IHS fulfills this responsibility by maintaining a Sanitation Deficiency System (SDS) list. As of December 2020, the SDS list identified water and sanitation projects just on the Navajo Nation that were deemed necessary (including both feasible and infeasible projects) at a cost of $535 million, [2] with a total cost for all of Indian Country in excess of $2.6 billion for all projects. [3]

As the Committee is probably aware, the IHS continually updates the SDS list to include new deficiencies in water and sewage systems, but unfortunately this does not mean they are making much progress in fixing the problems identified on the list. Some projects have been on the IHS SDS list for more than a decade. Households where projects are delayed are forced to contend with band-aid solutions such as cisterns which still require families to haul water, sometimes from unregulated sources that may be unsafe. The Navajo Nation has at least 9,000 homes without any running water or sewage disposal, with some estimates as high as 16,000. Of those homes, 6,000 are included in projects on the SDS list, but are ineligible for IHS funding as they have been deemed economically infeasible. [4]

How Projects are Added to and Classified on the SDS Listing

To comprehend how this is possible, it is important to understand how this list is created. Projects are added to the SDS list if they are for existing facilities, and a tribe, the Bureau of Indian Affairs, or the IHS demonstrates that the water, sewage, and solid waste systems are insufficient based on federal standards of insufficiency. [5] The projects are given classifications on a scale of 1 to 5 based on their level of adequacy in terms of water delivery and solid waste/sewage disposal. Level 1 is where the water delivery system has reliable access to clean running water that meets federal standards for water quality and sanitation—the tribal community has reliable disposal of sewage and solid waste. It is the stated goal of the IHS Navajo Area Office that all tribal water and sanitation systems on the Navajo Nation meet level 1 criteria. [6] Level 2 projects require capital improvements to meet the standards of level 1. Level 3 projects include water supply and sanitation systems that are partially or somehow inadequate. Level 4 projects have either no reliable access to clean running water or no safe, healthy sewage disposal system, and level 5 projects have neither. [7]

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[1] Indian Health Service. (February 2020). Justification of Estimates for Appropriations Committees. P. CJ–201. Retrieved from: *https://www.ihs.gov/sites/budgetformulation/themes/responsive2017/display_objects/documents/FY_2021_Final_CJ-IHS.pdf*

[2] Roselyn Tso. (Dec. 23, 2020). RE: Navajo Area IHS sanitation deficiency system (SDS) list—FY 2021. Navajo Nation Department of Health & Human Services. See Appendix.

[3] Indian Health Service. (2018). Annual report to the Congress of the United States on sanitation deficiency levels for Indian homes and communities. Indian Health Service. P. 9. Retrieved from: *https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/Report_To_Congress_FY1 8_SanitationFacilitiesDeficiencies.pdf*

[4] From a conversation with Jason John, Director of the Navajo Nation Department of Water Resources, on July 8, 2021.

[5] Indian Health Service. (September 2019). SDS: A guide for reporting sanitation deficiencies for American Indian and Alaska Native homes and communities. Indian Health Service. P. 5–12. Retrieved from: *https://www.ihs.gov/sites/dsfc/themes/responsive2017/display_objects/documents/Final_SDS_Guide_v2.pdf*

[6] From a conversation with David McConnell, Chief Project Engineer for the Navajo Area Indian Health Service, on June 8, 2021.

[7] Indian Health Service. (September 2019). SDS: A guide for reporting sanitation deficiencies for American Indian and Alaska Native homes and communities. Indian Health Service. P. 18. Retrieved from: *https://www.ihs.gov/sites/dsfc/themes/responsive2017/display_objects/documents/Final_SDS_Guide_v2.pdf*

SDS Project Prioritization

SDS projects are then prioritized based on eight (8) factors. The first is health impacts, which evaluates the link between disease outbreaks in tribal communities and the deficiencies in their water supply, solid waste, and sewage systems. The second is the project deficiency level, where they are assigned one of the aforementioned classifications of levels 1–5. The third evaluates whether a house, facility, or community system has been funded in the past by IHS to address its deficiencies. If it has not been funded in the past, it gets a higher score. The fourth is the capital cost, where the most expensive projects are often given negative scores to move them to a lower position on the priority list.[8] The fifth is local tribal priorities, where the tribe can provide input to adjust the position of the different projects on the SDS list. The sixth is operation and maintenance capability, where the results on annual reports on each project are factored in. The seventh is contributions, an optional assessment criterion where the availability of outside funding is assessed, if applicable. The eighth is other factors, another optional criterion, which include other legal or environmental issues that stand in the way of a project such as rights of way, or geologic impediments such as the clay soil in the vicinity of Chinle, Arizona.[9] The point values from all of these criteria are combined to produce an assessment score, which is weighed against the others to find the position of each project on the SDS list from highest to lowest priority.[10]

SDS Listing for the Navajo Area

The Navajo Nation IHS Area has more level 4 and 5 projects than any of the other IHS Areas throughout the country.[11] About 40 percent of households on the Navajo Nation are multigenerational, with extended families all living under one roof, increasing the need for safe, reliable water delivery and sanitary sewage disposal.[12] Finally, many of the homes that have been addressed in the past have septic systems that are failing because the households cannot afford to have them cleaned and maintained, and/or the homeowners were not instructed how to take care of them.[13]

II. Concerns and Issues We See

Inadequate Funding and Staffing

For fiscal years 2017–2021, the Sanitation Facilities Construction Program that administers the SDS list received the following amounts:

FY 2017—$101,772,000
FY 2018—$192,033,000
FY 2019—$193,577,000
FY 2020—$192,931,000

An annual appropriation of nearly $200 million is woefully insufficient. As noted above, the total estimated cost of all reported projects is approximately $535 million for the Navajo Region and $2.6 billion for Indian Country for fiscals year 2019 and 2018, respectively. If we continue this funding trajectory, which only provides approximately 7 percent of the funding needed, the needs will never be met, especially as new projects are added to the list every year. Congress is turning a blind eye to the overwhelming need of delivering safe water to American Indians.

In addition to funding, we know the IHS offices for the Navajo Area are chronically understaffed, with 30 positions that the agency is currently struggling to fill.

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[8] From a conversation with David McConnell, Chief Project Engineer for the Navajo Area Indian Health Service, on June 8, 2021.

[9] Indian Health Service. (September 2019). SDS: A guide for reporting sanitation deficiencies for American Indian and Alaska Native homes and communities. Indian Health Service. P. 27–32. Retrieved from: *https://www.ihs.gov/sites/dsfc/themes/responsive2017/display_objects/documents/Final_SDS_Guide_v2.pdf*

[10] Indian Health Service. (September 2019). SDS: A guide for reporting sanitation deficiencies for American Indian and Alaska Native homes and communities. Indian Health Service. P. 32–33. Retrieved from: *https://www.ihs.gov/sites/dsfc/themes/responsive2017/display_objects/documents/Final_SDS_Guide_v2.pdf*

[11] From a conversation with David McConnell, Chief Project Engineer for the Navajo Area Indian Health Service, on June 8, 2021.

[12] From a conversation with Jason John, Director of the Navajo Nation Department of Water Resources, on July 8, 2021.

[13] From a conservation with Ronnie Ben, Navajo Nation Environmental Agency Environmental Department Manager, on July 8, 2021.

They need to be able to attract and maintain engineers and engineering assistants to make these projects go smoothly and be addressed as soon as possible. [14]

Prohibitive Internal Policies and Procedures with the SDS Listing

The IHS has internal policies and procedures governing how they complete assessments which further frustrates IHS' ability to address our needs, even if Congress fully funds projects listed on the SDS listing. For example:

- The criteria IHS employs to determine whether a project is "feasible" is arbitrary and subjective. If a project is too costly, it is "not feasible." If the project has an issue that cannot be easily addressed, it is "not feasible." If a project is deemed to be "not feasible" it is ineligible for IHS funding, even though it remains on the SDS list.
- The Sanitation Deficiency list does not take the age of a reported project into account, meaning some older projects remain untouched on the list, while newer projects get funded.
- Navajo areas with the most need, such as the most remote parts of the Navajo reservation, are sparsely populated, and may never be addressed under current rules because the IHS deems projects that exceed the cost of $107,500 per household in Arizona and $101,500 in New Mexico and Utah [15] as economically infeasible and ineligible for funding. Western areas, such as the former Bennett Freeze Area, [16] are among the communities that have long been neglected and are in dire need of water.
- The Navajo Nation is unable to receive its full proportionate share of funding because too many projects are deemed not feasible. Currently, the Navajo Nation is only eligible to receive a third of the IHS funding of what is actually needed to bring all households up to level 1 (reliable access to running water, sanitary disposal of sewage, compliance with federal water quality and sanitation standards).
- IHS is permitted to add negative points to any project on the SDS listing with potential issues. For example, a project with a right of way issue may be assigned negative points, pushing the project further down the line from being funded. Changes need to be made internally at BIA to resolve these issues to limit unnecessary delays.

Growth is not a Factor in the SDS Listing

The IHS SDS list documents the backlog of water and sanitation deficiencies, but it does not account for future economic growth, nor does it consider the fact that the Navajo Nation has a chronic housing shortage for our current population notwithstanding additional people and families in the future. As a matter of fact, the IHS is not allowed to consider future needs for funding. [17] The Navajo Nation is planning for water needs 40 years into the future. [18] This puts our assessed water development needs at $4 billion total, well over the $535 million that would fix current deficiencies. Of this, $2.4 billion would go to the most imperative domestic and municipal projects alone. [19]

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[14] From a conservation with Roselyn Tso, Area Director for the Navajo Area Indian Health Service, on July 8, 2021.

[15] Indian Health Service. (September 2019). SDS: A guide for reporting sanitation deficiencies for American Indian and Alaska Native homes and communities. Indian Health Service. P. 47. Retrieved from: *https://www.ihs.gov/sites/dsfc/themes/responsive2017/display_objects/documents/Final_SDS_Guide_v2.pdf*

[16] The former Bennett Freeze Area consists of nine (9) Navajo Chapters or Navajo local governments, located in Coconino County, Arizona on the Navajo Nation, 1) Bodaway/Gap; 2) Coppermine; 3) Kaibeto; 4) Coalmine Canyon; 5) Leupp; 6) Tolani Lake; 7) Tuba City; 8) Tonalea; and 9) Cameron. More than 12,000 Navajo people living in the area were subjected to a 41-year freeze on development until Congress lifted that freeze in December 2006.

[17] Indian Health Service. (September 2019). SDS: A guide for reporting sanitation deficiencies for American Indian and Alaska Native homes and communities. Indian Health Service. P. 6 & 15. Retrieved from: *https://www.ihs.gov/sites/dsfc/themes/responsive2017/display_objects/documents/Final_SDS_Guide_v2.pdf*

[18] From a conversation with Jason John, Director of the Navajo Nation Department of Water Resources, on July 8, 2021.

[19] Jason John. (March 24, 2021). Build back better: Water infrastructure needs for Native communities. Navajo Nation Department of Water Resources. P. 2. Retrieved from: *https://www.indian.senate.gov/sites/default/files/2021-03-22%2024March2021_Testimony_draft%20-%20final.pdf*

Proposed Changes

We are concerned that even if S. 1895 is passed with its current language, IHS' internal rule that bars economically "infeasible" projects from being funded would limit the intent of the bill. For the Navajo Nation, which has the second longest SDS listing in all of Indian Country, second only to Alaska,[20] there is nothing more frustrating than having funds with no ability to spend them. Therefore, we urge Congress to consider changes to the proposed legislation that address these concerns or demand that IHS remove administrative barriers in order to fully realize and address the true magnitude of the inadequacies of water infrastructure in Indian Country and the human impact that this widespread problem has.

In addition, IHS should also be permitted to spend a portion of these funds on educating household members on how to maintain their water and sewer systems and assist them with upkeep. Maintenance of critical infrastructure is just as important as constructing it.

III. Conclusion

We applaud Congress and the current Administration for their commitment to honoring the federal trust obligation by making a meaningful investment in Indian Country. Although significant administrative hurdles remain, the bill currently under consideration, S. 1895, would provide the resources needed to make significant progress toward addressing the current water and sanitation needs of the Navajo Nation and Indian Country in general. The funding it will provide is long overdue, and perhaps most importantly, will literally save lives by reducing the spread of disease through improved sanitation in Indian Country.

As we make progress towards fixing many of the problems that afflict our people, the Navajo Nation is reminded of the valuable partnership we have with the Indian Health Service and the members of this Committee. We look forward to working with the 117th Congress to continue the work on legislation such as S.1895 that can protect the public health and environment of our tribal communities.

Ahéhee' and thank you.

The CHAIRMAN. Thank you very much.

Next, we have the Honorable Gil Vigil, President, National Indian Child Welfare Association, in Portland, Oregon.

STATEMENT OF HON. GIL VIGIL, PRESIDENT, NATIONAL INDIAN CHILD WELFARE ASSOCIATION

Mr. VIGIL. Thank you, Chairman. Good morning, Chairman Schatz, and Vice Chair Murkowski, and members of the Committee. It is an honor to be providing testimony on behalf of the National Indian Child Welfare Association on H.R. 1688, the Native American Child Protection Act.

My name is Gil Vigil, and I am President of the National Indian Child Welfare Association and Executive Director for the Eight Northern Indian Pueblos Council here in New Mexico. I am a former governor of the Pueblo Tesuque. By virtue of that, I am a lifetime council member of our council.

Today my testimony is provided on behalf of the National Indian Child Welfare Association. NICWA is located in Portland, Oregon, and we are the only national Indian organization solely dedicated to child welfare issues in the United States. We accomplish our missions through technical assistance to tribal communities, training to child welfare professionals, advocacy to improve services to Native children and families, and research to fill gaps in data regarding the well-being of Native families.

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[20] Indian Health Service. (2018). Annual report to the Congress of the United States on sanitation deficiency levels for Indian homes and communities. Indian Health Service. P. 1–31. Retrieved from: *https://www.ihs.gov/sites/newsroom/themes/responsive2017/display__objects/documents/Report__To__Congress__FY1 8__SanitationFacilitiesDeficiencies.pdf*

My written testimony provides background, statistics and other context related to child maltreatment in Indian Country. But I want to use my oral testimony to show why we think the Native American Child Protection Act is worth your support.

NICWA has been involved in supporting the proper implementation of the original statute that H.R. 1688 is reauthorizing, the Indian Child Protection and Family Violence Prevention Act, which was enacted in 1990. We watched as then Senator McCain and Senator Inouye worked together to craft this legislation and move it through the Congress.

Like most legislation, it was not perfect. But Senator McCain knew how important it was, because of the large gap in funding of child abuse and neglect prevention and victim treatment services that existed for tribes. He also saw the perils of what happens when a community doesn't have the capacity to effectively respond to child maltreatment. Even today, over 30 years later, tribal nations are still trying to secure dedicated funding for these purposes where they don't have to compete with State or other populations.

As an example, the Federal Government's largest source of dedicated child abuse prevention funding, the Child Abuse Prevention and Treatment Act, provides only two tribal grants each year to tribal nations. We greatly appreciate Senator Murkowski's effort to address the concerns with CAPTA, but even if that effort is successful, not all tribal nations can be funded. The Native American Child Protection Act provides an opportunity to ensure every tribe will have funding to provide child abuse and neglect prevention and treatment services.

Why is this legislation so important for Indian Country? Notwithstanding the risk factors for child maltreatment that exist in our communities, we also have incredible potential to develop programs that can address the risk of child abuse and neglect before it gets to the stage where a child has to be removed from their home. Sometimes, it is necessary to remove a child from their home to protect them. But even with good intentions, children and families experience trauma from these actions.

When we can intervene early with more prevention oriented, culturally based services, we can reduce foster care placements and strengthen families to help them avoid the foster care system altogether.

Where tribes have resources and have redesigned their child welfare system to incorporate cultural practices, we can see evidence of how successful these programs are. For example, the Confederated Tribes of Umatilla several years ago, like many tribes in States, were seeing their foster care rates rising and struggling to find enough foster homes for their children that were being removed. They came together as a community and put in motion a redesign of their child welfare program that emphasized prevention service and trauma informed service to heal families who themselves had suffered significant trauma in their lives. The result was that they were able to have 85 children in out-of-home placements to less than 20 in a couple of years after the redesign was complete.

Their successes continue, and it is happening in other tribal communities, too. But we can't replicate this on a large scale without additional funding authority.

Over the last 35 years, NICWA has followed and been involved in numerous child welfare policy debates. Most of them were addressing services for children who already had been placed in foster care. The Native American Child Protection Act provides an opportunity to address the struggles families have before they reached a crisis state. We are very grateful for that.

I hope you will join us in supporting the Native American Child Protection Act. Thank you for this opportunity, and I am ready to respond to any questions. Thank you.

[The prepared statement of Mr. Vigil follows:]

PREPARED STATEMENT OF HON. GIL VIGIL, PRESIDENT, NATIONAL INDIAN CHILD WELFARE ASSOCIATION

I would like to start by thanking the Chairman and Vice-Chairman of the committee for holding this hearing. I am Gil Vigil, and I am a member of the Pueblo of Tesuque in New Mexico and Executive Director of the Eight Northern Indian Pueblos Council also located in New Mexico. Today I am providing testimony on behalf of the National Indian Child Welfare Association (NICWA) located in Portland, Oregon where I serve as the President of the Board of Directors. NICWA is in full support of H.R. 1688 and has long advocated for the reauthorization of this important law so tribal nations and urban Indian programs may have the opportunity to effectively address child maltreatment and domestic violence in American Indian and Alaska Native (AI/AN) communities.

Our understanding of these issues comes from more than 40 years of experience working with tribal governments, their child welfare programs, and the communities themselves. We have developed this knowledge as nationally recognized providers of training and technical assistance, leaders in federal and state policy development, and researchers that examine key issues in Indian child welfare. We do this work in close partnership with both Indian and non-Indian organizations, such as the Child Welfare League of America and the National Congress of American Indians (NCAI). These partnerships allow us to participate in work that supports increased access to healing services for affected AI/AN children and families and improve tribal and urban Indian organization capacity to provide culturally based prevention and treatment services. From 1998 to2018, we provided technical assistance to the System of Care Children's Mental Health tribal grantees who were on the front lines designing and operating culturally based mental health services for AI/AN children with serious mental health disorders. We understand the impact of trauma on children and their families and the toll it takes on communities, especially when the trauma goes unaddressed or untreated. Our experience has taught us the importance of supporting tribal self-determination and the important roles tribal governments play in developing sustainable and culturally based solutions to child abuse and neglect and domestic violence.

Our testimony will focus on:

- The historical context of, and past government responses to, child maltreatment in tribal communities
- The current research and data available on the risk factors for, and rates of, AI/AN child maltreatment
- The current challenges to tribal program funding and data collection related to AI/AN child maltreatment
- Tribal-state relationships and their impact on efforts to address AI/AN child maltreatment
- Solutions that are working in tribal and urban AI/AN communities

We also want to note that child maltreatment comes in a variety of forms, including sexual abuse, physical abuse, and neglect, among others. Among these different forms of child maltreatment, neglect is by far the most frequent occurring within AI/AN families- 89 percent of all AI/AN child maltreatment victims were the result of child neglect (National Child Abuse and Neglect Data Center Technical Team [NCANDS], 2014). Child neglect is often a form of child maltreatment that responds

best to prevention and treatment efforts, which fits well with the purposes of the grant programs contained within H.R. 1688.

UNDERSTANDING CHILD MALTREATMENT IN INDIAN COUNTRY

> "The diversity of American Indian and Alaska Native tribes and villages cannot be overemphasized when thinking about child maltreatment in Indian Country. Tribes, villages, reservations, and urban Indian communities have vastly different resources, social and economic conditions, and cultural and traditional practices. These differing conditions affect child abuse and neglect and mean that no statements about child maltreatment can apply to all tribes, villages, and urban communities across the country" (Crofoot, 2005, p. 123).

The Historic Context

To understand the context of child maltreatment for AI/AN children, it is essential to understand that AI/AN communities are at high risk for child maltreatment in large part because of disparate treatment of AI/AN families and communities by federal and state governments, such as funding and service limitations. It is equally important to understand the lingering effects of historical governmental policies and practices—including the placement of AI/AN children in boarding schools, the relocation of AI/AN peoples to major cities, and the large numbers of AI/AN children removed from their families, often unnecessarily, by public and private child welfare agencies.

Prior to contact with European immigrants, tribal child-rearing practices and beliefs allowed a natural system of child protection to flourish. Traditional Indian spiritual beliefs reinforced that all things had a spiritual nature that demanded respect, including children (Cross, Earle, & Simmons, 2000). Not only were children respected, but they were also taught to respect others. Extraordinary patience and tolerance marked the methods that were used to teach Indian children self-discipline (Cross et al., 2000). Behavior management or obedience was obtained through the fear and respect of something greater than the punishment of a parent (Cross et al., 2000).

At the heart of this natural system were beliefs, traditions, and customs involving extended family with clearly delineated roles and responsibilities. Child-rearing responsibilities were often divided between extended family and community members (Cross et al., 2000). In this way, the protection of children in the tribe was the responsibility of all people in the community. Child abuse and neglect were rarely a problem in traditional tribal settings because of these traditional beliefs and natural safety nets (Cross et al., 2000).

As European migration to the United States increased, traditional tribal practices in child-rearing were often lost as federal programs sought to systemically assimilate AI/AN people. Efforts to "civilize" the Native population were almost always focused on their children. It began as early as 1609, when the Virginia Company, in a written document, authorized the kidnapping of AI/AN children for the purpose of civilizing local AI/AN populations through the use of Christianity (Cross et al., 2000). The "Civilization Fund Act" passed by Congress in 1819 authorized grants to private agencies, primarily churches, to establish programs in tribal communities designed to "civilize the Indian" (Cross et al., 2000).

From the 1860s through the 1970s, the federal government and private agencies established large boarding schools, far from tribal communities, where AI/AN children were involuntarily placed (Crofoot, 2005; Cross et al., 2000). Indian agents had the authority to withhold food and clothing from parents who resisted sending their children away (Crofoot, 2005; Cross et al., 2000). The boarding schools operated under harsh conditions; children were not able to use their Native languages or traditional customs, were required to wear uniforms and cut their hair, and were subjected to military discipline and standards (Crofoot, 2005). The rate of deaths among AI/AN children that were sent to boarding schools was extremely high with many dying from infectious diseases, overworking, harsh discipline, child abuse, and extreme mental or emotional trauma.

In the 1960s and 1970s, the child welfare system became another avenue that state and federal governments used to force the assimilation of AI/AN children. It was during this era that the Child Welfare League of America and the Children's Bureau, a federal government agency, sponsored the Indian Adoption Project, which involuntarily removed hundreds of AI/AN children from their homes and communities out West and placed them in non-Indian homes on the East Coast (Cross et al., 2000). At the same time, AI/AN children were unofficially being removed from their homes and placed in non-Native homes in large numbers. The Association on American Indian Affairs conducted a study in the 1970s that found between 25 percent and 35 percent of all Indian children had been separated from their families

(Jones, Tilden, & Gaines-Stoner, 2008). This study also found that 90 percent of the removed Indian children were placed in non-Indian homes (Jones et al., 2008).

The outcome of these assimilation efforts is heightened risk factors for child maltreatment in AI/AN communities. These policies left generations of parents and grandparents subjected to prolonged institutionalization without positive models of family life and family discipline (Crofoot, 2005). These individuals, many of them current parents and grandparents of AI/AN children, may subject their children or their relatives' children to the harsh discipline and child maltreatment they endured in boarding school. Further, boarding schools and relocation efforts to large cities have resulted in the destruction of kinship networks and traditional understandings of child-rearing and protection, damaging the natural safety net that was in place traditionally (Crofoot, 2005). It was not until 1978, with the passage of the Indian Child Welfare Act (ICWA), that the federal government acknowledged the inherent sovereign right of tribal governments and the critical role that they play in protecting their children and maintaining their families. After two centuries of the United States usurping tribal nation's rights to care for their families and significant erosion of the natural helping system in tribal communities, the federal government enacted ICWA to end the earlier policies that brought so much trauma to AI/AN children and families.

The effects of these programs are longstanding. Challenges in AI/AN communities today, including poverty, mental and physical health problems, poor housing, and violence, are directly related to federal reservation and relocation policies. Socially and economically isolated reservations and urban Indian communities are fraught with disadvantage, including a heightened risk for child maltreatment (Crofoot, 2005).

The pattern of mistreatment of AI/AN people and communities over the course of centuries described above, has had an additional effect on AI/AN families that creates a heightened risk for child maltreatment: historical trauma. The concept of historical trauma in AI/AN people and communities originates from studies that examined the lingering effects that the Holocaust had on the children and grandchildren of families affected (Brave Heart & DeBruyn, 1998). Researchers and experts believe that the shared experience by AI/AN people of historic traumatic events such as displacement, forced assimilation, suppression of language and culture, and boarding schools creates a legacy of unresolved grief that, when left untreated, is passed down through generations (Cross, 2006; Brave Heart & DeBruyn, 1998), and experienced in ways that reflect reactions to trauma, such as increased mental health disorders, substance abuse, stress, and social isolation—all risk factors for child maltreatment.

Risk Factors for Child Maltreatment

There is little information on the risk factors for child maltreatment in AI/AN families specifically (Bigfoot, 2005). This is problematic because national policy and child welfare practice focus on the prevention of child maltreatment, and successful prevention programming requires an understanding of culturally specific risk factors. (Centers for Disease Control, 2012; Children's Bureau, 2011; Administration for Children and Families, 2003)

Without an accurate, nuanced understanding of the complex interaction of risk factors for child maltreatment in AI/AN families, prevention, identification, and intervention may be ineffective. For instance, although mainstream research points to "disorganized" families as a potential risk factor for abuse and neglect, AI/AN families often thrive and are most healthy when they take the form of codependent kinship networks. These codependent networks may be seen by a mainstream case manager as "disorganized" and thus a risk factor—when it is a protective factor and its disruption could only further hurt the family in question.

Although not ideal, mainstream child maltreatment risk factors can be used to provide a general understanding of the likelihood of risk of child maltreatment in AI/AN communities. The following national statistics show that AI/AN families appear to be particularly vulnerable to child maltreatment.

Parental Risk Factors

- AI/AN children are more likely to live in households that are below the poverty line. Thirty-four percent of AI/AN children live in households with incomes below the poverty line as compared to 20.7 percent of children nationwide (Maternal and Child Health Bureau, 2012).
- AI/AN parents are more likely to struggle with substance abuse. Eighteen percent of AI/AN adults needed treatment for an alcohol or illicit drug use problem in the past year compared to the national average of 9.6 percent (SAMHSA, 2009).

- AI/AN parents are more likely to struggle with mental health issues and distress related to unresolved trauma. Among U.S. adults ages 18 and over who reported only one race, AI/ANs had the highest rate of serious psychological distress within the last year (25.9 percent), and the highest rate of a major depressive episode within the last year (12.1 percent) (Urban Indian Health Institute, 2012).
- AI/AN children are more likely to live in families where no parent has full-time, year-round employment than the national average. Forty-nine percent of AI/AN children are in homes where no parent has full-time, year-round employment compared to 25 percent of White homes (Annie E. Casey, 2012).
- AI/AN mothers are likely to be a young age at the birth of their children. AI/AN women on average have their first child at age 21.9, younger than all other races and ethnicities; the average age of first birth for the U.S. population is 25.0 years (Mathews & Hamilton, 2011).
- AI/AN parents are less likely to have high educational attainment. In 2007, 20 percent of AI/AN adults over 25 had not attained their high school diploma; 36 percent of AI/AN adults over 25 had completed high school but did not continue to postsecondary school (DeVoe & Darling-Churchill, 2008). In 2006, 74.7 percent of AI/AN graduation-aged students, compared to 87.8 percent of the general population, received their high school diploma (DeVoe & Darling-Churchill, 2008).
- AI/AN families are more likely to be single-parent than the average family. Fifty-two percent of AI/AN children are raised in single-parent households, while nationally only 34 percent of children are raised in single-parent households (Annie E. Casey, 2012).

Family Risk Factors

- Many AI/AN families are socially isolated. Reservation communities are located in remote and sparsely populated areas, and often the housing within those communities is spread out over a large area. Because of this, the health care community has recognized that a major barrier to quality medical care for AI/AN individuals is social isolation, including the cultural barriers, geographic isolation, and low income common in reservation communities (Office of Minority Health, 2012).
- AI/AN women are more likely than any other single racial group to experience intimate partner violence (IPV, also known as domestic violence); 39 percent of AI/AN women report having experienced IPV at some point in their lives (Black & Breiding, 2008).

Community and Structural Risk Factors

- AI/AN individuals are more likely to live in communities where they will experience high rates of criminal victimization and where there is limited law enforcement presence (Wells & Falcone, 2008; Wakeling, Jorgensen, Michaelson, & Begay, 2001).
- AI/AN families are more likely to live in communities where there is a high level of unemployment. The rate of joblessness on or near reservation communities is 49 percent (BIA, 2005).
- AI/AN families are more likely to live in areas of high poverty than the average family; 24 percent of AI/AN children live in areas of highly concentrated poverty compared to the national average of 11 percent (Annie E. Casey, 2012).
- AI/AN individuals are less likely than the average American to own their homes, one guarantee of housing stability. Only 56 percent of AI/AN households were homeowners, compared with 66 percent of total households (Ogunwole, 2006).

The Prevalence of Child Abuse and Neglect in AI/AN Families

National data on AI/AN children who experience child abuse and neglect are limited. The National Child Abuse and Neglect Data System (NCANDS) collects comprehensive data on the rates and characteristics of child abuse and neglect in all families that enter public child welfare systems. The data input into this system, however, is only for families who interface with state and county child welfare systems. Tribal programs, Bureau of Indian Affairs (BIA) or Indian Health Services (IHS) programs, or tribal consortia are often the primary service providers for AI/AN children and families, yet NCANDS does not include AI/AN children who come to the attention of, and are served by, tribal child welfare systems.

Research has shown that state and county workers are only involved in approximately 63 percent of all tribal abuse and neglect cases (Earle, 2000). These findings would lead to the conclusion that abuse and neglect of AI/AN children are underreported (Fox, 2003). Other issues, however, such as the definition of child abuse and neglect, the process for counting incidents of abuse and neglect in NCANDS, or the fact that reporting is primarily based on non-Native perceptions and substantiation of maltreatment would lead to the opposite conclusion—that numbers of AI/AN abuse and neglect cases in NCANDS are artificially high (Bigfoot et al., 2005).

It is also important to note that national research studies of the child welfare system have found a biased treatment of AI/AN families in state systems. Although these studies tend to focus on out-of-home placement, one recent study found that, due in part to systematic bias, where abuse has been reported, AI/AN children are two times more likely to be investigated, two times more likely to have allegations of abuse substantiated, and four more times likely to be removed from their home and placed in substitute care (Hill, 2007).

Nonetheless, the limited data that is available does provide some basic understanding of the prevalence of child maltreatment in AI/AN families and communities:

- AI/AN children are 1.3 percent of all child maltreatment victims reported to state and county child welfare agencies (Children's Bureau, 2017).
- AI/AN children experienced a rate of child abuse and neglect of 14.3 per 1,000 AI/AN children. This rate compares to the national rates of victimization of 9.1 per 1,000 (Children's Bureau, 2017).

NICWA requested a special data report from the Department of Health and Human Services in 2014 regarding select child abuse and neglect data that is not published or available to the public (NCANDS, 2014). This special report was not able to provide data for AI/AN on all of the NCANDS data set but does provide specific data on 18 different indicators. Some key findings include:

Maltreatment Types by Victim

- Of all maltreatment victims, 89.3 percent of AI/AN children were involved in the child welfare system because of a disposition of neglect, compared to 78.3 percent of all children nationwide
- Of all maltreatment victims, 15.6 percent of AI/AN children were involved in the child welfare system because of a disposition of physical abuse, compared to 18.3 percent of all children nationwide
- Of all maltreatment victims, 5.6 percent of AI/AN children were involved in the child welfare system because of a disposition of sexual abuse, compared to 9.3 percent of all children nationwide

Child Fatalities Subject to Child Maltreatment

- 2.21 AI/AN children out of 100,000 were reported as fatalities due to child maltreatment, compared to 2.2 of 100,000 children nationwide

Children and Caregiver Risk Factors

- Alcohol Abuse:
  - —30 percent of AI/AN child victims had a parent with an alcohol abuse problem, compared to 28.5 percent of child victims nationwide
  - —14 percent of AI/AN child non-victims had a parent with an alcohol abuse problem, compared to 4.9 percent of children nationwide
- Drug Abuse:
  - —24.5 percent of AI/AN child victims had a parent with a drug abuse problem, compared to 20 percent of child victims nationwide
  - —11.7 percent of AI/AN child non-victims had a parent with a drug abuse problem, compared to 8.4 percent of children nationwide
- Domestic Violence:
  - —24.8 percent of AI/AN child victims had a parent involved in domestic violence, compared to 28.5 percent of child victims nationwide
  - —11.4 percent of AI/AN child non-victims had a parent involved in domestic violence, compared to 8.6 percent of children nationwide

Although NCANDS is the primary source of data on the abuse and neglect of children, there are a few other sources of data for AI/AN children, such as select Bureau of Indian Affairs regional offices, Indian Health Services, and other agencies concerned with this information that may collect data on the prevalence of child mal-

treatment in the tribal communities with which they work (Bigfoot et al., 2005; Earle, 2000). This data, however, is not kept consistently or nationally.

Effects of Child Maltreatment

Facing trauma in the form of child maltreatment has long-term effects on the well-being of AI/AN children, particularly when it goes undetected and untreated. Studies have shown that children who have been abused or neglected have higher rates of mental health and substance abuse disorders, are more likely to be involved in the juvenile justice system, have worse educational outcomes (truancy and grade repetition), and are more likely to have early pregnancies (Office of Planning, Research and Evaluation, 2012). It is also important to understand that individuals who experience abuse and neglect are more likely to be perpetrators of intimate partner violence and child maltreatment, creating a cycle of violence that is difficult to break (Child Welfare Information Gateway, 2013). In addition, child abuse and neglect can have a long-term effect on physical health. One study has shown that at up to three years following a maltreatment investigation, 28 percent of children were diagnosed with a chronic long-term health condition (Office of Planning, Research and Evaluation, 2007).

Child maltreatment does not just have long-term effects on the victims; it also comes at a great cost to society and the communities it touches. According to the Centers for Disease Control, to manage all of the services associated with the immediate response to all child maltreatment costs $124 billion a year (Child Welfare Information Gateway, 2013). Although AI/AN children are only a small fraction of child maltreatment victims nationally, that would still equate to billions of dollars a year being spent to respond to child maltreatment of AI/AN children. For tribes who are already under-resourced in the area of child welfare and who do not have access to federal child abuse prevention funding (with the exception of two small, competitive grant programs), responding to child maltreatment can be a huge drain on available resources.

Beyond the direct or immediate costs of child maltreatment, there are also many long-term indirect costs. These include long-term economic consequences to society such as an increased likelihood of employment problems, financial instability, and work absenteeism. In addition, child maltreatment creates long-term economic consequences related to increased use of the healthcare system, increase cost due to juvenile and adult criminal activity, and increased use of mental illness, substance abuse, and domestic violence services (Child Welfare Information Gateway, 2013).

Chronic social problems like child maltreatment hold back communities. When they are unaddressed, they ultimately interfere with efforts to create and encourage economic development by taking from tribal resources that could be used for economic and infrastructure development to "manage" these chronic and persistent social problems. Furthermore, as Cornell and Kalt (1998) discuss, "nation building," an approach to successful economic development for Indian tribes, requires a community where both businesses and humans must flourish because they are in relationship with one another. Cornell argues that success in economic development is more than just jobs—it also includes social impacts and making a community a place where investors want to do business and where the community is healthy enough to engage successfully with the economy.

Issues with Funding for Child Abuse Prevention and Child Protection

Funding for child maltreatment prevention, and treatment efforts is limited in Indian Country. Most funding for child welfare services comes from federal sources, such as the Bureau of Indian Affairs or the Department of Health and Human Services. Tribes do have access to some funds that are flexible (e.g., Bureau of Indian Affairs ICWA Title II funds, or Department of Health and Human Services Social Security Act Title IV–B funds) and can be used to prevent and intervene in child maltreatment cases. However, since tribal funding in child welfare overall is very limited, available flexible funding sources are often used to support non-prevention, non-child protection crisis-oriented services, such as foster care or child welfare case management. States, while not having access to adequate prevention funding, still receive proportionately more funding, as well as funding from two major sources that tribal programs are not eligible for: the Title XX Social Services Block Grant and the Child Abuse Prevention and Treatment Act (CAPTA) State Grants.

CAPTA, reauthorized by the CAPTA Reauthorization Act of 2010 (P.L. 111–320), is the only federal law that focuses solely on prevention, assessment, identification, and treatment of child abuse and neglect. Tribes are eligible for the two discretionary grant programs under CAPTA through the Community-Based Grants for Prevention of Child Abuse and the Discretionary Funds (which support research and demonstration grants and training programs). This is for one-time, special projects

funding and does not support ongoing prevention and treatment services. Tribes, however, are not eligible for CAPTA State Grants used to improve child protection services programs, which provide a small foundation of funding for child protection services to every state. Thus, tribal funding to prevent and address child abuse is almost nonexistent. Under the entire CAPTA statute, tribes typically receive less than $300,000 a year from the over $100 million a year in appropriated funds.

Although all tribes recognize the importance of prevention, and many provide programs that incorporate child abuse prevention activities, they do so with little or no federal support. Furthermore, the prevention work they do is in communities with families that are very high risk for child abuse and neglect. While the funding levels for states are low under CAPTA, every state still receives some level of funding to conduct these activities, whereas funding for tribal governments under this program does not even reach 1 percent of the tribes nationwide. Furthermore, CAPTA provides support in the form of matching funds for state Child Abuse Trust Funds, which provide support for advocacy and child abuse prevention services. Tribes receive little or no benefit from these state trust funds, and there is no provision for support to local or a national tribal child abuse prevention trust fund under CAPTA.

The Title XX Social Services Block Grant is a capped entitlement that, among other things, supports programs that strive to prevent and remedy abuse, neglect, or exploitation of those who cannot protect themselves by promoting community-based care. Recipients (states and territories) are afforded a great deal of flexibility in terms of how they use the Title XX funding to meet these goals. These funds are often used to fill service gaps that exist in other more restrictive federal child welfare programs-specifically child abuse prevention and child protection services. The Social Services Block Grant is currently one of the only major sources of federal funding used for child welfare services by states to which tribes do not have access.

The Family Violence Prevention and Services Act provides funding for tribal nations from a set-aside within the law. Currently, the program provides about $14 million annually that provides small grants to about 270 tribes to conduct prevention efforts and services to address family violence. Specific services that can be supported with the grant funds include increasing public awareness about, and primary and secondary prevention of, family violence, domestic violence, and dating violence, and to provide immediate shelter and supportive services for victims of family violence, domestic violence, or dating violence, and their dependents. Most of the 270 tribes funded receive grants under $50,000 a year leaving little room for anything but crisis services. It is important to note that the presence of domestic violence in a home is a risk factor for child maltreatment and effectively addressing domestic violence is critical to prevention of child abuse or neglect.

To fill gaps in funding due to underfunding and lack of access to other federal sources, Congress enacted the Indian Child Protection and Family Violence Prevention Act (P.L. 101–630), which contains three separate grant programs designed to address child abuse prevention, investigation, and treatment services. The act authorizes Indian Child Resource and Family Service Centers staffed by multidisciplinary teams (MDTs) with experience in "prevention, identification, investigation and treatment" of child abuse and neglect (AI/AN tribes may contract to run these centers). The act also authorizes funding for grant programs for the development of Indian child protection and family violence prevention programs and for the treatment of victims of child abuse and neglect and family violence. The resource centers grant program is the only grant program to have received any appropriations of the three and this only occurred in one year during the mid-1990s. Tribes are not different from states in their need to respond to child abuse and neglect in their communities, and they need additional funding to develop a continuum of services and programming to prevent and respond to child abuse and neglect.

Issues with Data Collection

Tribal governments need reliable mechanisms for collecting their own data and the ability to access data for their tribal members who are under federal or state jurisdiction. Accurate, reliable, well-coordinated, and accessible data collection is critical to understanding the scope and trends of child maltreatment in Indian Country. Data must include AI/AN children under tribal, state, and federal jurisdiction to paint an accurate picture and highlight unique issues within each of these systems.

The Indian Child Protection and Family Violence Prevention Act identifies the federal requirements for reporting and investigating child abuse in Indian Country. If the alleged abuse, such as child sexual abuse, is considered to be a criminal violation, the agency receiving the report is to notify the FBI. In a scenario where child sexual abuse of an AI/AN child on tribal land is reported and then investigated,

there could be as many as three different governments and/or law enforcement authorities responding (tribal, federal, or state) and each collecting different or similar data. While theoretically each of these entities could share this data, this may be complicated by conflicting policy mandates or each government's principles regarding confidentiality and the sharing of information.

Many tribes have established agreements with local child protection agencies and law enforcement in their area to address issues of coordination, but this is a complicated and often long process that is not well resourced and contains several collaboration challenges. One primary challenge can be misperception by health agencies, whether they are tribal, federal, or privately operated, that due to the Health Insurance Portability and Accountability Act (P.L. 104–19, HIPAA), they cannot share client information with other outside agencies. Agencies or individuals that operate under this assumption have often not received accurate information or training on the discretion allowed under the law, the law's application in child abuse reporting and investigations, and/or the interaction of federal Indian law with HIPAA. While the Indian Child Protection and Family Violence Prevention Act implies that information pertaining to a report or investigation can and should be shared, it does not provide additional incentives or resources to assist tribes as they negotiate these complex relationships and roles.

Tribal and urban AI/AN organizations struggle with data collection regarding child maltreatment and access to existing data sources. As mentioned previously, states submit their child maltreatment data to NCANDS, which was established in amendments to CAPTA in 1988. NCANDS is a data system that collects child abuse and neglect information both at the aggregate and case level. The aggregate data is used by the Department of Health and Human Services to publish an annual report on the characteristics of child abuse and neglect in the United States titled *Child Maltreatment*. Although data on AI/AN children are included in this report, the data reflected does not include those children in tribal child welfare systems. In addition, many data elements specific to AI/AN children that would be helpful to urban and tribal programs are not reported for this publication. Tribal governments do not currently submit to NCANDS nor do they have a similar central repository to which they can submit their data for analysis and annual report.

A few tribal governments have been able to develop their own databases and accompanying infrastructure in this area, but the vast majority of tribes do not have the resources to build and maintain such a system. The ability to develop these tools and activities has been primarily tribally funded work with little investment from federal sources. However, tribes that have been able to develop a child abuse and neglect database are often looking to develop a system that not only helps them collect data on individual cases, but also serves as an electronic case management system, a tool for tracking client and service trends, and program evaluation. Tribes that develop and operate these systems are more likely to be able to develop carefully thought-out responses to children's needs in their community and engage in larger systems reforms efforts.

It is worth noting that the Bureau of Indian Affairs and Indian Health Services may collect some limited data based on their roles as funders or service providers for AI/AN children affected by child maltreatment, but this data is not readily available to tribes, is not coordinated with other data sources, and lacks the comprehensiveness necessary to inform policy and practice.

In addition to accurate systemic data, tribal child protection and prevention teams also need research specific to child maltreatment in Indian Country to create and promote effective prevention strategies, interventions, and policy change. There is little information on the cultural interventions and assessments that are being used with AI/AN children. This is largely due to the fact that tribal and urban AI/AN communities lack the resources necessary to establish evidence-based practices and create cultural adaptations of evidence-based practices (BigFoot and Braden, 2007). There is no national focus and very limited support for funding these types of projects at the federal level. Much of the federal research on child maltreatment has been funded by demonstration and discretionary grants authorized under CAPTA. Typically, these grants are awarded to large public and private universities, hospitals, or private organizations with extensive research capacity and infrastructure. These grants support some of the key research on the effects of child maltreatment; characteristics of abuse and neglect; and effective prevention, intervention, and treatment practices. Until the recent reauthorization of CAPTA in 2010, tribes were not eligible to apply for these demonstration or research grants, and since that time no tribe has been awarded a grant. Another consequence of this lack of research is that as federal, state, and private funders increase their focus on projects that contain evidence-based practices, tribes and urban AI/AN organizations are increasingly finding themselves left out since many evidence-based practices have not es-

tablished program effectiveness with AI/AN populations, and tribes may deem some evidence-based programs culturally inappropriate for the families and children they serve.

TRIBAL–STATE RELATIONS

Because of the direct federal government-to-tribal government relationship, historically, tribal-state interaction was limited. The direct tribal relationship with the federal government led to the sense that there was little role for state governments in tribal affairs. Although states have no authority to pass laws that interfere with the federal-tribal relationship, the development of tribal-state relationships is critical to providing appropriate services to AI/AN children and families. Additionally, as the federal government has decreased its involvement in providing direct services to AI/AN children and families and states have increased their efforts to implement ICWA, the need for increased intergovernmental coordination and cooperation among state, county, and tribal governments is greater.

Tribes and states have identified a variety of mechanisms and models to improve intergovernmental relationships and to provide more accessible, culturally based, and more effective services to AI/AN children and families. These mechanisms include (1) coordinating internal tribal child welfare resources; (2) engaging in discussions about key child welfare issues such as ICWA implementation or child abuse/neglect investigations; (3) educating one another on respective service trends and model practices; (4) negotiating respective governmental responsibilities; and (5) developing cooperative strategies for intergovernmental relationships and service delivery agreements.

It is extremely important for tribes and states to use these successful mechanisms and models to develop and maintain positive relationships with one another. Poor tribal-state relationships can negatively affect the prevention and treatment of child abuse and neglect on tribal lands. With the federal government serving a supporting role, tribal-state relationships can be successfully developed and improved. When tribes and states are unwilling or unable to develop cooperative relationships, it is children and families who suffer the most.

In areas where tribal-state relationships in child welfare are the most successful, there is a policy infrastructure in place—such as intergovernmental agreements and state ICWA policies—that outlines the roles and responsibilities of tribes or urban AI/AN organizations and states in responding to reported child maltreatment of AI/AN children. While these agreements or policies are not mandatory, they have proven to be extremely helpful in clarifying expectations and responsibilities for each of the parties as they carry out their designated roles in child welfare services. Over 25 states have some form of ICWA related policy or agreements in place with new policy development happening each year. The agreements and state policies provide tribes and urban AI/AN organizations with opportunities to participate in child protection activities and provide their expertise and resources, even when they cannot directly provide the services themselves.

SOLUTIONS TRIBES AND URBAN CENTERS ARE EMPLOYING

Elements of Successful Responses to Child Maltreatment in Indian Country

To effectively address child maltreatment in Indian Country, tribal governments and urban programs have drawn on the wisdom of their communities and culture. Programs and services that have been successful are designed with input from the community and implemented by those with intimate knowledge and deep understandings of the unique community needs and the tribal culture. Services are based in cultural beliefs, teachings, customs, and traditions and aligned with trauma-informed care that treats both the symptoms of child maltreatment and also the causes and effects of trauma on all family members.

Another common element of effective child maltreatment prevention and treatment services is a successful collaboration, whether across different governments (tribal, federal, state, and local) or within a particular governmental structure. Collaborative relationships help leverage funding, clearly define roles and responsibilities, incorporate cultural resources, eliminate service disparities, and improve overall communication between agencies serving the same children and families. Tribal governments, in their efforts to address child maltreatment, are subject to a variety of jurisdictional challenges and varying service delivery and funding schemes that can impact their ability to provide prevention and treatment services. The ability to form successful collaborative relationships with various governmental entities outside of tribal lands is critical to addressing these jurisdictional, funding, and service delivery challenges. Urban AI/AN programs also experience many of these challenges, especially those related to funding and service delivery. They will often develop partnerships with local, state, and sometimes tribal governments. Success-

ful tribal and urban AI/AN programs work within their respective governance structures to coordinate between agencies as well.

A third common element of successful child maltreatment programming for AI/AN children is a strong understanding of the importance of familial connections as a protective factor for AI/AN children. While removal may be necessary to protect children in more serious abuse and neglect circumstances, the removal itself is traumatic for children who can be separated from their family, community, and culture. A balanced approach to child protection can keep children safe from harm while nurturing family and community relationships. By keeping family relationships intact, children remain connected to their culture, have a positive sense of belonging, and gain an understanding of their identity as an individual as well as a member of the collective community. Tribal and urban AI/AN programs serve an important role in facilitating these connections through both formal services and access to informal helping networks.

A fourth element is the location of appropriate community-based services for AI/AN children and families. Families struggling with child maltreatment often have multifaceted needs and treatment plans that require access to different service providers. AI/AN populations on tribal lands are very often located in rural areas where access to affordable and timely public transportation can be extremely limited, if available at all. With high unemployment rates on tribal lands, other modes of reliable private transportation can also be out of reach. Services that are located in off-reservation areas and operated by other public and private entities generally do not incorporate the values and culture of tribal families and consequently are limited in their ability to do successful outreach and services for these children and families. Community-based services ensure that tribal child protection responses can be accessible, tailored to the needs of children and families, and incorporate tribal culture.

The following section will describe several tribal and urban AI/AN programs that have been successful in addressing child maltreatment. This includes prevention of child maltreatment, community engagement, healing trauma in adult family members, providing supports to family members to help keep children safely in their homes, and treating the trauma in child victims. These examples do not constitute an exhaustive list, but instead seek to provide some brief examples of how tribal communities and Indian organizations are using limited resources to creatively and effectively address child trauma issues, especially child maltreatment.

Primary and Secondary Child Abuse Prevention

NICWA is a leader in helping tribes build capacity to address the complex issues surrounding child abuse and neglect in their communities and develop effective prevention strategies that use cultural resources and traditions. Grassroots Child Abuse Prevention is a NICWA training curriculum that helps tribal communities develop community-wide child abuse and neglect prevention campaigns (NICWA, n.d). Trainees are provided information about child abuse and neglect, community organizing techniques, cultural adaptations of mainstream prevention strategies, and social marketing to develop and support community-based prevention strategies for AI/AN communities. NICWA also provides on-site technical assistance to help tribal communities implement their prevention strategies. School settings can provide an effective environment for prevention efforts. NICWA provides a training curriculum that helps Native parents, administrators, and teachers develop a child sexual abuse prevention program for their Head Start and pre-school programs. Children's Future: A Child Sexual Abuse Prevention Curriculum for Native American Head Start Programs covers program administration, recognizing indicators of abuse, reporting procedures, and parent and community involvement (NICWA, n.d.). It also includes a nine-month lesson plan for use in the classroom.

As discussed earlier, the Child Abuse Prevention and Treatment Act (42 USC § 5116) provides funding authority for small grants to tribal grantees to fund child abuse and neglect prevention activities (Community-Based Child Abuse Prevention). The amount of funding has allowed two grantees to be funded every three years. However, these grantees have developed activities and programs that have been very successful. In 2008, two tribal grantees used these funds to develop and operate primary and secondary prevention activities. The grantees were the Mississippi Band of Choctaw Indians in Mississippi and the Cahuilla Band of Mission Indians in California. The projects used cultural adaptations of mainstream models of prevention with additional cultural activities included.

- Each project sought to address both primary and secondary prevention strategies targeting both offending and non-offending parents, as well as other families within their communities that showed interest in the activities. Below are

some additional elements of these projects that used a combination of education, parent support, and outreach activities

- Included activities for both children and parents separately and together
- Nurtured protective factors in non-offending parents who remain with the children (Choctaw)
- Empowered parents to reduce risk and incidence within their own families, while also becoming mentors or coaches to other parents in the community (Choctaw)
- Conducted regular sessions for the community at large on parenting, marriage, and strengthening cultural connections (Cahuilla)
- Provided intensive referral and case management for parents to help them secure needed family supports and services; as much as possible, these services will be provided in the home (Cahuilla)
- Culturally adapted mainstream, evidence-based models (Incredible Years parenting program-Cahuilla)
- Integrated family advocate model for case management (Choctaw)

As this list suggests, the importance of culture and family was a key part of many interventions as was systems collaboration. A common thread noted in the assessment of each project was a recognition that historical trauma and past government efforts to assimilate AI/AN people have had a negative effect on parenting, and important traditional values and parent strategies had been replaced with less effective and sometimes dysfunctional interventions and care.

In-Home Services

In-home services can be an effective method for reducing risk and still protecting children without creating additional stressors by placing children in out-of-home care. In-home services are intensive by definition and require regular contact with parents and children. To create an in-home service plan, family members contribute to the risk assessment, help identify formal and informal services to alleviate stressors that contribute to risk behaviors and engage with a case manager as well as a network of identified support. These services allow parents and siblings to maintain their family and cultural connections, which is critical to the successful rehabilitation of AI/AN families, while intervening early on any issues that could lead to child maltreatment.

Denver Indian Family Resource Center

The Denver Indian Family Resource Center (DIFRC) in Denver, Colorado, has been providing in-home supportive services to AI/AN families who are involved in the child welfare system since 2000. They serve a very diverse urban AI/AN population that lives in the Front Range in and around Denver. To help families meet their basic needs and provide safe homes for their children, DIFRC provides supportive services that include job search assistance, life skills education, housing assistance, and health advocacy (Medicaid/CHP enrollment). For some families, stabilization begins with learning how to keep a monthly family budget, maintain a household schedule, and procure transportation to work or school. Many of these core services are provided in the home, including coaching for improved communication and parenting skills, behavior and anger management, consultation with other social services providers, supervision of home visitation, and helping families acquire basic needs. DIFRC programs, like the Strong Fathers and Strong Mothers Parenting Program, are based on American Indian values and promote the development of positive parenting skills and the cultivation of cultural resources. As much as 80 percent of the case management process at DIFRC involves helping families meet basic needs and balance responsibilities. Based on data compiled by the Colorado Disparities Resource Center, DIFRC reduced the overall number of AI/AN children in Colorado being removed from their families and placed in foster care by 33 percent (NICWA, 2010).

Central Council of the Tlingit and Haida Indian Tribes of Alaska

The Central Council of the Tlingit and Haida Indian Tribes of Alaska (CCTHITA) has been working closely with the state and their own Temporary Assistance to Native Families (TANF) department to better support families at risk of child maltreatment and keep children in their homes. In Alaska, Alaska Native (AN) children make up over 62 percent of the state foster care system while only representing 15 percent of the state's youth population (Summers, Wood, & Russell, 2012). There, as elsewhere, structural risk factors such as poverty, joblessness, inadequate housing, substance misuse, and untreated mental health problems contribute to reports

of maltreatment and are often conflated with neglect. Although neglect, not abuse, is the primary form of child maltreatment reported, the most common intervention for AN families is the removal of their children, not in-home services. Efforts to address these issues by Alaska Native communities have been ongoing, but state efforts to use tribal in-home services have been slow in many areas based on a lack of understanding and trust in tribal services.

The CCTHITA Preserving Native Families Department provides services to member families and children in both rural southeast Alaska and in the urban boundaries of Juneau designed to keep children at risk of maltreatment safely in their homes. CCTHITA also operates a TANF program. Over half of the families that are served by TANF are also involved with the Preserving Native Families program or state Office of Child and Family Services.

The CCTHITA TANF program was often the first program with which CCTHITA families at risk of abuse or neglect came into contact. At the same time, referrals from the state OCS to Preserving Native Families were low, despite significant risk factors within the CCTHITA community and the availability of robust tribal in-home services. The Preserving Native Families program uses a cultural adaptation of an evidence-based assessment tool, Structured Decision Making, to evaluate families at risk of maltreatment and develop plans to protect children and rehabilitate families. The Preserving Native Families department saw an opportunity to increase early identification of at-risk families and offered training and support to TANF staff on the Structured Decision-Making tool. The Preserving Native Families program also used the assessment tool as a platform to educate the state OCS staff on how to improve referrals of CCTHITA families and help them access in-home services that can eliminate the need for removal of children into out-of-home care. These efforts have led to earlier and more frequent referrals of families at risk and a decrease in the number of children removed from their homes.

Tribal Home Visiting Program Approaches

Home visiting programs have shown to be effective at helping children and their families prevent, reduce, and seek timely treatment for child-related ailments, including child maltreatment. In 2010 tribal communities became eligible for the newly authorized Tribal Maternal, Infant, and Early Childhood Home Visiting Program. This program aims to improve outcomes in a range of critical areas of child well-being such as maternal and prenatal health; infant health; child health and development; reduction in child maltreatment; improved parenting practices; school readiness; improved family socioeconomic status; improved referral and coordination with community resources and supports; and reduced incidence of injuries, crime, and domestic violence. To reach these outcomes, the program provides funding to tribal grantees to culturally adapt conventional evidence-based models of home visiting programs, or to use national in-home service models that have included AI/AN clients in their test population in their communities (Del Grosso et al., 2011). Tribal grantees have elected to focus on a number of different evidence-based models and integrate cultural traditions and practices into their newly designed tribal programs. A number of the tribal programs combined home visiting services with other services to create more complete in-home service models. Many of the programs sought to incorporate cultural teachings and use paraprofessional staff indigenous to the community being served. Through the use of these culturally adapted models, tribal participants have reported outcome measures related to the reduction of child maltreatment, family violence, juvenile delinquency, and crime (Del Grosso et al., 2011).

Indian Country Child Trauma Center

Over the last 30 years, we have seen increasing efforts by AI/AN professionals and tribal programs to develop treatment approaches that are rooted in an intimate knowledge of the characteristics of trauma in Indian Country, historical trauma, and the criticality of using culture in developing effective interventions. One of the leaders in this movement has been the Indian Country Child Trauma Center (ICCTC). Located at the University of Oklahoma Health Sciences Center, the ICCTC strives to develop trauma-related treatment protocols, outreach materials, and service delivery guidelines specifically designed for AI/AN children and their families. ICCTC has developed an array of culturally based trainings and resources for treatment professionals that are working with AI/AN children and families affected by trauma. A number of their resources are grounded in evidence-based practices, such as Project Making Medicine, which is a national clinical training program designed around *Honoring the Children, Mending the Circle*, a cultural adaptation of trauma-focused cognitive behavioral therapy curriculum. In *Honoring the Children, Mending the Circle*, clinicians are taught to use cognitive behavioral techniques within a tra-

ditional Native framework that supports the Native belief in spiritual renewal as a core element of healing from trauma. Similarly, *Honoring Children, Making Relatives* is a culturally adapted curriculum based on parent-child interaction therapy where clinicians are taught to coach parents with traditional Native ways of teaching that move from observation to active teaching to promote positive interactions and enhanced parenting skills. It is resources like these that clinicians across Indian Country are using to effectively treat trauma and decrease the risk factors for child maltreatment.

American Indian Life Skills Development Curriculum

AI/AN youth are at high risk for suicide. Childhood maltreatment is a traumatic experience that increases the likelihood of suicidal behavior. Developing skills and supports for AI/AN youth that confront suicide risk factors is essential to reducing risk and addressing associated trauma. *American Indian Life Skills Development Curriculum*, the only evidence-based suicide prevention program in Indian Country, incorporates features of risk and protective factors specific to tribal youth to support suicide prevention strategies (SAMHSA, 2007). The curriculum, designed to be used with middle- and high-school-age youth, teaches life skills such as communication, problem solving, depression and stress management, anger regulation, and goal setting. Youth are taught to seek out cultural knowledge within their communities as they learn positive strategies for reducing risk for suicide. This curriculum has been adapted by several tribes across the United States.

Native Aspirations Program

The Native Aspirations Program provides tribal communities with help to build their capacity to prevent violence, bullying, and youth suicide (One Sky Center, 2008). The program provides resources and training to tribal communities on how to use and culturally adapt evidence-based treatment and practices. Community mobilization and planning events are central components of Native Aspirations, along with the identification of tribal cultural interventions that can be used in the development of prevention programming. As tribal communities grapple with the violence that can hurt young people, there is a need to develop new approaches to addressing the risk factors that can increase threats to safety. In order to do that, tribal communities need education about the issues impacting their children, a structured process for identifying and developing culturally based solutions, and resources to improve their capacity to successfully implement change.

References

The Annie E. Casey Foundation. (2012). Kids count data book: State trends in child well-being. Baltimore, MD: The Annie E. Casey Foundation.

Administration for Children and Families, Office of Child Abuse and Neglect. (2003). A coordinated response to child abuse and neglect: The foundation for practice. Washington DC: U.S. Department of Health and Human Services. Retrieved from *http://www.childwelfare.gov/pubs/usermanuals/foundation/index.cfm*

Children's Bureau, Administration for Children and Families. (2011). Definition of child abuse and neglect. Rockville, MD: U.S. Department of Health and Human Services. Retrieved from *http://www.childwelfare.gov/systemwide/laws__policies/statutes/define.pdf*

BigFoot, D. S., & Braden, J. (2007). Adapting evidence-based treatments for use with American Indian and Native Alaskan children and youth. Focal Point 21(1), 19–22.

Bigfoot, D., Cross, T., & Fox, K. (2005). Child abuse prevention in Indian Country. In D. S. Bigfoot, T. Crofoot, T. L. Cross, K. Fox, S. Hicks, L. Jones, & J. Trope (Eds.), Impacts of child maltreatment in Indian Country: Preserving the seventh generation through policies, programs, and funding streams. Portland, OR: National Indian Child Welfare Association.

Black, M. C., & Breiding, M. J. (2008). Adverse health conditions and health risk behaviors associated with intimate partner violence-United States, 2005. Morbidity and Mortality Weekly Report, 57(5), 113–117. Atlanta, GA: Centers for Disease Control and Prevention. Retrieved from *http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5705a1.htm*

Brave Heart, M. Y. H, & DeBruyn, L. M. (1998). The American Indian holocaust: Healing historical unresolved grief. American Indian and Alaska Native Mental Health Research, 8(2), 60–82.

Bureau of Indian Affairs, Department of the Interior. (2005). American Indian population and labor force report. Washington, DC: U.S. Department of the Interior.

Retrieved from *http://www.bia.gov/cs/groups/public/documents/text/idc-001719.pdf*

Crofoot, T. (2005). Effects of abuse and neglect on American Indian/Alaska Native children. In D. S. Bigfoot, T. Crofoot, T. L. Cross, K. Fox, S. Hicks, L. Jones, & J. Trope (Eds.), Impacts of child maltreatment in Indian Country: Preserving the seventh generation through policies, programs, and funding streams. Portland, OR: National Indian Child Welfare Association.

Child Welfare Information Gateway. (2013). Long-term consequences of child abuse and neglect. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau.

Cornell, S., & Kalt, J. (1998). Sovereignty and nation-building: The development challenge in Indian Country today. Cambridge, MA: Harvard University.

Cross, T. L., Earle, K. A., & Simmons, D. (2000). Child abuse and neglect in Indian Country: Policy issues. Families in Society, 81(1), 49.

Cross, T. L., (2005). Child abuse prevention in Indian Country. In D. S. Bigfoot, T. Crofoot, T. L. Cross, K. Fox, S. Hicks, L. Jones, & J. Trope (Eds.), Impacts of child maltreatment in Indian Country: Preserving the seventh generation through policies, programs, and funding streams. Portland, OR: National Indian Child Welfare Association.

Del Grosso, P., Kleinman, R., Esposito, A. M., Sama Martin, E., & Paulsell, D. (2011). Assessing the evidence of effectiveness of home visiting program models implemented in tribal communities. Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.

Earle, K. A. (2000). Child abuse and neglect: An examination of Indian child welfare data.

Seattle, WA: Casey Family Programs.

Fox, K. A. (2003). Collecting data on the abuse and neglect of American Indian children. Child Welfare, 82(6), 707–726.

Hill, R. B. & Casey-CSSP Alliance for Racial Equity in Child Welfare, Race Matters Consortium Westat. (2008). An analysis of racial/ethnic disproportionality and disparity at the national, state, and county levels. Seattle, WA: Casey Family Programs. Retrieved from *http://www.cssp.org/publications/child-welfare/alliance/an-analysis-of-racial-ethnic-disproportionality-and-disparity-at-the-national-state-and-county-levels.pdf*

Maternal and Child Health Bureau, Health Resources and Services Administration. (2012). Child health USA 2011. Rockville, MD: U.S. Department of Health and Human Services.

Mathews, T.J., and Hamilton, B. E. (2009). Delayed childbearing: More women are having their first child later in life. NCHS data brief, no. 21. Hyattsville, MD: National Center for Health Statistics.

National Child Abuse and Neglect Data Center Technical Team. (2014). NCANDS ad hoc data request: American Indian/Alaska Native children. Unpublished data.

National Indian Child Welfare Association. (2010). Exemplary programs in Indian child welfare: Profiles of tribal and urban programs. Portland, OR: Author.

National Indian Child Welfare Association. (n.d.). On-site training. National Indian Child Welfare Association. Retrieved from *http://www.nicwa.org/training/onsite/*

Office of Minority Health. (2012). Profile: American Indian/Alaska Native.OMH. Retrieved from *http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=3&lvlid=62*

Office of Planning, Research and Evaluation, Administration for Children and Families. (2007). Special health care needs among children in child welfare (NSCAW Research Brief No.7). Retrieved from *http://www.acf.hhs.gov/sites/default/files/opre/special_health.pdf*

Ogunwole, S. U. (2006). We the people: American Indians and Alaska Native in the United States: Census 2000 Reports. Washington, DC: U.S. Department of Commerce Economics and Statistics Administration U.S. Census Bureau.

One Sky Center. (2008). Culture based interventions: The Native aspirations project. Portland, OR. Author.

Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2009). Results from the 2008 National Survey on Drug Use and Health: National findings. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Substance Abuse and Mental Health Services Administration. (2007). American Indian life skills development/Zuni life skills development. Retrieved from *http://nrepp.samhsa.gov/ViewIntervention.aspx?id=81*

Summers, A., Wood, S., & Russell, J. (2012). Technical assistance bulletin: Disproportionality rates for children of color in foster care. Reno, NV: National Council of Juvenile and Family Court Judges. Retrieved from *http://www.ncjfcj.org/sites/default/files/Disproportionality%20Rates%20for%20Children%20of%20Color%202010.pdf*

Urban Indian Health Institute, Seattle Indian Health Board. (2012). Addressing depression among American Indians and Alaska Natives: A literature review. Seattle, WA: Seattle Indian Health Board. Retrieved from *http://www.uihi.org/wp-content/uploads/2012/08/Depression-Environmental-Scan__All-Sections__2012–08–21__ES__*FINAL.pdf

U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2013). Child maltreatment 2017. Rockville, MD: U.S. Department of Health and Human Services. Retrieved from *https://www.acf.hhs.gov/sites/default/files/cb/cm2017.pdf#page=30.*

U.S. Department of Health and Human Services. (n.d.). Tribal and migrant programs for community-based child abuse prevention discretionary grant cluster. Retrieved from *https://www.childwelfare.gov/management/funding/funding__sources/tribal.cfm*

Wakeling, S., Jorgensen, M., Michaelson, S., & Begay, M. (2001). Policing on American Indian reservations: A report to the National Institute of Justice. Washington, DC: U.S. Department of Justice, Office of Justice Programs. Retrieved from *https://www.ncjrs.gov/pdffiles1/nij/188095.pdf*

Wells, E., & Falcone, D. N. (2008). Rural crime and policing in American Indian communities. Southern Rural Sociology 23(2), 199–225.

Wilson, E., Dolan, M., Smith, K., Casanueva, C., & Ringeisen, H. (2012). NSCAW child well-being spotlight: Adolescents with a history of maltreatment have unique service needs that may affect their transition to adulthood. OPRE Report #2012–49. Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services. Retrieved from *http://www.acf.hhs.gov/sites/default/files/opre/youth__spotlight__v7.pdf.*

The CHAIRMAN. Thank you very much.

Next, we have Ms. Robyn Sunday-Allen, the Vice President of the National Council of Urban Indian Health in Washington, D.C.

STATEMENT OF ROBYN SUNDAY–ALLEN, VICE PRESIDENT, NATIONAL CONGRESS OF URBAN INDIAN HEALTH

Ms. SUNDAY-ALLEN. Good afternoon, Chairman Schatz, Vice Chair Murkowski, Senator Lankford, and members of the Senate Committee on Indian Affairs. Thank you for the opportunity to testify today.

I am Robyn Sunday-Allen, a citizen of the Cherokee Nation and currently Vice President of the National Council of Urban Indian Health, which represents the 41 Urban Indian organizations with 77 facilities in 22 States. UIOs provide high quality, culturally competent care to Urban Indians or over 70 percent of the American Indians and Alaska Natives living off reservation.

I am the CEO of the Oklahoma City Indian Clinic, a UIO that provides comprehensive health care to over 21,000 Native patients representing over 220 tribes. I would like to thank the Committee for working tirelessly to help equip the Indian Health system with essential resources.

I testify today in support of the Urban Indian Health Providers Facilities Improvement Act, S. 1797, which will expand the use of existing Indian Health Service resources under Section 509 of the

Indian Health Care Improvement Act. This legislation would enable IHS Urban Indian health dollars to be spent where they are needed, including for necessary facilities maintenance and renovation.

I applaud Senators Lankford and Padilla for introducing this bill that will fix an unnecessary barrier to care and allow UIOs to make critical updates to all facilities. Specifically, this bipartisan bill corrects and oversight in Section 509 of the Indian Health Care Improvement Act that effectively prohibits us from using our IHS funding on infrastructure and facilities improvement projects, unless the project is undertaken for accreditation by The Joint Commission.

TJC is no longer the applicable accrediting body among the vast majority of UIOs. Forty of 41 UIOs do not utilize TJC accreditation. Since 2004, at the Oklahoma City Indian Clinic, we have used the Accreditation Association for Ambulatory Health Care, AAAHC, a nationally accepted accreditation body. IHS promotes AAAHC as an option for the UIOs and even regularly holds AAAHC training for UIO staff.

However, AAAHC accreditation effectively bars Oklahoma City from using IHS funds for any facility improvements because the statute only mentions TJC. Ultimately, this restriction impacts the provision of services to our Native patients. For instance, during the COVID–19 pandemic, UIOs were unable to use IHS funds to make critical facility renovations to safely serve patients despite the immediate need for updates, like transitioning to tele-health, air circulation updates like negative pressure rooms, and air purification systems and redesigning or adding space to allow for social distancing. One UIO could not use its IHS funding to purchase a new HVAC system. In other words, a health facility could not use its funding from a health agency to make air purification changes amidst a global pandemic of an airborne virus that could kill its patients and staff, solely because of this restriction this bill seeks to fix.

At Oklahoma City Indian Clinic we have been faced with difficult decisions, at times having no choice but to divert revenue from patient care to meet the critical infrastructure needs essential to continue serving our patients. As a nurse administrator, I am aware of what health care looks like in a well-maintained medical facility. Inadequate facilities and safety issues are never something I nor any other UIO want impacting the care we give our patients. We are in a race against time, and we need this legislative fix now.

This bill would remove this prohibition immediately allowing UIOs to use their IHS funding more efficiently and efficiently. This bipartisan bill has widespread support, including within Indian Country. For example, NCUIH and 29 Indian organizations included it in an infrastructure newsletter to Congress. In addition, the National Congress of American Indians recently passed a resolution in support of this fix. It also has wide support among policy makers who with House Interior Appropriations included the UIO facilities fix in its fiscal year 2022 bill. The President's fiscal year 2022 budget, similarly included it, also noting it has a zero score.

All of this support makes one thing clear: we must act now to pass this urgent and no-cost legislative fix.

Finally, this issue is not only urgent and ripe for resolution with the Senate considering the largest infrastructure framework bill in history. We respectfully request the inclusion of this bill in this infrastructure package.

We respectfully urge the members of this Committee to include S. 1797 in bipartisan infrastructure framework. In addition, we recommend the Committee hold a markup on this bill as soon as possible to allow for Floor consideration.

Finally, we ask all members to co-sponsor S. 1797 and thank you to those who have already taken this important step.

Again, thank you for your time today and for working with NCUIH as we ensure American Indian and Alaska Native people receive high quality care regardless of where they live.

[The prepared statement of Ms. Sunday-Allen follows:]

PREPARED STATEMENT OF ROBYN SUNDAY-ALLEN, VICE PRESIDENT, NATIONAL CONGRESS OF URBAN INDIAN HEALTH

Chairman Schatz, Vice Chairman Murkowski, and Members of the Senate Committee on Indian Affairs, thank you for the opportunity to testify today on the vital topic of urban Indian health facilities. My name is Robyn Sunday-Allen, I am a member of the Cherokee Nation, and currently the Vice President of the National Council of Urban Indian Health (NCUIH), which represents the 41 Urban Indian Organizations (UIOs) across the nation who provide high-quality, culturally-competent care to Urban Indians, who constitute over 70 percent of all American Indians/Alaska Natives (AI/ANs). I also serve as the Chief Executive Officer of the Oklahoma City Indian Clinic (OKCIC), a permanent program within the Indian Health Service (IHS) direct care program and a UIO, which provides culturally sensitive health and wellness services including comprehensive medical care, dental, optometry, behavioral health, fitness, nutrition, and family programs to our nearly 20,000 patients representing over 220 different tribes. I would like to thank Chairman Schatz, Vice Chairman Murkowski, Members of the Committee and their staff who have worked tirelessly to help equip the Indian health system with essential resources. I appreciate you holding this important hearing on vital facilities and infrastructure issues which have impacted Indian Country, including UIOs.

I testify today in support of the *Urban Indian Health Providers Facilities Improvement Act*, S. 1797, which will expand the use of existing IHS resources under Section 509 of the Indian Health Care Improvement Act (IHCIA) (25 U.S.C. § 1659). This legislation would enable IHS urban Indian health dollars to be spent where they are most needed, including for necessary facilities maintenance and renovation, ultimately improving patient care without any added cost. As it stands, UIOs can only use our IHS funding for facilities expenses if the renovation or maintenance is undertaken in order to meet a specific accreditation standard, which is inapplicable to the vast majority of UIOs. In effect, we are left without the ability to use our funding efficiently and most effectively to best serve our patients. I will speak to you today about the importance of the technical fix to this restriction and how it would improve health care outcomes for Oklahoma City's Urban Indian community, as well as the larger UIO system and, ultimately, the more than 70 percent of AI/AN people that reside in urban Indians.

We urge the Members of this Committee to request leadership to include this simple but urgent fix in the bipartisan infrastructure framework. In addition, we recommend the Senate Committee on Indian Affairs hold a markup on this bill as soon as possible to allow for floor consideration. Finally, to demonstrate a strong showing of commitment to improving urban Indian health, we ask all Members to cosponsor S. 1797.

Background

NCUIH represents 41 UIOs operating 77 facilities across 22 states. As part of the trust obligation, the federal government funds UIOs who provide high-quality and culturally competent care to urban Indian populations. UIOs are a critical part of the Indian Health Service (IHS) system, which includes IHS facilities, Tribal Programs, and UIOs. This is commonly referred to as the I/T/U system. Unfortunately, UIOs experience significant parity issues as compared to the other components of the I/T/U system as well as other federally funded health care systems, which great-

ly impact their services and operations. This includes the inability to use IHS funding for facilities improvements or maintenance, even if that is where the dollars are most needed. OKCIC is the UIO serving the Oklahoma City area, with more than 35,000 annual patient visits. Since OKCIC's creation in 1974, the demand for quality health care has steadily increased, and the clinic has grown in response. Because of the restriction preventing UIOs from using IHS funds for facilities, we have multiple times throughout our history been forced to make difficult decisions to keep up with demand—having to use limited funding pools and divert revenue from AI/AN patient care in order to have adequate space to provide critical services.

The inability to use IHS funds for essential facilities renovation and maintenance expenses impacts patient care, with patients paying the ultimate price. For example, as our existing medical and behavioral health facilities age alongside the increased demand for services due to the COVID–19 pandemic, associated building equipment and components are deteriorating to a point of failure. This, combined with the decreasing availability of replacement parts on aged equipment, significantly disrupts health care service delivery—making it exceedingly difficult to meet the increased needs for medical and behavioral health services.

This need is not unique to OKCIC as it impacts all UIOs and their patients. In fact, NCUIH and 29 other AI/AN-focused organizations recently sent a joint letter urging Congressional leaders to address Indian Country's infrastructure priorities, including this legislative oversight. The National Congress of American Indians also passed a resolution in support of the UIO facilities fix this past June. This broad support makes one thing clear—the need is real and the time to act is now. As a registered nurse, I am aware of what health care looks like in a quality and well-maintained medical facility; and gambling with my patients care due to insufficient facilities is not a burden that I nor any other UIO wants to continue to bear. We are in a race against time! We need this legislative fix now.

Remove Facilities Restrictions on UIOs

I applaud Senator Alex Padilla (D–CA) and Senator James Lankford (R–OK) for introducing the *Urban Indian Health Providers Facilities Improvement Act* (S. 1797) to allow us to make critical updates and pave the way for increased investment in renovation and construction of our facilities by undoing the unnecessary restriction on our funds. Specifically, this bipartisan bill represents the critical legislative fix to an oversight in Section 509 (25 U.S.C. § 1659) of IHCIA that prohibits UIOs from using money appropriated through IHS on infrastructure and facilities improvement projects unless the project is undertaken to meet accreditation standards from The Joint Commission (TJC), which is no longer the most used accreditation body among the vast majority of UIOs. In fact, 40 of 41 UIOs do not utilize TJC accreditation, with many utilizing other, more applicable accreditation bodies.

For instance, OKCIC has received full primary care practice accreditation by the Accreditation Association for Ambulatory Health Care (AAAHC) for more than 15 years. AAAHC is a nationally accepted accreditation body, which is even recognized by IHS with an IHS circular dating back to 1997 encouraging UIOs "to obtain and maintain accreditation" through a "choice among nationally accepted accrediting/certifying bodies[,]" including AAAHC.[1] IHS even provides funding for UIOs to attend AAAHC trainings. However, despite IHS's express encouragement of UIOs choosing to maintain accreditation through AAAHC, this accreditation nonetheless effectively bars OKCIC from utilizing IHS funds for any facilities improvements because Section 509 only expressly mentions TJC, which IHS has interpreted to exclude UIOs from utilizing IHS funds for facilities improvements.

This restriction prevents OKCIC and other UIOs from making essential facilities improvements and maintenance, which impacts the provision of services to our patients. This prohibition compounds on decades of chronic underfunding of UIOs, which has been absent of any facilities funding. This has real and significant impacts.

For example, as the COVID–19 pandemic was devastating Indian Country, the whole IHS system had to immediately adjust (i.e. transition to telehealth, install negative pressurizing rooms, upgrade air purification systems, and make other facility renovations) to safely serve patients. However, UIOs were unable to make some of these necessary improvements because of this restriction, with one UIO even being denied for installing a new HVAC system that would better purify and circulate air in the facility. A UIO could not use its funding from a health agency to make these changes amidst a global pandemic of an airborne virus that causes severe respiratory illness for health care staff and patients.

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[1] Indian Health Service Circular No. 97–01, Accreditation/Certification of Hospitals and Health Centers (effective March 6, 1997).

Moreover, this issue predates the pandemic, which only highlighted an existing problem—the lack of an avenue for using existing resources for infrastructure improvements at UIOs. In fact, in a NCUIH survey, 86 percent of UIOs surveyed reported a need to make facilities and infrastructure upgrades, while 74 percent reported unmet needs for new construction to better serve patients. These needs include, but are not limited, to the construction of urgent care facilities and infectious disease areas, capacity expansion projects, ventilation system improvements, and upgrades to telehealth and electronic health records systems. All of these upgrades are vital to patient care.

The Urban Indian Health Providers Facilities Improvement Act would remove this prohibition, immediately allowing UIOs to use their IHS funding more effectively and efficiently. This bipartisan bill has widespread support, including within Indian Country as mentioned earlier and also among policymakers. The House Appropriations Subcommittee on Interior, Environment, and Related Agencies included the UIO facilities fix in its FY22 bill; as did the President's FY22 IHS budget, noting it has a zero score. All of this support makes one thing clear—we must act now to pass this urgent and no-cost legislative fix.

Finally, this issue is not only urgent and widely supported, but it is also ripe for resolution, with the Senate this week considering the largest infrastructure framework bill in history. Because removing this restriction is vital to the provision of health care to our patients and the fulfillment of the trust obligation to AI/AN people, we respectfully request the inclusion of S. 1797 in this infrastructure package.

Conclusion

S. 1797 is an essential parity issue for UIOs that ensures that AI/ANs residing in urban areas have access to high quality, culturally competent health services. For too long, urban Indian health care has been burdened and limited by an unnecessary restriction on UIO funds that prohibits us from making critical upgrades. The U.S. has the trust obligation to provide health care for AI/AN people residing in urban areas and removing this barrier to the use of existing IHS urban Indian health funding will bring us closer to meeting that responsibility.

We urge the Committee to enact this legislative fix and continue to work to enable UIOs to continue providing high quality, culturally competent care to AI/AN people, regardless of where they live.

The CHAIRMAN. Thank you very much to all of the testifiers.

Senator Smith?

STATEMENT OF HON. TINA SMITH, U.S. SENATOR FROM MINNESOTA

Senator SMITH. Thank you, Chair Schatz. I want to thank you for holding this hearing today and also I want to thank all of our panelists for being with us.

I would like to touch on the issue of child welfare, and then also talk a little bit about the Urban Indian Health Providers bill, which I am proud to cosponsor. First on child welfare. I want to recognize the tragic discoveries of children's' remains at the Indian residential school sites in Canada. These discoveries have forced Native communities to relive the trauma of boarding school policies and to confront the conditions and practices in these schools.

Unfortunately, of course, the United States government also has a long history of separating Native children from their families, divorcing them from their language and their culture and their spirituality and disrupting Native communities. This legacy is shameful. It is long past time that we address it.

Mr. Vigil, I know that in your role in the Native Indian Child Welfare Association, as well as Executive Director of the Eight Northern Pueblos in New Mexico, my original home State, you understand this issue well, even as you focus on providing and protecting Native children today, both in the child welfare system and in their own communities.

I am wondering, Mr. Vigil, if you could tell us about how you see the connection between the Indian boarding school era and your work today, the work that we have to do today and our ongoing challenges in addressing child welfare.

Mr. VIGIL. Thank you, Senator Smith, for that question. Certainly, I agree with the comment that you made about what is happening in Canada. We are seeing similar effects here in the United States. We applaud Secretary Deb Haaland for her initiative in addressing this issue in the United States.

Boarding school trauma has affected a lot of our people, all the way from our young ones to our elders. So today we are seeing some of that trauma still being connected with some of the things that are happening with our people. Our efforts are continuous to provide services, to heal them, from these kinds of issues. This act certainly will assist us in doing that.

In fact, with COVID, it has become more apparent that we need more culturally relevant practices to be incorporated with our programs, so that we can address those issues in a more meaningful way, with traditional healing practices. This effort is going to provide services to our people by the funding that we get appropriated. Thank you.

Senator SMITH. Thank you very much. I appreciate your raising Secretary Haaland's commitment to this issue. I completely agree with that.

I am really glad to be cosponsoring Senator Warren's legislation to create a Truth in Healing Commission on Indian boarding school policies. I look forward to working with this Committee, Chair Schatz, to understand how this historic trauma affects so much of the work that we have to do ahead of us today.

I would like to direct my next question to Ms. Sunday-Allen. The Indian Health Board, which is an Urban Indian health organization in Minneapolis, has been in the front lines of the COVID–19 pandemic for over a year now. Like other UIOs, the Indian Health Board has struggled to continue providing services with scarce resources, but of course, they have gotten creative. They have found ways of using community-driven solutions to get their patients tested and treated and vaccinated in the scope of this terrible pandemic.

Despite these added challenges, the Indian Health Board stands ready to continue trying to figure out how to innovate and improve their services to benefit the growing indigenous community in Minneapolis. In fact, the Indian Health Board is planning on extending and expanding their facilities. I have heard from Dr. Rock at the IHB that he is unable to spend the Indian Health Service money on construction, getting exactly at the issue that we have here. So I am proud to cosponsor this legislation with Senator Padilla and Senator Lankford.

Ms. SUNDAY-ALLEN. could you just talk about how these restrictions on construction have impacts on UIOs like the Indian Health Board in Minneapolis?

Ms. SUNDAY-ALLEN. First, let me thank you again for sponsoring this legislation. The story that we are hearing from your home State is far and wide across Indian Country, unfortunately, because of the restrictions that this bill has. A lot of the UIOs, many of the

UIOs, I am going to say probably all of us, have infrastructure needs that we cannot use IHS funds for. No fault of IHS, it is just that they are following the letter of the law.

So with this fix, we hope that our facilities will be able to have those renovations. Some of those renovations will also help us certainly right now during the pandemic to mitigate some of the risks we are currently facing each day, just like those which you mentioned you are seeing in your home State at your Urban Indian organization that Dr. Rock has.

But again, across Indian Country and in our urban settings, there is certainly a need for these renovations. A lot of the facilities are just really cramped for space. A lot of the infrastructure are old facilities and with that comes old HVAC systems, old roofs. It is not equipped for the cabling that IT needs to reach out for our telehealth.

Hopefully, it will fix what I would call the bones of the operation, the infrastructure, if we can get this fix passed in S. 1797.

Senator SMITH. Thank you so much. You did a great job painting a picture of why this is so crucial to be able to provide good, excellent health care.

Thank you, Chair Schatz, for allowing me to go over time.

The CHAIRMAN. Thank you, Senator Smith. Senator Hoeven?

STATEMENT OF HON. JOHN HOEVEN,
U.S. SENATOR FROM NORTH DAKOTA

Senator HOEVEN. Thank you, Mr. Chairman.

A question for both Deputy Director Grinnell and Senior Advisor Todacheene. A question for both of you, H.R. 1688 would update and reauthorize three programs established by the Indian Child Protection and Family Violence Prevention Act. What changes does H.R. 1688 make that you believe are important updates to the program? If I can, Heidi, I would ask you to start.

Ms. TODACHEENE. Sure. Thank you, Senator Hoeven, for having me speak here today. Some of the updates that are critical in the program from the past bill language, it would expand services, funding for the services to be expanded to the Urban Indian organizations, and as you know, those are critical services to help tribal communities, especially in places where American Indians and Alaska Natives don't have access to some of the services on reservations.

Then it also increases the funding from the original text of the bill, and that is critical, due to inflation rates. And just providing some of the base funding opportunities for tribes. Again, as you know, there are issues with tribes getting funding or professionals to very rural locations on reservations as well. Some of these services are not reimbursable under Medicaid.

I see those as two critical provisions that have been expanded or included in the updated text.

Senator HOEVEN. If you would expand a little bit on some of those services that you think are particularly important.

Ms. TODACHEENE. The services that are just included in the bill generally?

Senator HOEVEN. Yes, the services that it would provide funding for that are critically important.

Ms. TODACHEENE. Yes. This bill is unique because right now there is no tribal-specific preventive services for child abuse and neglect in Indian Country. As you know, there is child welfare service funding available. But this is specific to preventive services.

So some of those services that it helps bolster to both the National Resource Family Service Center and then also to the Protection and Family Violence Prevention Program, help improve intergovernmental work and coordination. Then funding to help investigate training that would bolster judicial services in tribal courts.

Senator HOEVEN. Thank you.

Let me ask Deputy Director Grinnell, the National Indian Child Resource and Family Services Center was authorized by the Indian Child Protection and Family Violence Prevention Act, but wasn't established. Why wasn't the center established after it was authorized? What gaps existed that the center would play a role in filling?

Mr. GRINNELL. Thank you, Senator, for that question.

My understanding is that there was never any funding that was appropriated for that particular activity. So going forward, one of the things I did want to mention, you asked about several of the programs that would be available now under this particular bill. It actually authorizes treatment programs for Indians where in the past it did not specify that. It also is going to allow $30 million per year in grants that would be made available to tribes as well as the urban programs that Heidi mentioned earlier.

It also requires IHS to provide culturally appropriate treatment services and programs.

Senator HOEVEN. Okay. So it is just the funding that has been the issue as far as getting it established?

Mr. GRINNELL. Yes, sir.

Senator HOEVEN. Okay.

In regard to 1895, the Indian Health Services Sanitation Facilities Construction Enhancement Act, how does the additional funding in this bill, how is it going to be used and allocated?

Mr. GRINNELL. Thank you for that question, Senator. As members of Congress are well aware, the IHS Sanitation Facilities Construction Program has used the methodology that is referred to as the Sanitation Deficiency System. That program starts with communication and coordination at the local level, with tribes and with IHS staff as well as tribal contracted staff. As they begin to build the need, that information is actually put into the system. It is reported annually to Congress.

As stated earlier in both my testimony as well as others today, that current unmet need is over $3 billion right now. So any funding that comes forth with this particular bill will be directly targeted at those priority projects that have been established within the priority system.

Senator HOEVEN. Thank you, Mr. Grinnell. Thank you, Ms. Todacheene. I appreciate it. And thank you, Mr. Chairman.

Senator SMITH. [Presiding] Thank you.

Next, we have Senator Luján.

STATEMENT OF HON. BEN RAY LUJÁN,
U.S. SENATOR FROM NEW MEXICO

Senator LUJÁN. Thank you, Chair Smith. It is an honor to be with you and to Chair Schatz and Vice Chair Murkowski for holding this hearing to review important legislation, the Indian Health Services Sanitation Facilities Enhancement Act, which provides $3 billion to IHS for sanitation projects, and the Native American Child Protection Act, with Senator Rounds, Representative Gallego, Representative Young, to ensure Native communities have the resources they need to help prevent and treat child abuse are two pieces of legislation that I introduced that we are reviewing today. I want to thank our witnesses for being with us.

First, I want to share a story of a constituent I am honored to represent by the name of Helene Archeletta. Helene, who sadly does not have running water and wastewater where she lives in Councilor, New Mexico, is one of the families, one of too many families that does not have running water in the Navajo Nation. Many residents must drive 40 or more miles every day to haul water home for drinking, cooking, and bathing. The lack of local water infrastructure makes it difficult for residents to follow CDC guidelines for sanitation and hygiene in order to stop the spread of COVID–19.

President Nez, I was hoping I could ask you a question, and I am asking a yes or no question. President Nez, yes or no, did the lack of basic utilities like running water hurt the Navajo Nation's ability to respond to and mitigate the COVID–19 pandemic?

Mr. NEZ. Absolutely, yes.

Senator LUJÁN. President Nez, yes or no, would providing IHS with additional funding for water projects save lives and strengthen the Navajo Nation's ability to respond to and recover from the pandemic?

Mr. NEZ. Yes.

Senator LUJÁN. President Nez, I think I read in your testimony that you included between 9,000 and 16,000 households who currently do not have access to running water in their home on the Navajo Nation. Is that accurate?

Mr. NEZ. Yes.

Senator LUJÁN. President Nez, I am hoping I can work with you to make sure we are able to share where that data came from, so we can work together in that space. Thank you so much for that.

President Nez, what would access to water mean for the Navajo people's quality of life, for those who are not currently connected to running water?

Mr. NEZ. Thank you, Chairman and members of the Committee, Senator Luján, for that question. The improvement the quality of life that many U.S. citizens take for granted turning on that faucet in the home. Because of the pandemic, it elevated this problem to number one.

Of course, you always need electricity. Electricity pulls water into various communities. Right now we are going through a drought, as you know, Senator, here in the southwest. The need for water is critical for our animals, our farms, and our hygiene. If we are going to push back more on COVID–19, we need to be able to get running water.

So some of our Navajo citizens haul water, and they bring the water home. You have to put it in our world view as an indigenous person, the first allocation of water that you bring home goes to your animals, because they sustain life, and it goes to the farms. Then whatever is there after that goes to drinking water. Whatever is left over is for hygiene.

I saw the numbers, I think we hit national media attention that we got hit hard here on the Navajo Nation. Just imagine if you had running water how many of these deaths would not have to be. Some of our people are going through the long-term health problems from catching COVID–19.

So I appreciate that question. I think we have the ability to fix this problem within Indian Country.

Senator LUJÁN. Thank you, Mr. President.

Mr. Grinnell, would any of the projects on the deficiency list provide water to the Native communities in Councilor, New Mexico, where Helene lives?

Mr. GRINNELL. Thank you, Senator, for that question. The information that I was provided, yes, there is a project on the SDS for 60 scattered homes that will provide water to several communities, including Councilor. They have identified seven homes in the Councilor community that would be on that project.

Senator LUJÁN. Mr. Grinnell, what would $3 billion in appropriated funds for the IHS Sanitation Facilities Construction account mean for IHS's ability to complete the backlog of sanitation deficiency projects?

Mr. GRINNELL. Yes, Senator, thank you for that question. The $3 billion would go a long way in providing all the funding necessary to complete all those projects. One point I would like to make, that in addition to the $3 billion this bill is proposing for the projects, it would take an additional $700 million or more of other funding in order to complement the $3 billion that would be made available to IHS to successfully complete all those projects, both the feasible and those ones that are more expensive to complete.

So it is an expensive proposition all the way around. But the $3 billion would go a long way in addressing this unmet need.

Senator LUJÁN. Thank you. Chair Smith, thank you so much for your time today.

Governor Vigil, I apologize, I didn't have time to ask you questions. It is an honor to see you as well, my brother from Tesuque Pueblo. Thank you again, Chair Smith, and I will be submitting the rest of my questions to the record.

Senator SMITH. Thank you, Senator Luján.

Senator Daines?

STATEMENT OF HON. STEVE DAINES, U.S. SENATOR FROM MONTANA

Senator DAINES. Thank you, Senator Smith.

First, I would like to thank our witnesses for being here today. We have taken a look at the data and found that as of 2018, there are 63, 63 facilities in Montana that were listed on the Indian Health Services Sanitation Facilities Program's list of deficiencies. As we have seen throughout the Country, a lack of proper sanitation and infrastructure has exacerbated the impact of COVID–19

in Indian Country. I led the effort to get tribes the access to assistance they needed to combat the pandemic in one of the most important bipartisan bills we passed last year.

However, we have seen fundamental shortfalls in tribal infrastructure that has helped cause Indian Country to be hit harder by COVID–19 than the rest of the Country.

Mr. Grinnell, under the Indian Health Service's current regulations, is it correct that IHS sanitation funding cannot be used to provide access to water and sanitation for non-residential facilities, even for schools, for grocery stores that are much-needed, to address education in some of the food deserts we see in Indian Country?

Mr. GRINNELL. Thank you, Senator, for that question. You are correct in that the funding that IHS has appropriated from Congress since the program started back in 1959, with Public Law 86–121, those funds have to be targeted for Indian homes and communities.

Any time that there is a project that goes beyond those residential needs and has to locate any commercial or other type of needs, that funding has to come from another source other than IHS.

Senator DAINES. Thank you. So the IHS program does not provide services to extremely critical components of a reservation's community, such as schools or other forms of economic development. So the question is then, are these needs even included in the IHS current deficiency list, and if not, do we really have a true picture of the sanitation deficiency in Indian Country?

Mr. GRINNELL. Thank you for that question. They are not included on the SDS as it is provided to Congress. As I mentioned earlier, and made the point about, there is over 800 of these projects that would require over $700 million of other funding. In many cases, IHS will work with other Federal agencies and other entities and they will provide their funding to the IHS project. They will in turn collectively complete that project and address both the residential, community, and even commercial needs of a given community.

Senator DAINES. I think many in the community want to know what steps IHS takes that might better address sanitation needs in Indian Country?

Mr. GRINNELL. Thank you, sir. One of the things that, as I mentioned earlier, is all the projects that are developed are done so in consultation with the tribes, with those tribal communities, and with our engineering staff. As they develop these project lists, then they are ranked and prioritized based on available funding.

So the ranking of those projects is actually done so in consultation with those local communities, so that they establish what the most priority projects need to be going forward.

Senator DAINES. Mr. Grinnell, thank you. Chairman Schatz, I yield back.

The CHAIRMAN. [Presiding] Senator Cortez Masto.

STATEMENT OF HON. CATHERINE CORTEZ MASTO, U.S. SENATOR FROM NEVADA

Senator CORTEZ MASTO. Thank you, Mr. Chairman, and Ranking Member Murkowski.

Ms. SUNDAY-ALLEN. let me start with you. Thank you to the panelists and thank you for this discussion today.

One of the issues I am most concerned about as we emerge from the public health emergency is the impact that this health pandemic has had on the mental health and wellness of Native families. In your testimony, you mentioned that the inability of the Urban Indian organizations to utilize their IHS funding for facility and infrastructure needs has meant that patients pay the ultimate price, especially as there is an increase in demand for medial and behavioral health services due to the COVID–19 pandemic.

Ms. Sunday-Allen. can you talk more on how this fix to S. 1797 would impact behavioral health and medical services?

Ms. SUNDAY-ALLEN. Yes, and thank you for that question.

When we think about mental health and medical, I hope that we are thinking of it as all one, that is encompassing. I think a lot of times they are considered separately, and it should not be so. The brain can be diseased, just like every other part of the body.

So when I think about this infrastructure bill, I think about it holistically in that it is not just a fix for facilities or for the medical side of the house, but it encompasses the entire framework of all the services that we provide, including mental health, behavioral health, substance abuse.

In turn, the bill, this fix, would encompass exactly what you are talking about and that is addressing those mental health, behavioral health issues that we have seen certainly now coming more so out of the pandemic. So I do believe that this is something that will enable us to continue to focus on our much-needed behavioral health components with this legislative fix. So thank you for that question.

Senator CORTEZ MASTO. Thank you. And thank you for your comments. I agree 100 percent that they shouldn't be put in buckets or silos separate from one another. They are one and the same. They should be treated that way, and funded. People should be able to fund them and access these services in the same way. There should be parity.

So I completely agree with you, and I hope to work with you on this issue even more so to make sure we are providing adequate services along with the medical services, behavioral services, and wellness services that we need for Indian Country.

President Vigil, with respect to 1688, the Native American Child Protection Act, in your testimony you mentioned elements of success in child maltreatment in Indian Country consisting of culturally competent programs, successful collaboration among different governments, strong understanding of familial connections, and locally based community services.

Can you elaborate for me on how this legislation would aid in bolstering these elements of success and solutions that tribes are currently employing? Specifically, how will smaller tribes across Indian Country be able to obtain the support they need in implementing these efforts?

Mr. VIGIL. Thank you, Senator Cortez Masto. Here at Eight Northern, we have embarked on a journey. By no means do I want to criticize anybody, but we are calling it decolonizing ourselves from western models and concepts of how we do our work through-

out Eight Northern. In our efforts, we have come to recognize that the way we address these issues is that we have to go to our communities and we ask the questions in our communities, from our people. So we came up with a project, we are calling it Of the Community, For the Community. That is basically asking the tribes what their concerns and what their needs are. So we are moving in that direction.

Certainly, this act will allow us to seek funding, and not just Eight Northern, but all the tribes throughout the Country. I think we are looking at going to more of a culturally appropriate healing process. Certainly, the western model is still working. But our effort is to gap that bridge and bring it together, so that our services are going to be provided in a way that many of our people will have a better healing process, if you will.

With the pandemic, a lot of these things have been brought to the forefront. Certainly, being from a community of Pueblo, where we couldn't hold our ceremonies, and this is throughout Indian Country, the very thing that we did to heal ourselves was taken away. We couldn't do our cultural ceremonies, our dances, our songs, as we did in gatherings.

So even that has an impact on our people. Now that we are coming out of COVID an moving forward, I hope that we can really bring those back, but more at a level that will address the need for healing of our community and our people in general, throughout Indian Country.

Senator CORTEZ MASTO. I do, too.

Thank you so much. Thank you to the panelists.

The CHAIRMAN. Senator Lankford.

Senator LANKFORD. Thank you, Mr. Chairman.

Robyn, it is good to see you. Thanks for being here and thanks for your testimony today. I want to pummel you with a few questions to get some things on the record on it.

Robyn, can you talk us through just the decision on accreditation, the accreditation from AAAHC, how that actually works, how you receive your accreditation and the process for making a decision and the cost, if you can give us any details on that.

Ms. SUNDAY-ALLEN. Sure. Thank you, Senator, for the question. Yes, we chose AAAHC over Joint Commission when we first became accredited back in 2004. Threefold: one, it was substantially more cost effective for us. We have to hang onto every dollar that we get. It was over half the cost it would have cost us if we had went with the Join Commission. Secondly, AAAHC was more of a fit as well as for the other UIOs. The Joint Commission was originally set up to accredit inpatient hospital settings. AAAHC has always been in the mission of accrediting outpatient ambulatory sites like the UIOs, and like Oklahoma City Indian clinic.

So we chose, for those two reasons. Then lastly, AAAHC has surveyors that are oftentimes from the ITU, the IHS tribal or urban settings. So our experience has been, we have had two retired IHS pharmacists as surveyors, one urban CEO, and two retired IHS physicians. So it has been a great experience for us because they know the type of patients that we serve and the infrastructure and the ITU system. So it has been a great fit for the UIOs, including Oklahoma City.

Senator LANKFORD. Was IHS supportive of this accreditation decision, to go with AAAHC?

Ms. SUNDAY-ALLEN. Yes, so much so that they offered to provide ongoing trainings for UIO. I have actually provided some of those trainings for our Oklahoma City IHS area, for new CEOs, that they have training there. So we have had a great deal of support.

Senator LANKFORD. But you have been limited in the use and flexibility of your funds based on your accreditation when IHS has supported it, when AAAHC is a well-recognized entity, meets the cost objectives. Can you talk us through any limitations that you have had specific projects or things that you have been denied or a process that you have had to make your decisions different based on that accreditation?

Ms. SUNDAY-ALLEN. Yes, Senator. We actually have had several asks, one most recently was to renovate our ambulatory car lobby to make it more friendly during—when I say friendly, actually wanting to mitigate the risk of COVID–19 in our lobby. We were denied that request because it wasn't tied to Joint Commission accreditation.

Prior to the pandemic, we had asked for a new HVAC system and upgrades to our aging parking lot, because we were having some patients and employees fall in our parking lot. Because those two asks were not tied to Joint Commission accreditation, we were not able to utilize our funds.

So what we ended up doing was taking revenue from what could have gone to patient care into infrastructure fixes so that we could make our place, the facility safe for our patients.

Senator LANKFORD. But the bill we are discussing today would eliminate that disparity, so that you have greater flexibility, is that correct?

Ms. SUNDAY-ALLEN. That is correct.

Senator LANKFORD. Okay. Thank you, by the way, for that, Robyn, very much.

Mr. Grinnell, I want to ask you a quick question. I do appreciate that in the fiscal year 2022 Congressional justification IHS is including some encouragement, I would say, toward this. Are there any reasons that you see that accreditation limitations should still exist based on a preference for one accreditation or another, as long as they are a recognized accreditation?

Mr. GRINNELL. Thank you, Senator, for that question. No, sir, I do not see any reason to expand accreditation beyond the Joint Commission. As Ms. Sunday-Allen has mentioned, AAAHC is more preferred among the UIOs and would be more appropriate for that group.

One thing I do also want to mention in addition to the testimony by Ms. Sunday-Allen is that the UIO program does have a $1 million infrastructure study that they will begin at the end of this calendar year and continue through the end of next calendar year. The idea is to gather information about all the 41 UIOs in terms of their infrastructure needs and make that information available.

Senator LANKFORD. So you do not see a gain in all UIOs having the exact same entity for accreditation? You see a gain in them having flexibility, or at least not a problem with them having flexibility for their accreditation?

Mr. GRINNELL. Letting them have the flexibility.

Senator LANKFORD. Okay, thank you for the clarification on that. I appreciate it very much.

Thanks, Mr. Chairman.

The CHAIRMAN. Senator Tester?

STATEMENT OF HON. JON TESTER,
U.S. SENATOR FROM MONTANA

Senator TESTER. Thank you, Mr. Chairman.

My first question is for Robyn Sunday-Allen. First of all, I want to thank all the folks who testified.

Robyn, my question, since you are with the National Congress of Urban Indian Health, were Urban Indian Health Centers distributed vaccines to be able to put in Native American's arms?

Ms. SUNDAY-ALLEN. Yes, sir, we were. We had a choice to go with our State or go to HHS, IHS, to receive our vaccines.

Senator TESTER. But they could also go through Urban Indian Health Centers, correct?

Ms. SUNDAY-ALLEN. Yes, correct.

Senator TESTER. So tell me why, tell me why we have heard from some urban tribal members in Montana that have been unable to secure vaccinations where they live that have had to travel to Indian Country and to reservations to get to those facilities? Is it simply because they didn't have an Urban Indian Health center? Or is there another reason?

Ms. SUNDAY-ALLEN. I would think that that is exactly what it is, was just the access to the vaccine in certain locations. I have heard that it was rolled out later in a lot of, across Indian Country. Here in Oklahoma, we were fortunate enough to be early in the game. But I have heard stories that you are absolutely right, that there was limited access. So we saw Indian people having to travel far and wide for vaccines.

Senator TESTER. Have you been able to do any surveys or have any of the panelists been able to do any surveys as far as uptake in vaccination rates in urban areas versus reservations? I know the uptake in Montana, the reservations, is quite high. Maybe the highest in the State overall. Is there any comparison on the vaccination rate uptake in urban towns, or the urban Indian population versus on the reservation?

I am not hearing any answers, so I assume we don't have that. Okay.

Another topic. Mr. Grinnell, are you familiar with 1895, Senator Luján's bill?

Mr. GRINNELL. Yes, sir, I am.

Senator TESTER. Okay. I think it was Senator Daines that asked about sanitation dollars, if they could go to places like schools and hospitals, and you said no, it is specifically for Indian homes and communities. Correct?

Mr. GRINNELL. Yes, sir.

Senator TESTER. So I assume communities does not include hospitals, retail stores, schools, those kinds of things?

Mr. GRINNELL. No, sir.

Senator TESTER. Who made that call?

Mr. GRINNELL. That is actually in the initial Public Law 86–121 legislation that established the sanitation facilities construction program for IHS.

Senator TESTER. I appreciate that perspective.

It looks to me like it could have been interpreted differently, but we will stick with what you have. Does Senator Luján's bill, does it allow for investments in sanitation facilities to be used with schools, hospitals, retail outlets in Indian Country?

Mr. GRINNELL. Thank you for that question, Senator. The funding that is proposed in that bill is targeted to address the needs of Indian homes and communities and does not include funding that will address those other considerations.

Senator TESTER. Good. If Senator Luján is listening, I would ask him to take a peek at that to see if we can change that. It makes a lot of sense to deal with homes first. But I think we also should be dealing with other entities in Indian Country that are deficient when it comes to sanitation facilities. I think it is very, very important.

That is about all I have for this. I want to thank the Chairman for allowing me to get in to ask a few questions.

The CHAIRMAN. Thank you, Senator Tester.

Senator Lankford has a 30-second question.

Senator TESTER. I just wanted to be able to comment to Senator Tester as well, just to spike the football a little bit on this. When you were asking Robyn about vaccination rates, we had a very, very efficient system for vaccinations in Oklahoma among our tribal leaders and UIOs. In fact, I was tracking and watching our tribes in Oklahoma and Washington, D.C. to see who was actually vaccinating faster. Our tribes were vaccinating in Oklahoma much faster than what was actually happening in Washington, D.C. itself.

So it was a very efficient system, and there is a lot that we can actually learn from how the tribes were handling the vaccines in Oklahoma, and the distribution system they put in place.

Senator TESTER. I appreciate that. All I would say is that you are exactly correct. By the way, in Indian Country they got the vaccinations distributed very, very well, too. It is when I hear urban areas, and the world has changed now from what it was in March, when vaccinations were hard to get. But in urban areas, where they weren't quite as efficient, I think we should find out why, that is all. I know you don't have any reservations in Oklahoma, but that is it, yes.

Senator LANKFORD. Thanks.

The CHAIRMAN. Senator Cantwell.

STATEMENT OF HON. MARIA CANTWELL, U.S. SENATOR FROM WASHINGTON

Senator CANTWELL. Thank you, Mr. Chairman. I thank you and Senator Murkowski for holding this important hearing.

I wanted to ask Ms. Sunday-Allen, how long can we continue to go on without fully funding the urban FMAP, and what effect does it have on Urban Indian health, the fact that we don't have a fix for this?

Ms. SUNDAY-ALLEN. Thank you for that question. It is unfortunate, because it is detrimental to Urban Indians not to have a 100 percent FMAP. I would just like to say that the $3 billion that is being discussed today, not one dollar of that will go to UIOs. So having that 100 percent FMAP would certainly be a game changer for our facilities, because getting less than 1 percent of the overall IHS budget is very difficult to run a program and do it efficiently when you are appropriated less than around $600 per patient compared to some of the other national programs that are getting upwards of $4,000 or $5,000 per patient.

So it is critical to get 100 percent FMAP approved.

Senator CANTWELL. How can we continue to have this gap in Urban Indian health? Are we just really treating Urban Indians differently than others in, say, rural parts of the United states?

Ms. SUNDAY-ALLEN. There is definitely a parity issue. I can agree to that. It is just longstanding. But we appreciate this Committee working very hard to get us the parity that we deserve in the ITU system.

Senator CANTWELL. Thank you.

Mr. Grinnell, or Ms. Todacheene, how much long is it going to take us to fix this?

Mr. GRINNELL. Senator, could you repeat that question?

Senator CANTWELL. How much longer is it going to take us to get full FMAP funding for Urban Indian health?

Mr. GRINNELL. Yes, thank you, Senator.

Senator CANTWELL. I have a lot of people in Seattle who are waiting, and Portland and probably even Honolulu, although I am not sure.

Mr. GRINNELL. Yes, Senator. And from what I understand, there is a temporary two-year approval that now allows the States to enter into negotiations with Urbans to allow them to do 100 percent FMAP over the next two years. So we hope to continue to work with CMS and with the UIOs to make that a permanent fix.

Senator CANTWELL. Okay. How long before we can get this program, I think which we got as part of the last COVID package, how long will it take for that to take effect?

Mr. GRINNELL. I will have to provide that back to you. I am not sure about the duration on that. But we will get that information and provide it to you.

Senator CANTWELL. I appreciate that.

This is, it really is about parity, and the inequity that exists in the law. So the challenges facing all of that inequity during the COVID pandemic really made it a lot tougher. So we really do want to get parity, and we want to get that now, and we want to get it permanently fixed.

But we also want to show with these funds that we can get out the door right now why this is so critical and the difference it makes in serving and delivering health care in urban parts of the United States. We have a very big Urban Indian population that covers tribes from many parts of the United States that just happen to live in the Seattle area.

Thank you very much. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Cantwell.

Ms. Todacheene, how does the work of the National Indian Child and Family Service Resource Center and its advisory board differ or complement the work currently being done by the Alyce Spotted Bear and Walter Soboleff Commission on Native Children that is charged with conducting a comprehensive study on Native children?

Ms. TODACHEENE. Thank you, Chairman Schatz. To answer your question, the Alyce Spotted Bear Commission, that studies programs and grants to support Native children through government agencies and tribal communities to help develop systems to delivery wraparound services for them. The advisory board under this bill advises the National Resource and Family Services Resource Center on best practices to provide tribes for child abuse and treatment prevention programs.

So the commissions differ because one advises on how to carry out abuse treatment and prevention activities, and the Alyce Spotted Bear Commission analyzes the grant programs to support Native children.

The CHAIRMAN. Thank you.

President Nez, your testimony highlights the urgent need for Congress to provide sanitation infrastructure for the Navajo Nation. Can you explain for the Committee and for the record how the lack of sanitation facilities affects overall health, the overall health of communities on the Navajo Nation? What benefits would providing sanitation infrastructure, in addition to the obvious health benefits, bring to the Navajo Nation?

Mr. NEZ. Thank you, Chairman Schatz, and members of the Committee. Thank you, Chairman, for that question.

Just to give you an overview, NTUA, the Navajo Tribal Utility Authority, states that for water, 16,000 of the Navajo residents do not have access to running water. Electricity, over 14,000 of our citizens don't have electricity. We need both in order to provide drinking water. As you know, because of the uranium legacy here on Navajo Nation, some of these wells are contaminated with uranium, too, and of course that's health.

But in terms of economic development, and Senator Tester mentioned earlier the need for getting water into communities is important. That way economic and community development projects can get developed.

The other thing I wanted to mention on that note is that there has been much money coming into Indian Country. We thank the Senators and our Representatives and the President and Vice President for that infusion of dollars into Indian Country. But there is also a regulatory change that needs to happen within Federal trust lands, so that we can be able to get construction projects done more quickly. We have allotted money and there is a timeline in the process right now that we have to abide by.

But it is hard, as you were saying, the IHS has some regulatory processes, the Bureau of Indian Affairs has another process. I would hate for some of our tribes to be sitting on a lot of these, maybe ARPA monies, CARES Act monies, where we could be able to provide water to communities and electricity for the permanent needs of our Nations.

So those are things that we would like for Congress to address as well, alongside the need for water and sanitation. Thank you.

The CHAIRMAN. Thank you very much.

My final question, and I will submit a few additional questions for the record, Mr. Grinnell, the most recent IHS sanitation deficiency report outlines nearly $2.6 billion in tribal sanitation infrastructure needs. Here is the interesting part from my standpoint. It breaks down those unmet needs into something that you call feasible and infeasible.

What does that even mean? It seems to me that what you are actually saying is that some things are more expensive than others. But it is public policy whether or not we fund it. It is not a matter of it being technically infeasible. Someone is just drawing a line between types of projects based on cost per unit connected or whatever it may be.

But infeasible is not the right word to use if what you are saying is high cost.

Mr. GRINNELL. Yes, thank you for that question, Senator. You are correct; it is the projects that are more expensive to complete versus those that are determined to be more economically cost effective to complete. At the end of the day, the need still does exist across Indian Country to address both projects. As we have identified in our report to Congress, that need still is over $3 billion.

The CHAIRMAN. I don't want to nitpick here, but it is not a trivial thing if you report back to Congress that certain projects are infeasible, because that creates a political and public policy making context in which, what, we are going to fund infeasible projects? So I think it is really worth it for the Department to change its language as it relates to the cost of projects. We are doing rural broadband. And there is a big cost per connect if you are in hilly West Virginia or a vast square State in the middle of the Continental United States, or trying to connect the northwest Hawaiian islands.

But nobody calls that infeasible. We have decided as public policy that we are going to try to connect everybody with broadband infrastructure, even if it is obviously cheaper to connect people in places where there is density than where there is not.

I know this may sounds like sort of a linguistic nitpicking, but it is not that. I think the Department is in no position to tell us what is feasible and infeasible. All they can tell us is how much something might cost. I am wondering if you can please make that change.

Mr. GRINNELL. Yes, sir, we will take that back. I did look up some of the information that drives that particular category of feasible and infeasible. That was actually developed based on the IHS health facilities cost index and the Department of Housing and Urban Development's total development cost index. Again, those were determined in order to prioritize projects, based on input from the tribes locally as well as the engineers, in determining which projects would rank as the highest priority.

I will take that information back. Thank you, Senator.

The CHAIRMAN. Yes. It is just that if you use that philosophy for government spending and government infrastructure, Laupahoehoe never gets a public library, right? And lots of tribal communities

never get roads, and clinics, and electricity infrastructure because the cost per person served is going to be higher in rural areas, in hard to serve areas.

So we do think this is important to get right, and we will follow up with you.

If there are no more questions for our witnesses, members may also submit follow-up written questions for the record. The hearing record will be open for two weeks.

I want to thank all the witnesses for taking their time today and providing their testimony. This hearing is now adjourned.

[Whereupon, at 4:02 p.m., the hearing was adjourned.]

A P P E N D I X

PREPARED STATEMENT OF ESTHER LUCERO, PRESIDENT/CEO, SEATTLE INDIAN HEALTH BOARD

Legislative Request

In alignment with the President Biden's Fiscal Year (FY) 2022 Indian Health Service (IHS) Congressional Justification, we respectfully request your support of *S. 1797 Urban Indian Health Providers Facilities Improvement Act* or consider including this no-cost legislative fix provision in the upcoming infrastructure package.

Healthcare Informed by Indigenous Knowledge

SIHB is one of 41 IHS-designated Urban Indian Organizations (UIO) in the Urban Indian Health Program and a HRSA 330 Federally Qualified Health Center, which serves nearly 5,000 American Indians and Alaska Natives living in the greater Seattle, Washington area. Nationwide, UIOs operate 74 health facilities in 22 states and offer services to over 2.2 million American Indian and Alaska Native people in select urban areas. As a culturally attuned service provider, we offer direct medical, dental, traditional health, behavioral health services, and a variety of social support services on issues of gender-based violence, youth development, and homelessness. We are part of the Indian healthcare system and honor our responsibilities to work with our tribal partners to serve all tribal people by supporting the community and health needs of the over 71 percent of American Indian and Alaska Native people living in urban areas.

Our research division, the Urban Indian Health Institute (UIHI), is a public health authority and IHS-designated tribal epidemiology center—the only national tribal epidemiology center serving more than 60 UIOs nationwide. UIHI recognizes research, data, and evaluation are integral to informed decisionmaking by policy and funding partners. UIHI assists Native communities in making data-driven decisions, conducting research and evaluation, collecting and analyzing data, and providing disease surveillance to improve the health of our entire Native community.

Documented Infrastructure Needs for IHS and Tribal Health Facilities

The chronic underfunding of IHS and tribal health facilities is well-documented by IHS,[1] Congressional committees,[2] the Government Accountability Office,[3] and the United States Commission on Civil Rights.[4] Currently, the IHS Division of Facilities and Construction has a backlog of $515 million and it is not uncommon for IHS or tribal health facilities to be on the waitlist for construction and renovation projects for over 10 years.[5] The IHS line item for facilities and construction is and should continue to be reserved for the enormous backlog in facility needs of tribal nations and IHS direct facilities.

Significant Infrastructure Gaps for Urban Indian Health Programs

There is no national level data on the infrastructure needs of Urban Indian Health Programs. The FY 2020 Appropriations set aside $1 million for IHS to con-

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[1] Indian Health Service. Annual Congressional Justifications. FY2009–FY2018. Retrieved from: *https://www.ihs.gov/budgetformulation/congressionaljustifications/*

[2] House Committee on Energy & Commerce. (2017). Walden and Pallone Announce Bi-partisan Taskforce to Examine Indian Health Service. Retrieved from: *https://energycommerce.house.gov/newsroom/press-releases/walden-pallone-announce-bipartisan-task-force-to-examine-indian-health*

[3] United States Government Accountability Office. (2018). Indian Health Service: Spending Levels and Characteristics of IHS and Three Other Federal Health Care Programs. Retrieved from: *https://www.gao.gov/assets/700/695871.pdf*

[4] United States Commission on Civil Rights. (2018). Broken Promises: Continuing Federal Funding Shortfall for Native Americans. Retrieved from: *https://www.usccr.gov/pubs/2018/12-20-Broken-Promises.pdf*

[5] Indian Health Service. (2016). Health Facilities Construction. Retrieved from: *https://www.ihs.gov/newsroom/factsheets/healthfacilitiesconstruction/*

duct an infrastructure study for UIO facilities through the Urban Indian Health Program. This report will be the first of its kind for UIO facilities. Yet, we know from experience that UIOs operate out of severely aged, inefficient, and overcrowded healthcare facilities which compromise the provision of critical health services and contribute to health disparities among urban Indian communities. For example, SIHB serves nearly 5,000 patients out of an aged facility and has temporary paused services at our 95-bed in-patient behavioral health facility due to dilapidating infrastructure. Our current facility is in need of significant renovations to accommodate a growing patient population and meet the standards of modern medical practices including integrated care.

Supplemental Investments Support Facilities Improvements

Recent COVID–19 supplements have allowed for some flexible spending to address the overwhelming and longstanding infrastructure needs of UIOs. UIOs have been able to use flexible COVID–19 supplemental funding from IHS, Health Resources and Services Administration (HRSA), and the Substance Abuse and Mental Health Services Administration (SAMHSA) to address minimal improvements to facilities and infrastructure including testing equipment, vaccine freezers, ultra-violet (UV) ventilation systems, plexi-glass barriers, telehealth services, and minor facility renovations to accommodate social distancing. This has demonstrated that with additional flexible funding, UIOs can implement infrastructure projects for integrated care models that are patient-centric to meet the needs of our community.

Structural Barriers to Addressing Infrastructure Needs Among UIOs

Currently, the constraints of the Indian Health Care Improvement Act (IHCIA) 25 U.S.C. § 1659 restrict UIOs from using IHS contract funding for infrastructure projects. These IHS contract funds and limited programmatic funding are often the sole source of IHS funding received by UIOs. UIOs do not receive funding from the IHS Health Care Facilities Construction line item including construction, maintenance, leasehold improvements, renovation, and equipment.

UIOs receive less than 1 percent of the IHS budget to deliver services to the 71 percent of American Indians and Alaska Natives who live in urban areas. UIOs rely on IHS dollars for operating budgets and investing in infrastructure is not an option without dedicated infrastructure dollars and flexible use of funds. Current IHCIA law prohibits UIOs from making even minor renovations to their facilities using their annual appropriations unless the renovations are connected to achieving Joint Commission for Accreditation of Health Care Organizations (JCAHO) standards. The initial intention of this provision was to help UIOs maintain or attain specific health center accreditation, but instead has impeded UIOs from using their already limited funding for any infrastructure needs in an era where many UIOs seek a variety of health center accreditations outside of JCAHO. Amending IHCIA will allow for greater resources to reach UIO healthcare facilities to enhance quality care, accessibility to care, and improve health outcomes for American Indian and Alaska Native people.

We thank you for your leadership to improve the health and well-being of urban American Indian and Alaska Native people.

PREPARED STATEMENT OF THE NATIONAL INDIAN HEALTH BOARD

Chairman Schatz, Vice Chair Murkowski, and Members of the Committee, thank you for holding a legislative hearing on July 21, 2021 to receive testimony on S. 1797, S. 1895, and H.R. 1688. On behalf of the National Indian Health Board and the 574 federally-recognized sovereign American Indian and Alaska Native (AI/AN) Tribal Nations we serve, we submit this testimony for the record on S. 1895.

On May 27, 2021, Senator Lujan, along with Senators Heinrich and Sinema, introduced S.1895, which requires the Secretary of the Department of Health and Human Services to provide additional funding for the Indian Health Service (IHS) sanitation facilities construction program. Such additional funding would assist in addressing a significant need in Tribal communities.

Sanitation Conditions in Tribal Communities

Human health depends on safe water, sanitation, and hygienic conditions. The COVID–19 pandemic has highlighted the importance of these basic needs and illustrated the devastating consequences of gaps in these systems, including the spread of infectious diseases. The lack of access to safe drinking water and basic sanitation in Indian Country negatively impacts the public health of AI/AN communities.

However, according to the IHS, "at the end of FY 2020 about 7,140, or 1.8 percent, of all AI/AN homes tracked by IHS lacked water supply or wastewater disposal fa-

cilities. About 112,082, or approximately 28 percent, of American Indian and Alaska Native homes tracked by IHS needed some form of sanitation facilities improvements."[1]

For example, in Alaska, the Department of Environmental Conservation reports that over 3,300 rural Alaska homes across 30 predominately Alaska Native Villages lack running water, forcing the use of "honey buckets" that are disposed in environmentally hazardous sewage lagoons.[2] Because of the sordid history of mineral mining on Navajo lands, groundwater on or near the Navajo Nation reservation has been shown to have dangerously high levels of arsenic and uranium. As a result, roughly 30 percent of Navajo homes lack access to a municipal water supply, making the cost of water for Navajo households roughly 71 times higher than the cost of water in urban areas with municipal water access.[3] The lack of clean, running water and adequate sanitation facilities makes disease prevention, especially during the COVID–19 pandemic, far more challenging for Tribal communities.

The IHS Sanitation Facilities Construction Program

The IHS is one of the primary providers of community water projects in Tribal communities. The Sanitation Facilities Construction (SFC) Program provides many AI/AN homes and communities with essential water supply, sewage disposal, and solid waste disposal facilities. The IHS environmental engineers plan, design, and manage most SFC projects. Many of those engineers are assigned to one of the twelve IHS Area Offices. The SFC program is an integral part of the IHS disease prevention effort that could potentially impact approximately 413,454 AI/AN homes.

The IHS has identified a Total Database Cost of $2.57 billion in estimated costs for 1,563 water infrastructure projects to address existing drinking water and wastewater needs in its 2019 Annual Report to Congress on Sanitation Deficiency Levels for Indian Homes and Communities. Specifically, IHS determined that over 110,500 Native households need some form of sanitation facility improvement, over 51,700 are without access to adequate sanitation facilities, and over 6,600 are without access to a safe water supply system and/or sewage disposal system.[4]

More than 80 percent of the cost of the highest deficiency level projects per the IHS sanitation deficiency database were in the IHS Alaska and Navajo areas. The IHS has not released its 2020 report, but indicated in its testimony that the cost to fund all needed projects will rise above $3 billion in fiscal year 2020. For the most part, in a typical year, the IHS is limited to annual appropriations to fund feasible water projects identified in the Annual Report, approximately $196.5 million for FY 2021, to address existing water and wastewater needs. Additional projects and needs waiting to be added to the sanitation deficiencies list far exceed that amount, with over $1.1 billion in Alaska Native villages alone. Costs for the much-needed projects will continue to grow without funding to address the needs.

The IHS estimates that every $1 spent on water and sanitation infrastructure will save $1.18 in avoided direct healthcare cost.[5] During FY 2020, 373 sanitation projects were funded at $220 million. Once constructed, these sanitation facilities will benefit an estimated 143,000 American Indian and Alaska Native people and help avoid over 235,000 inpatient and outpatient visits related to respiratory, skin, and gastroenteric disease over 30 years.[6] The health care cost savings for these visits alone is estimated to be over $259 million.[7]

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[1] *Legislative Hearing To Receive Testimony on S. 1797, S. 1895, and H.R. 1688 Before the S. Comm. On Indian Aff.*, 117th Cong. 1 (2021) (statement of Randy Grinnell, Deputy Director for Management Operations, Indian Health Service, Department of Health and Human Services) (emphasis added).

[2] U.S. Water Alliance. 2019. Closing the Water Access Gap in the United States. Retrieved from *http://uswateralliance.org/sites/uswateralliance.org/files/Closing%20the%20Water%20Access%20Gap%20in%20the%20United%20States__DIGITAL.pdf*

[3] Ingram, J. C., Jones, L., Credo, J., & Rock, T. (2020). Uranium and arsenic unregulated water issues on Navajo lands. Journal of vacuum science & technology. A, Vacuum, surfaces, and films : an official journal of the American Vacuum Society, 38(3), 031003. *https://doi.org/10.1116/1.5142283*

[4] Department of Health and Human Services, Indian Health Service. Annual Report to the Congress of the United States On Sanitation Deficiency Levels for Indian Homes and Communities, Fiscal Year 2019, at 7.

[5] Department of Health and Human Services. Fiscal Year 2022, Indian Health Service, Justification of Estimates for Appropriations Committees, at CJ 224.

[6] *Id.*

[7] *Id.*

S. 1895—the Indian Health Service Sanitation Facilities Construction Enhancement Act

Funding. The bill, S. 1895, the *Indian Health Service Sanitation Facilities Construction Enhancement Act* authorizes an additional $3 billion for fiscal year 2022 (available until expended) for the planning, design, construction, modernization, improvement, and renovation of water, sewer, and solid waste sanitation facilities. Of that amount, $350 million is set aside for additional staffing support to carry out this Act. These amounts are in addition to funds provided for under any other provision of law. These amounts will contribute to addressing the significant sanitation deficiency levels identified in Tribal communities.

Project Eligibility. The bill requires that the Secretary shall prioritize sanitation facilities in accordance with the IHS Sanitation Deficiency System established pursuant to 302(g) of the Indian Health Care Improvement Act (25 U.S.C. 1632(g)).

According to the IHS, the Total Database Estimate of $2.57 billion for FY 2019, and $3.09 billion projected for FY 2020, includes both economically feasible and infeasible projects. However, those projects determined to be economically infeasible, according to the IHS, are not eligible for IHS funding.[8] The bill does not prohibit the economically infeasible projects from being funded.

The IHS also cites a national average of four years for the design and construction of the feasible projects.[9] The 2019 Annual Report notes that there are 1,088 feasible and 475 infeasible projects.[10] The average project length and number of projects creates a significant waiting period for the projects. The amount of funding in the bill made available immediately until expended should serve to reduce the waiting period.

The IHS has indicated that "[a]ll projects are re-evaluated annually to determine whether the costs and priority scoring factors have changed."[11] However, clarification may be needed regarding how infeasible projects should be addressed, in light of the additional funding and current Sanitation Deficiency System priority.[12]

Conclusion

We thank the Senate Committee on Indian Affairs for holding this hearing on important legislation. We stand ready to work with Congress in a bipartisan manner to enact legislation that strengthens the government-government relationship, improves access to care for all AI/ANs, and raises health outcomes.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. LISA MURKOWSKI TO HON. GIL VIGIL

In your written testimony, you describe the current challenges that Tribal programs are facing with funding instability and data collection issues, and also on the differing tribal-state relationships over Native child maltreatment.

Question. What are the biggest challenges that Tribes are facing when trying to offer prevention and treatment services within their communities?

Answer. Tribal nations struggle with a patchwork of federal funding sources to support prevention and treatment services. This patchwork of funding is almost exclusively discretionary sources that can ebb and flow from one year to the next and in some cases, requires they compete against states or other communities to receive the grant funding. Furthermore, the amount of funding available is often very

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[8] Department of Health and Human Services, Indian Health Service. Annual Report to the Congress of the United States On Sanitation Deficiency Levels for Indian Homes and Communities, Fiscal Year 2019, at 8-9. ("The feasible project cost estimate forms the basis for the IHS Funding Plan, which is used for developing budget requests and for allocating appropriated funds to the IHS Areas. Projects with high capital costs on a per-home basis are considered infeasible and are not considered when allocating appropriated funds to the Areas by IHS headquarters.")

[9] Legislative Hearing To Receive Testimony on S. 1797, S. 1895, and H.R. 1688 Before the S. Comm. On Indian Aff., 117th Cong. 1 (2021) (statement of Randy Grinnell, Deputy Director for Management Operations, Indian Health Service, Department of Health and Human Services)

[10] Department of Health and Human Services, Indian Health Service. Annual Report to the Congress of the United States On Sanitation Deficiency Levels for Indian Homes and Communities, Fiscal Year 2019, at 9.

[11] *Id.*

[12] *Id.*, at 11. ("The IHS may still support the planning, design, and construction of projects that are infeasible, typically as a result of funding contributions from other federal agencies and/or tribal sources. The SFC Program has provided and will continue to provide eligible AI/AN homes with other less costly types of sanitation facilities (e.g., offsite watering points and sewer haul systems). The SFC Program will also continue to track and estimate project costs to serve these homes with piped water and sewer systems.)"

small, sometimes with tribes receiving less than $10,000 per year from some primary sources of child welfare funding such as Title IV–B of the Social Security Act. Unlike states that have mandatory funding from programs like Medicaid or the Title XX Social Services Block Grant, tribes have to contend with small amounts of funding that do not provide the regular, stable funding needed to address prevention and treatment needs of their community members who are at risk or have been victims of child abuse and neglect or family violence. In H.R. 1688 we see an opportunity to reauthorize grant programs specifically designed for tribal nations where they would not have to compete with states and others to receive funding specifically targeted to preventing and treating child abuse and family violence.

One other major challenge is existing funding at the federal level is often not designed with tribal communities in mind. The one-size-fits-all approach to funding prevention and treatment services can make it much more difficult for tribes to develop effective programs that are culturally appropriate and can be successful with Native children and families. When tribes have the opportunity to develop programs of this nature, as we see in H.R. 1688, it optimizes the community wisdom and resources already there to address challenging issues like child abuse and neglect and family violence. One additional benefit is when tribal nations have stable and effective programs they are also more likely to be able to be partner with states more effectively too. Having strong partners on both ends is much more likely to produce better outcomes for Native children and families.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. BEN RAY LUJÁN TO HON. GIL VIGIL

Question 1. Mr. Vigil, are there any other Tribal grant programs targeted at preventing child abuse in Indian Country?

Answer. The only other federal funding for tribes that is dedicated to child abuse and neglect prevention comes from the Child Abuse Prevention and Treatment Act, Community-Based Child Abuse Prevention grant program. This grant program has historically provided prevention grants to one to two tribes each five-year grant cycle and tribes must compete with migrant communities to secure a grant. The grants are relatively small at around $130,000 per year.

Question 2. Mr. Vigil, what other sources of funding are there at BIA for Tribes to use to support their child welfare programs? Do all Tribes have access to these funds? Are these funds sufficient hire at least one caseworker per Tribe?

Answer. The BIA provides sources of funding for child welfare services, but none that is dedicated to child abuse and neglect prevention. BIA programs that fund some type of child welfare services include the Indian Child Welfare Act on-reservation grants, BIA Social Services grants, and Child Assistance. The Indian Child Welfare Act grants are primarily used to support tribal involvement in cases where tribal families are under state jurisdiction. BIA Social Services can be used for child welfare purposes, but it is also for other social service purposes and is not available to all tribes. BIA Child Assistance supports foster care and other out of home placements, but doesn't support the administrative costs of managing cases, just the monthly payment for the caregiver, and is not available to all tribes. All of the BIA child welfare related funds are discretionary. The Department of Health and Human Services provides discretionary grants for tribal child welfare purposes, such as the two programs that fall under Title IV–B of the Social Security Act, but these are not dedicated to child abuse and neglect prevention and come in very small amounts so tribes must use this to help fund services to families already in crisis as opposed to prevention.

The National Indian Child Welfare Association estimates it would require at least $120,000 to hire one professional child welfare staff person and support their salary, benefits, and administrative expenses for a year. Almost three-quarters of tribes that apply for the BIA Indian Child Welfare Act, On Reservation grant program, are not eligible to receive this amount of funding. Other BIA programs, such as BIA Social Services, may provide grants closer to this size, but this funding source is not available to over 47 percent of tribal nations and the funding must support more than just child welfare services. Creating an adequately staffed and effective child welfare program in Indian Country is extremely challenging given the patchwork of discretionary grant funds available to them and the amounts provided.

Question 3. Mr. Vigil, why is it important that Tribes have flexibility in how they can use the funds included in the formula grants in this bill? Can you give some examples of ways Tribes might use these funds based on current needs?

Answer. Flexibility allows tribal nations to develop culturally based services that will be successful in their communities and can be administered within the re-

sources tribes have access to. Few federal child welfare programs were developed with tribal communities in mind, which can lead to roadblocks for the development and operation of programs and services that tribal communities need and want. Being successful in child abuse and neglect and family violence prevention and treatment is highly dependent upon a tribe's capacity to respond to the unique conditions, culture, and realities of providing services in their community. Where tribes have this flexibility we can see great outcomes for Native children and families. In my testimony I shared what the Confederated Tribes of Umatilla was able to do to reduce foster care placements by over 70 percent. In Alaska, the Native Village of Kwigillingok developed a community response protocol based upon their culture that checks in with families that are known to have risk for child abuse and neglect. Since implementing their protocol, they have not had any foster care placements in their community for over two years. These examples are testaments to what investment in tribal child welfare can provide with the right approach.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. BRIAN SCHATZ TO HON. GIL VIGIL

Question 1. In addition to the proposals contained in H.R. 1688, what further recommendations would NIWCA propose for improving the federal government's support of Tribal child welfare programs and Native child welfare more generally?

Answer. Improving tribal access to the same federal sources of funding that states have access to is a goal that will go a long way to ensuring that tribal governments have the resources they need to provide comprehensive services. Currently, tribal governments are not eligible for the Title XX Social Services Block Grant, which is a major funder of state child welfare services, both for child welfare and family violence services. Providing tribes access to this funding source could help tribes weather changes in need caused by things like the opioid crisis and pandemics like COVID–19. Another key recommendation would be to extend the flexibility that tribes operating the Title IV–E Foster Care and Adoption Assistance program directly with the federal government have to tribes that are in agreements with states to operate this program. Over 130 tribes are in Title IV–E agreements with states but are required to meet the same requirements as states to access the prevention services funding. This essentially prohibits them from using their culturally based services when serving Native children and families even when states want to support this flexibility too.

Question 2. Earlier this year, NICWA and a number of other Native organizations sent a letter to Congress indicating that lack of investment in Tribal child welfare data systems infrastructure negatively impacts Tribes. Can you provide some additional details on the cited data infrastructure needs?

Answer. The letter sent by Native organizations cited infrastructure needs in a number of tribal governance areas, including child welfare. The child welfare infrastructure needs for tribes identified included, (1) support for tribal child welfare data systems development, (2) support for tribal telemedicine options in working with children and families, and (3) establishing tribal eligibility to receive Title XX Social Services Block Grant funds directly through the federal government. With regard to the data infrastructure needs, federal funding for tribal child welfare services programs, whether administered under the Department of Interior or Department of Health and Human Services, requires data collection related to programs and services supported by the funds. In addition, tribal governments need accurate and reliable data collection to track trends in service delivery and outcomes for tribal children and families they serve, as well as help them address disaster planning requirements under federal law. However, little to no funding is available for tribal nations to develop this critical program infrastructure from existing federal child welfare programs, while state governments have been the beneficiary of tens of millions of dollars of data system development and operational funds from federal sources. As a result, there is little reliable data available on a regional or national level for child welfare services operated in tribal communities. This gap in data leaves tribal, state, and federal policymakers and administrators with little information on how to respond to trends in services that impact outcomes for tribal children and families. Congress and tribal leaders need quality data to understand what is happening on the ground with at-risk children and families and be able to evaluate options for improving services and outcomes. Not having good data also threatens the ability of tribes to respond effectively during natural disasters, which requires quick identification of high need families and children and the ability to track the whereabouts of families, children, and caregivers when people are displaced from their homes. Data systems also facilitate better collaboration between agencies that

are working with families and children, including funders, as they determine how best to respond to individual and collective needs.

Question 3. Are there other infrastructure needs you wish to highlight for the Committee?

Answer. Tribal child welfare capacity and resulting outcomes for Native children and families are tied together by the ability of tribal nations to establish quality infrastructure. Good infrastructure can help create stability in programming and help address dynamic and challenging environments like those found in child welfare. Infrastructure is also important to tribal nations attracting and developing a skilled workforce, reducing the crisis orientation of child welfare and the costly outlays for crisis-oriented services as compared to prevention services, and leveraging high value partnerships that can improve services access and collaboration in the public and private sector. Often tribal nations don't have the flexible funding that states do to develop necessary infrastructure or support services and are left with choices that don't address the root causes of child maltreatment and continue the crisis orientation which is so costly and ineffective. Creating access to a base level of funding for tribes that can help them develop data systems, train and support a quality workforce, and develop truly community-based and culturally appropriate services is the infrastructure that tribal nations need. As our written and oral testimony indicated, where tribal nations have been able to develop this infrastructure in child welfare they have been able to reduce costly out of home placements and reduce trauma to children while strengthening families for the long term.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. BEN RAY LUJÁN TO HON. JONATHAN NEZ

Question 1. You stated in your testimony that between 9,000 and 16,000 homes on the Navajo Nation do not have access to running water. Where did this data come from?

Answer. On June 8, 2021, David McDonnell, Chief Project Engineer for the Navajo Area Indian Health Service (NAIHS) advised us that approximately 9,600 homes on the Navajo Nation do not have running water. However, Jason John, our Director of the Navajo Nation Department of Water Resources, estimates that the actual number could be as high as 16,000. According to Mr. John, the IHS does not have the resources and capacity necessary to fully assess every home on the Navajo Nation, which is where the difference in numbers comes from.

Question 2. You stated in your testimony that between 14,000 homes on the Navajo Nation do not have access to electricity. Where did this data come from?

Answer. This number is based on the Public Power Association's Light Up Navajo project. The actual figure is about 15,000, according to their website. This comprises 32 percent of all homes on the Navajo Nation and 75 percent of all un-electrified homes in the United States, according to the same source.

Question 3. You have stated previously that roughly a third of Navajo Nation homes do not have access to running water. Is this still the most accurate estimate that Navajo Nation has? Where did this data come from?

Answer. As noted in an email from David McDonnell of NAIHS in 2020: "To the best of my knowledge, the 30 percent Navajo homes without piped water came from the 2000 Census, and more specifically from a report published by the Navajo Nation Division of Economic Development called "Navajo Nation Data from US Census 2000" that was published sometime in 2003. See: *http://www.navajobusiness.com/pdf/NNCensus/Census2000.pdf* In the beginning of that document there is a table of data, including "Housing Units Lacking Complete Plumbing Facilities" with a percentage of 31.9 percent (15,279/47,827 occupied homes = 0.319 = 31.9 percent)."

Others estimate an even higher number. A Public Broadcasting System feature called "How Off-the Grid Navajo Residents Are Getting Running Water," which aired June 20, 2018, estimated as many as 40 percent (or 18,000) of Navajo families still have not been connected to running water.

While these numbers need to be updated, there continues to be a struggle to identify what are classified as homes and their occupancy. The census data is a source of information on housing but the data behind it needs to be evaluated. There is an ongoing need to have a coordinated evaluation between the Navajo Nation, NAIHS, and other programs to understand the data that will reflect the needs for housing, water, electricity, and other infrastructure.

Question 4. How many Navajo Nation families have been connected to running water with CARES Act funding? How many of these are in New Mexico?

Answer. The Navajo Nation provided CARES Act funds to NTUA and through NTUA, 105 families received a cistern and septic system, and 30 Navajo families received a waterline and septic system connection to their homes. At this time, we are unable to assess the exact locations of these homes.

Question 5. How many Navajo Nation families have not been connected to water yet? How many of these are in New Mexico? How is the Navajo Nation tracking the need for running water in its communities?

Answer. According to NAIHS in 2020, approximately 9,600 homes still need to be connected to water, but local knowledge suggests it is much higher, potentially as high as 16,000 homes. Many of these homes are situated in the Bennett Freeze area in Arizona, but there exists a significant shortage of electrical and water infrastructure in the checkerboard areas of New Mexico as well.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. LISA MURKOWSKI TO HON. RANDY GRINNELL, M.P.H.

Question 1. H.R. 1688 removes references to the HHS Secretary from the existing law that established the Indian Child Resource and Family Service Center and allows for the Secretary of the Interior to establish a more centralized National Indian Child Resource and Family Services Center. Can you elaborate on whether removing the references to HHS Secretary in Section 2 of the legislation should be reconsidered by the Committee? The Indian Health Service provides important services to Indian people involving child abuse, neglect and maltreatment. Would it be beneficial for DOI and HHS to work together on these issues?

Answer. The bill H.R. 1688 would amend 25 U.S.C. 3209 to remove references of the Department of Health and Human Services (HHS) Secretary, eliminate the requirement for a Memorandum of Agreement (MOA) between HHS and the Department of the Interior (DOI), and require the DOI Secretary to establish one National Indian Child Resource and Family Services Center. The Indian Health Service (IHS) defers to the bill drafters as to whether this Committee should reconsider the deletion of the HHS Secretary from the cited statute in the bill.

The IHS efforts to identify and respond to child maltreatment include early intervention, screening, assessment, education, and community-based programming to build resiliency among children and youth and to promote family engagement. Many of the behavioral health grant programs administered by IHS provide programmatic expertise highlighting the success, challenges, and lessons learned related to expanding access to child advocacy centers within tribal communities. In addition to our grant programs, IHS facilities and organizations within the Indian health system provide comprehensive and culturally appropriate health services.

IHS has experience working through a coordinated approach to meet federal priorities with cross cutting priorities. As an example, the Tribal Law and Order Act required the establishment of an interagency MOA for the coordination and collaboration among key federal partners to understand the scope of substance use disorder among the American Indian and Alaska Native population.

Question 2. S. 1895 is a bill that will require the IHS to provide additional funding to the Sanitation Facilities Construction Program that will be used for the planning, design, construction, modernization, improvement, and renovation of water, sewer, and solid waste sanitation facilities funded by the agency. The bill requires the HHS Secretary to prioritize funding for sanitation facilities in accordance with the IHS Sanitation Deficiency System. Can you provide the agency's interpretation of this provision in how the IHS will prioritize the allocation of this funding?

Answer. If S.1895 bill becomes law, IHS plans to allocate funds and prioritize project funding following the current methodologies. The funds will be allocated by IHS Headquarters to IHS Areas using an allocation formula that includes economically feasible project costs and counts of tribal homes that have been evaluated as having sanitation deficiencies at a level of 3, 4, or 5. The allocated funds will then be used to fund projects that are ready to fund in priority order from each Area's list. Additional details about the project scoring methodology can be found in September 2019 guidance document the Sanitation Deficiency System (SDS) A Guide for Reporting Sanitation Deficiencies for American Indian and Alaska Native Homes and Communities, available on the IHS website: *https://www.ihs.gov/sites/dsfc/themes/responsive2017/display_objects/documents/Final_SDS_Guide_v2.pdf.*

Question 3. There are 49 underserved and unserved communities in Alaska and due to the high cost of construction for water and sanitation infrastructure are living without basic access to running water and flush toilets. Due to the lack of infrastructure, it has been reported that one in three children living in the Yukon-

Kuskokwim villages without running water were hospitalized with respiratory infections. How will this funding immediately, and in the long-term, help underserved and unserved Alaska Native communities?

Answer. Funds authorized by the bill S. 1895, similar to all sanitation facilities project funds appropriated to the IHS, will be used to address sanitation deficiencies that impact tribal homes and communities. Estimating which communities will be served by the funding from the proposed bill at this time is challenging since funds appropriated through the American Rescue Plan Act have not been applied to projects and removed from the list. Additionally, IHS is currently in the process of updating the sanitation deficiency needs list for calendar year (CY) 2021, which could include new projects. The CY 2021 update will be used to allocate the funds from this bill.

Taking into consideration the limitations described above, the table below estimates the total number of projects, Alaska Native Village Communities, tribal homes benefiting, and total eligible project cost which would be funded in Alaska based on funds authorized by S. 1895. This analysis assumed a total project funding amount for projects of $2.65 billion and used the CY 2020 SDS dataset after removing projects funded with the IHS fiscal year 2021 regular budget appropriation.

Estimate of Alaska Area IHS Projects funded based on funds authorized by S. 1895

Total Number of Projects Funded	Total Eligible Cost	Number of Alaska Native Village Communities Benefiting	Number of Tribal Homes Benefiting
108	$741,485,094	83	7,379

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. BEN RAY LUJÁN TO HON. RANDY GRINNELL, M.P.H.

Question 1. Mr. Grinnell, how many Tribes total stand to benefit from the projects on IHS's deficiency list?

Answer. In the CY 2020 IHS sanitation deficiency needs list there were 1,580 projects that when built would benefit 358 Tribes. An updated list will be available before the end of CY 2021.

Question 2. Mr. Grinnell, which of the Area Offices have the greatest number of identified sanitation deficiencies?

Answer. Using the CY 2020 SDS data, the Navajo Area and Alaska Areas have the greatest number of project to address identified sanitation deficiency needs. These numbers will change once IHS updates the SDS data for CY 2021.

IHS Area	Sum of Eligible Homes	Count of SDS Project Number	Sum of Total Eligible Cost
Albuquerque	19,052	96	$73,188,581
Alaska	29,236	373	$1,844,522,330
Bemidji	12,349	84	$59,360,865
Billings	9,005	40	$26,378,799
California	9,523	93	$112,265,365
Great Plains	48,426	182	$ 147,926,384
Navajo	37,406	374	$535,580,490
Nashville	7,262	30	$59,063,240
Oklahoma	11,123	161	$47,775,351
Phoenix	30,606	90	$113,355,089
Portland	9,965	43	$59,592,496
Tucson	1,196	14	$7,764,163
Grand Total	225,149	1,580	$3,086,773,153

Question 3. Mr. Grinnell, how many projects and how much money are identified for the Navajo Nation?

Answer. Estimating which communities will be served by the funding authorized by S. 1895 at this time is challenging since funds appropriated through the American Rescue Plan Act have not been applied to projects and removed from the list. Additionally, IHS is currently in the process of updating the sanitation deficiency needs list for CY 2021, which could include new projects. The CY 2021 update will be used to allocate the funds from this bill.

Taking into consideration the limitations described above, it is estimated that 349 projects included on the CY 2020 sanitation needs list will be funded on the Navajo Nation if the amount of project funding ($2.65 billion) authorized in S. 1895 stays the same. The total eligible cost of these projects are estimated to be $516 million.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. LISA MURKOWSKI TO HEIDI TODACHEENE

Question. Ms. Todacheene, I have been proud to work on many legislative efforts to protect the vulnerable, whether that is supporting Native children, reducing domestic violence against Native women, or addressing the ongoing epidemic of missing or murdered Indigenous women. Often what we need to do to address these vulnerabilities and disparities is strengthen tribal institutions, improve coordination, and support Indian self-determination.

This is important because we know Native children face overwhelming obstacles, including experiencing levels of post-traumatic stress, dramatically increased risks of suicide, and lower high school graduation rates than any racial or ethnic demographic in the country. In NICWA's testimony, they point out that in Alaska, Native children make up over 62 percent of the state foster care system, but they are only 15 percent of the state's youth population.

H.R. 1688 allows for the National Indian Child Resource and Family Services Center, with the assistance of its Advisory Board, to develop intergovernmental agreements between Tribes and states relating to family violence, child abuse, and neglect. Alaska Tribes have been able to access BIA funding for their Tribal courts to oversee cases that may involve child welfare and domestic violence, and this includes the drafting of codes relating to child and family protection.

How would this bill provide stability for Tribal courts to better operate and develop stronger relationships with states? Additionally, how might intergovernmental agreements improve existing tribal-state relations?

Answer. The bill renames the Indian Child Resource and Family Services Centers as the National Indian Child Resource and Family Services Center. It also requires the Center, among other things, to develop model intergovernmental agreements between tribes and states to prevent, investigate, treat, and prosecute incidents of family violence, child abuse, and child neglect involving Indian children and families. State-tribal agreements to coordinate prevention, investigation and treatment services, will build stronger intergovernmental relationships to identify and coordinate child abuse, investigation, and prosecution services between governments, which depending on location, may not currently exist or could strengthen these efforts.

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