National Indian Health Board

SENATE COMMITTEE ON INDIAN AFFAIRS OVERSIGHT/LEGISLATIVE FIELD HEARING ON "IMPROVING ACCOUNTABILITY AND QUALITY OF CARE AT THE INDIAN HEALTH SERVICE THROUGH S. 2953"

Testimony on Behalf of the National Indian Health Board
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June 17, 2016
Rapid City, South Dakota

Good morning, my name is Stacy Bohlen, and I am the Executive Director of the National Indian Health Board (NIHB)[1]. Chairman Barrasso, Vice Chairman Tester and Members of the Committee, thank you for holding this important hearing on "Improving Accountability and Quality of Care at the Indian Health Service Through S. 2953". And, furthermore, thank you for honoring the Tribal leaders and Tribal members of the Indian Health Service (IHS) Great Plains Service Area by traveling to their traditional lands to hold one of many hearings and meetings to examine the state of the Indian health system.

The National Indian Health Board is a non-profit organization that serves all 567 federally recognized Tribes to provide policy analysis and advocacy, program development and assessment, and training and technical assistance in Indian healthcare and public health policy and programs. It is our mission to be the **one voice** affirming and empowering American Indian and Alaska Native (AI/AN) peoples to protect and improve health and reduce the health disparities our people face. I appreciate the opportunity to provide this testimony before the Committee today. The NIHB stands with and supports the Tribes of the Great Plains IHS Service Area in this time of crisis and I'll conclude my testimony today with specifics on what action NIHB is taking outside of working with both the Administration and Congress to do so. I am here today to offer the national perspective of all 567 federally recognized Indian Tribes – both those that receive direct services from the Indian Health Service, and those that have chosen to compact or contract with the Service to provide their own services.

Unfortunately, we are all here today because of longstanding, systemic issues within the IHS that have lead to crises situations in the Great Plains Area. In the last year, several hospitals in this region have lost, (or received threats of revocation) their ability to bill Centers of Medicare and Medicaid Services (CMS) due to the failure of federally run sites to comply with basic safety and regulatory procedures. As early as this week, an IHS facility, the Rosebud Hospital on the Rosebud Sioux Reservation here in South Dakota,

[1] The National Health Board (NIHB) is a 501(c) 3 not for profit, charitable organization providing health care advocacy services, facilitating Tribal budget consultation and providing timely information and other services to all Tribal Governments. Whether Tribes operate their own health care delivery systems through contracting and compacting or receive health care directly from the Indian Health Services (IHS), NIHB is their advocate. Because the NIHB serves all federally-recognized Tribes, it is important that the work of the NIHB reflect the unity and diversity of Tribal values and opinions in an accurate, fair, and culturally-sensitive manner. The NIHB is governed by a Board of Directors consisting of representatives elected by the Tribes in each of the twelve IHS Areas. Each Area Health Board elects a representative and an alternate to sit on the NIHB Board of Directors.

closed their surgical and obstetrics care services division. Now, patients seeking surgical and obstetrics care must go to privately owned facilities over 40-50 miles away. This is unacceptable.

Many of the issues now coming to light are not new to American Indian and Alaska Natives that rely on the Indian Health Service as their primary source of health care and health information. At least five years ago then-Senator Dorgan released a report exposing the chronic mismanagement occurring at both the IHS regional (Area office) level and the Headquarters level of the Agency. A 2011 report by a separate U.S. Department of Health and Human Services (HHS) task force specifically noted that: "…the lack of an agency-wide, systematic approach makes it virtually impossible to hold managers and staff accountable for performance and to correct problems before they reach crisis proportions."

Now that we are in such crises situations there must be two separate courses of action taken. First and foremost, immediate corrective action must be taken to rectify the closing and cutting of IHS services so there are no more unnecessary deaths of our people in this region and nationally. Once the crisis is stabilized, we must then to address the fundamental and systemic issues that have been occurring within the agency for years. These reforms may start in the Great Plains Area; however, they must be implemented nationally so that all Tribes and Tribal citizens receiving their health care from IHS are assured safe, reliable and quality health service.

The legislation proposed by Chairman Barrasso and Senator John Thune, S. 2953 "The Indian Health Service Accountability Act of 2016", is attempting to address long-standing Tribal concerns about the IHS, and the move forward to attempt improving the overall accountability and transparency of the Indian Health Service is admirable and appreciated. The spirit and intent of this legislation is clearly aimed at responding to the call of Tribal leaders, patients and the families of those who have had adverse experiences within the IHS system. Significant and structural changes are needed and this this bill boldly steps into that arena as a first attempt to open the dialogue of change. We stand ready to work with the Committee as the bill is shaped and formed through a Tribally-engaged and informed process. During the years that Indian Country and Congress worked to achieve the reauthorization of the Indian Health Care Improvement Act (IHCIA) NIHB facilitated a national, Tribal Leader Lead committee on the IHCIA Reauthorization. Many of the details of this bill attempt to achieve reforms that will provide the Service with the authorizations they need to improve the quality and quantity of health care services delivered at IHS facilities. However, especially because this legislation proposes to amend IHCIA, it is the position of the National Indian Health Board that the bill must be vetted further with a process similar to that utilized during the IHCIA reauthorization. Resources will be required to facilitate such a process and the time is now to engage the Tribes and Tribal consumers of IHS services in order to achieve meaningful, lasting and effective reforms to the system set up to fulfill the Treaty and Trust promise and obligations of the Federal Government.

Federal Trust Responsibility

The federal trust responsibility for health is a sacred promise, grounded in law, which our ancestors made with the United States. In exchange for land and peaceful co-existence, American Indians and Alaska Natives were promised access to certain paybacks, including health care. Since the earliest days of the Republic, all branches of the federal government have acknowledged the nation's obligations to the Tribes and the special trust relationship between the United States and American Indians and Alaska Natives. The Snyder Act of 1921 (25 USC 13) further affirmed this trust responsibility, as numerous other

documents, pieces of legislation, and court cases have. As part of upholding its responsibility, the federal government created the Indian Health Service (IHS) and tasked the agency with providing health services to AI/ANs. Since its creation in 1955, IHS has worked to provide health care to Native people. As recently as 2010, when Congress renewed the Indian Health Care Improvement Act, it was legislatively affirmed that, *"it is the policy of this Nation, to ensure the highest possible health status for Indians ... and to* ***provide all resources*** *necessary to effect that policy."* [2]

DISPARITIES

While some statistics have improved for American Indians and Alaska Natives over the years, they are still alarming and not improving fast enough. Still, across almost all diseases, American Indians and Alaska Native are at greater risk than other Americans. For example, American Indians and Alaska Natives are 520 percent more likely to suffer from alcohol-related deaths; 207 percent greater to die in motor vehicle crashes; and 177 percent more likely to die from complications due to diabetes.[3] Most recently, a report has come out reporting that American Indian and Alaska Natives are disproportionately affected by the hepatitis C virus (HCV). Furthermore, Natives have the highest HCV-related mortality rate of any US racial or ethnic group – resulting in 324 deaths in 2013. And, most devastatingly to our Tribal communities, suicide rates are nearly 50 percent higher in American Indian and Alaska Natives compared to non-Hispanic whites.

Although the statistics give an idea of the problem, behind each statistic is the story of an individual, a family and a community lacking access to adequate behavioral health and health care services or traditional healing practices, and traditional family models that have been interrupted by historically traumatic events. Devastating risks from historical trauma, poverty, and a lack of adequate treatment resources continue to plague Tribal communities. American Indians and Alaska Natives have a life expectancy 4.8 years less than other Americans. But in some areas, it is even lower. For instance, here in South Dakota, for white residents the median age is 81, compared to only 58 for American Indians.

What more will it take for the U.S. government to fulfill its promise of providing the highest possible health status for Indians and to provide all resources necessary to effect that policy? How many more horror stories must we share, and how many more hearings like this must we endure? Clearly, the current system is not working. Our health care delivery is not even safe and reliable, let alone moving us toward the "highest possible health status" in Indian Country.

STRUCTURAL REFORM

There are unique challenges to delivering health care in any rural area, including provider shortages, isolation, long travel distances, scarcity of specialty care, and under-resourced infrastructure. However, there are successful rural health systems operating all around the country that are able to deliver especially innovative and locally responsive and coordinated care. A pressing need and opportunity exists within the Indian Health Service, and its many rural, geographically isolated hospitals and clinics, to reform the structure in administrative oversight of the Service Units and Service Area offices. We believe that rather than reinventing a health system out of whole cloth, or reform around the edges of a system desperately in need of dramatic and deep reforms, IHS should aspire to achieve parity with mainstream, successful

[2] Indian Health Care Improvement Act, §103(2009).
[3] *Ibid, p 5.*

medical and health systems. One element absolutely necessary to such an aspiration is dramatic increases in the current funding levels of the Indian Health Service; however, adopting standard and generally accepted business practices is also necessary. NIHB believes that creating partnerships with mainstream and private entities will help IHS improve operations and systems and perhaps provide a learning laboratory for system-wide reform. The Rural Hospital Association and the American Hospital Association are just two places to examine for potential collaboration and learning.

While S. 2953 would mandate the Secretary of HHS to provide a report each quarter of a fiscal year describing expenditures, outlays, transfers, programming, obligations, and other spending of each level of the Service to Congress, Tribes and the IHS, it does not have substantive measures in place to ensure that the mismanagement of these resources does not continue. In May 2015, the then Acting Director of the IHS, Mr. Robert McSwain, wrote a Dear Tribal Leader Letter informing Tribes of a settlement IHS reached with employee unions, costing the Service a total of $80million. The settlement was reported to have resolved claims by IHS employees for overtime compensation for work they performed in federally operated hospitals, clinics and facilities – overtime work that was done to cover shifts in the health care facilities that would have otherwise gone uncovered and left countless American Indian and Alaska Native patients without care. The claims began being filed in 2008 and settlement awards covered several years of back-pay for this overtime work that employees performed due to long-term staffing shortages and general mismanagement of staff, facilities, and funding. A significant portion of the funding used for the settlement payment came from both third party collections and funds obligated for employee positions that went unfulfilled. The Dear Tribal Leader Letter stated, "IHS is also working to address the management of overtime work performed by IHS employees.", but as far as we know, no further action or reporting has occurred on this blatant malpractice that could have many unseen and unreported consequences on both employees and patients of the IHS. This failure to appropriately staff facilities and compensate employees shows a break down in the multi-layered administrative system within IHS. Both the local Service Unit and the Area Office would have had to have known that these issues persisted over several years, and yet, no immediate corrective action was taken to improve the quality of care provided or quality of workplace for employees at the facilities. More must be done to ensure accountability at both the Service Unit and the Area Office level of the Agency.

QUALITY ASSURANCE

Many reports attribute the deplorable quality of care at IHS-operated facilities to poor agency management at all levels. We know that hiring decisions are often lengthy, and poor performing employees at both the service unit, clinic and hospital administration and Headquarters are not terminated, but rather moved to other positions within IHS – often to a position of equal or higher responsibility level. The cyclical chronic lack of funding and mismanagement of funds also means that managers are often doing more than one job, and managerial oversight of medical conditions is compromised. However, as the National Indian Health Board heard from Tribal leaders when visiting the Great Plains Area in April 2016, Tribal leaders and members acknowledge the staffing shortages and other issues, but consistently demand that focus remain on improving the quality of patient care, first and foremost. As one Tribal leader said during a town-hall style discussion with IHS leadership, "Without patients, there is no hospital."

So, in addition to the staffing and accountability provisions included in the newly proposed legislation we are discussing here today, attention must also be directed at improving the quality of care provided at federally run IHS facilities. This can be done by strengthening agency-wide standards for hiring quality

and qualified individuals who are capable of fulfilling the role as expected; for example, hiring a qualified Hospital Administrator to run a hospital or clinic and implementing quality and performance improvement measures from the top down. Quality would also be furthered through implementing and nurturing a culture and practice of Continuous Quality Improvement, management and supervisory training and setting performance benchmarks that are reviewed twice-yearly. If employees are not performing, generally accepted management practices and principals must be in place, respected and consistently upheld. Creating and sustaining a culture where quality and compassion are expected from all IHS employees is an absolute must.

The IHS currently has a hospital and health center accreditation policy requiring facilities to comply with at least one of any nationally accepted accrediting or certifying bodies, such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or by the Accreditation Association for Ambulatory Health Care (AAAHC). The responsibility for assuring compliance rests with both the Area and Service Unit Director, who through this IHS policy, are required to report to IHS Headquarters annually on the status of compliance with their accrediting body. As we have seen in the closures of services and service units in the Great Plains Service Area, this current model of reporting is inadequate for ensuring that accreditation, and therefore, full ability to bill to private insurance, Medicaid, and Medicare remains intact. Therefore, these reports must be made transparent and public, perhaps posted quarterly on a web-based dashboard so that both lawmakers, Tribal leaders, patients and IHS may view them and assess the status of whether the facility is meeting quality and accreditation measures.

Improving care delivery and reducing costs are critical in today's healthcare environment, especially in the underfunded Indian health system. There needs to be more accountability in the accrediting process and more measures put in place that will allow IHS facilities to more consistently assess and implement quality and performance improvements. There are resources both within the federal government and private sector that exist to assist in these processes. For example, the American Hospital Association's performance improvement entity, the *Hospitals in Pursuit of Excellence*, exists to accelerate performance improvement in hospitals around the nation, and has specific resources and support for rural hospitals and clinic – like so many in Indian Country are. The Health Resources and Services Administration (HRSA), another agency of the U.S. Department of Health and Human Services, is the primary federal agency for improving health and achieving health equity through access to quality services, a skilled health workforce and innovative programs. More intentional partnership and sharing of resources between HRSA and the IHS could aid in improving access to care for American Indian and Alaska Native patients and retaining skilled health professionals in Tribal communities. Overall, we know the hospitals and health systems that make quality and performance improvement a high priority will be rewarded with improved efficiency, better patient outcomes, and the ability to attract and retain the best people.

RECRUITING & RETENTION OF PERSONNEL

While we understand that it can be challenging to recruit medical professionals and health administrators to remote areas, it is critical that IHS, and other related agencies within HHS, employ all tools at their disposal to do so.

The proposed legislation at hand, provides for improved incentives to recruit and retain a quality health care workforce. It begins to address setting competitive pay scales for IHS employees that would be comparable to other physicians, dentists, nurses, and other health professionals, and the bill also attempts to address housing issues that Tribes and the agency have long said deters qualified medical professionals from moving into remote locations to work at IHS. However, while the bill seeks to provide housing vouchers and relocation assistance to new employees, it does not fully address the lack of housing available in these areas. It is often not just the cost of housing that deters employees, but the lack of nearby housing available. To rectify this, there will need to be further collaboration among the Tribes, government agencies such as HHS and the U.S. Department of Housing and Urban Development (HUD), and Congress to make investments in housing so that people working in IHS facilities have adequate housing. It is also critical to provide support for schools so that the families of medical providers will have access to adequate educational opportunities. Public/private partnerships should be sought as an innovative solution, rather than just assuming it cannot be done. Wouldn't it be something to imagine and possibly achieve, for example, a Walgreen's House of Health housing health care providers at the "Corner of Happy and Healthy" on the Pidge Ridge or Rosebud Indian Reservation?

Many policymakers do not realize that the system the United States employs to train medical residents, as well as dentists and some nurses, is through an entitlement program, Graduate Medical Education, within Medicare. The GME program exceeds $15 billion annually. Congress capped the number of residency training positions in the United States as part of the Omnibus Budget Reconciliation Act of 1997. Since 1997, several legislative amendments and changes have occurred to make slight increases and variances on the resident limit; however, the medical specialties remain highly motivated to increase the number of residency training positions within their various colleges and academies. One potential opportunity to increase the number of physicians serving in Indian Country is to set aside a certain number of *new* residency training positions for those willing to serve in Indian Country. The number of years of service in Indian Country following completion of residency training would be equal to the number of years the resident took to complete the residency. In states like Connecticut, where residency training positions are approximately $155.000 per resident per year, that is an astonishing incentive to complete service to Indian Country. Likewise, since most of the GME funding is in Indirect Medical Education expenses – paid directly to the training institution, perhaps a similar incentive could attach to the training institute if the resident does not fulfill the commitment. Further, there are very limited numbers of residency training programs in IHS facilities – and among the exceptions to the caps on new residency positions is if the new program were to be in a rural or medically underserved community or if a residency training program has never before existed in the training center. The Secretary of Health and Human Service has the authority to approve such growth: indeed, is this not the very definition of Indian Country?

We must also expand the ability of IHS to offer student loan repayment with already appropriated funds by passing S. 536 – The Indian Health Service Health Professions Tax Fairness Act. The S. 2953 bill does not address this issue, despite the Agency having asked for years to have similar authorizations as the National Health Service Corps in order to recruit qualified health professionals to work in Indian Country.

Likewise, one of the inherent flaws in the Indian Health system is the lack of qualified hospital administrators and lack of basic business acumen in the management, leadership and operation of health systems. We, therefore, also advocate for measures to recruit, retain and fund students to enter Masters

of Business Administration, Hospital Administration and related professions necessary to any chance of achieving and sustaining meaningful reforms in the IHS system.

But most importantly, we must make IHS a desirable place to work. Time and again, NIHB hears from physicians who leave IHS and cite the obstacles to working at these poorly-operated facilities. One of the most common reasons physicians leave is because they can't practice medicine with the resources available. Too many of them have had their hands tied by budget constraints and other bureaucratic obstacles. In addition to the compensation incentives outlined in the proposed legislation, the Administration needs to engage Tribes in the process of onboarding new physicians and health professionals, to create a more welcoming environment that makes both the new employees, and the Tribal members and patients feel safe and a part of the community.

Additionally, a long-term solution to addressing American Indian and Alaska Native health disparities lies in investing in our youth. We can improve the future of the Indian health care workforce by developing a culturally and linguistically competent workforce of Native health professionals and administrators. We know that AI/AN providers are more likely to remain in their own communities long-term and to provide culturally appropriate care. Therefore, Congress and the Service should prioritize resources and relationship building with academic institutions and national health professional organizations to engage Native youth in cultivating interest and capability in pursuing medical and health professions.

MEDICAL LITERACY FOR PATIENTS, PATIENT ADVOCACY

According to the National Assessment of Adult Literacy, only 12 percent of the U.S. population has a proficient health literacy level, and a total of 25 percent of American Indian and Alaska Native respondents scored at a "below basic" level. A white paper published by the IHS Health Literacy Workgroup in 2009 stated, "While low health literacy affects people from all facets of life, it is disproportionately burdensome on vulnerable populations, such as American Indian and Alaska Native people and their elders. Persons with limited health literacy skills make greater use of services designed to treat complications of disease and less use of services designed to prevent complications." The Agency for Health Care Research and Quality further reports that low health literacy is linked to higher risk of death and more emergency room visits and hospitalizations.

Given the disproportionate levels of low health literacy in AI/AN communities, and its direct impact on health outcomes and need for care, it is clear that more resources and training are needed within the Indian health system to improve patients' understanding of their own health and health care delivery. As well, those currently receiving their health care from IHS are the 3d Generation being cared for within this system. It is very important that such individuals have a scope of perception that includes what an average American expects from a medical encounter in mainstream America. Only then will patients within the IHS system have a clear understanding of their rights within the health system. And NIHB believes that Americans, including American Indian and Alaska Natives, have health care rights and among those rights is engaging in one's own personal health advocacy in a meaningful and informed manner. NIHB believes it is the right entity to engage in a national health literacy campaign with American Indians and Alaska Natives and requests support from Congress to undertake this crucial initiative.

Finally, we have heard numerous reports from patients who are afraid to report their negative patient encounters for fear of retaliation against themselves or their families. We believe it is vital to have a safe

method for patients to share their comments and experiences with the IHS system. Therefore, we believe a system that values feedback to improve the patient experience is a necessary component of quality. An anonymous, third party service that engages IHS patients about their care experiences would offer very valuable insights to inform the quality improvement process.

IN CONCLUSION

The National Indian Health Board stands with and supports the Tribes of the Great Plains IHS Service Area in this time of crisis. The NIHB will continue to work on behalf of all Tribes, in coordination with both the Administration and Congress, to rectify these longstanding, unacceptable conditions of health care delivery at IHS federally run hospitals and clinics. As evidenced by the stories I and others have and will share today, areas most in need of improvement include funding, staffing, culturally appropriate care, and most importantly, health outcomes.

We are pleased that the Senate Committee on Indian Affairs, and other legislators in both the House and Senate, have heard our stories and are now taking real, actionable steps to correct the issues within IHS that have been worsening over the past decade. In addition to Senator Barrasso and Senator Thune's *Indian Health Service Accountability Act of 2016*, several other bills to address accountability and transparency within the IHS have been introduced in the past several weeks. Most notably, the *Helping Ensure Accountability, Leadership, and Trust in Tribal Healthcare (HEALTTH) Act* (H.R. 5406) introduced on June 8, 2016 by Representative Kristi Noem (R-SD) that seeks to address many of the same issues as S. 2953 such as fiscal accountability, transparency of funding and compliance surveys, lack of quality of care, and mismanagement of resources.

The National Indian Health Board will be convening a special task force to further study the systemic challenges of the IHS, and make policy recommendations for long-term, sustainable reform of IHS. We are eager to work with this Committee and other policymakers to continue building on the legislation proposed and to meaningfully engage Tribal leaders, members and allies in these efforts to ensure truly holistic and appropriate reforms to the Indian health system.

Finally, because this legislation seeks to amend the Indian Health Care Improvement Act, the National Indian Health Board would like to take this opportunity to remind the Committee that the Indian Health Care Improvement Reauthorization and Extension Act (S. 1790, enacted in H.R. 3590) permanently reauthorized and made several amendments to the Indian Health Care Improvement Act (IHCIA). Numerous provisions of S. 1790 have not yet been fully implemented. Below is a summary of the progress in implementing these provisions. Without full funding and implementation the strides we have already made to achieve quality improvement remain unfulfilled.

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I. INDIAN HEALTH MANPOWER	**67% of provisions not yet fully implemented**	
Sec. 119. Community Health Aide Program	Authorizes the Secretary to establish a national Community Health Aide Program (CHAP).	Sufficient funds not yet appropriated.
Sec. 123. Health Professional Chronic Shortage Demonstration Project	Authorizes demonstration programs for Indian health programs to address chronic health professional shortages.	Sufficient funds not yet appropriated.
II. HEALTH SERVICES	**47% of provisions not yet fully implemented**	
Sec. 106. Continuing Education Allowances	Authorizes new education allowances and stipends for professional development.	Sufficient funds not yet appropriated.
Sec. 201. Indian Health Care Improvement Fund	Authorizes expenditure of funds to address health status and resource deficiencies, in consultation with tribes.	After consultation, IHS decided to make no change in use of funds at this time.
Sec. 204. Diabetes Prevention, Treatment, and Control	Authorizes dialysis programs.	Sufficient funds not yet appropriated.
Sec. 205. Other Authority for Provision of Services	Authorizes new programs including hospice care, long-term care, and home- and community-based care.	Sufficient funds not yet appropriated for long term care programs.
Sec. 209. Behavioral Health Training and Community Education Programs	Requires IHS and DOI to identify staff positions whose qualifications should include behavioral health training and to provide such training or funds to complete such training.	Identification of positions has occurred, but IHS and DOI have lacked funds to provide required training.
Sec. 217. American Indians into Psychology Program.	Increases institutions to be awarded grants.	Sufficient funding not yet appropriated for additional grants.
Sec. 218. Prevention, Control, and Elimination of Communicable and Infectious Diseases	Authorizes new grants and demonstration projects.	Sufficient funds not yet appropriated.
Sec. 223. Offices of Indian Men's Health and Indian Women's Health	Authorizes establishment of office on Indian men's health, maintains authorization of office on Indian women's health.	New offices have not yet been created due to lack of funds.
III. HEALTH FACILITIES	**43% of provisions not yet fully implemented**	
Sec. 307. Indian Health Care Delivery Demonstration Projects	Authorizes demonstration projects to test new models/means of health care delivery.	Sufficient funds not yet appropriated.

Sec. 312. Indian Country Modular Component Facilities Demonstration Program	Directs the Secretary to establish a demonstration program with no less than 3 grants for modular facilities.	IHS has not yet established the program due to lack of funds.
Sec. 313. Mobile Health Stations Demonstration Program	Directs the Secretary to establish a demonstration program with at least 3 mobile health station projects.	IHS has not yet established the program due to lack of funds.
IV. ACCESS TO HEALTH SERVICES	**11% of provisions not yet fully implemented**	
Sec. 404. Grants and Contracts to Facilitate Outreach, Enrollment, and Coverage Under Social Security Act and Other Programs	Directs IHS to make grants or enter contracts with tribes and tribal organizations to assist in enrolling Indians in Social Security Act and other health benefit programs	IHS has not yet established the grants due to lack of funds.
V. URBAN INDIANS	**67% of provisions not yet fully implemented**	
Sec. 509. Facilities Renovation	Authorizes funds for construction or expansion.	Sufficient funds not yet appropriated.
Sec. 515. Expand Program Authority for Urban Indian Organizations	Authorizes programs for urban Indian organizations regarding communicable disease and behavioral health.	Sufficient funds not yet appropriated.
Sec. 516. Community Health Representatives	Authorizes Community Health Representative program to train and employ Indians to provide services.	Sufficient funds not yet appropriated.
Sec. 517-18. Use of Federal Government Facilities and Sources of Supply; Health Information Technology	Authorizes access to federal property to meet needs of urban Indian organizations. Authorizes grants to develop, adopt, and implement health information technology.	Protocols developed, but property transfer costs require additional funding. Sufficient funds not yet appropriated.
VI. ORGANIZATIONAL IMPROVEMENTS	**0% of provisions not yet fully implemented**	
VII. BEHAVIORAL HEALTH	**57% of provisions not yet fully implemented**	
Sec. 702. Behavioral Health prevention and Treatment Services	Authorizes programs to create a comprehensive continuum of care.	Sufficient funds not yet appropriated.
Sec. 704. Comprehensive Behavioral Health Prevention and Treatment Program	Authorizes expanded behavioral health prevention and treatment programs, including detoxification, community-based rehabilitation, and other programs.	Sufficient funds not yet appropriated.

Sec. 705. Mental Health Technician Program	Directs IHS to establish a mental health technician program.	IHS has yet not established the program due to lack of funds.
Sec. 707. Indian Women Treatment Programs	Authorizes grants to develop and implement programs specifically addressing the cultural, historical, social, and childcare needs of Indian women.	Sufficient funds not yet appropriated.
Sec. 708. Indian Youth Program	Authorizes expansion of detoxification programs.	Sufficient funds not yet appropriated.
Sec. 709. Inpatient and Community Health Facilities Design, Construction, and Staffing	Authorizes construction and staffing for one inpatient mental health care facility per IHS Area.	Sufficient funds not yet appropriated.
Sec. 710. Training and Community Education	Directs Secretary, in cooperation with Interior, to develop and implement or assist tribes and tribal organizations in developing and implementing community education program for tribal leadership.	Comprehensive community education program has not been implemented due to lack of funds, although IHS and agencies do provide some trainings.
Sec. 711. Behavioral Health Program	Authorizes new competitive grant program for innovative community-based behavioral health programs.	Sufficient funds not yet appropriated.
Sec. 712. Fetal Alcohol Spectrum Disorders	Authorizes new comprehensive training for fetal alcohol spectrum disorders.	Sufficient funds not yet appropriated.
Sec. 713. Child Sexual Abuse and Prevention Treatment Programs	Authorized new regional demonstration projects and treatment programs.	Sufficient funds not yet appropriated.
Sec. 715. Behavioral Health Research	Authorizes grants to research Indian behavioral health issues, including causes of youth suicides	Sufficient funds not yet appropriated.
Sec. 723. Indian Youth Tele-Mental Health Demonstration Project	Authorizes new demonstration projects to develop tele-mental health approaches to youth suicide and other problems.	Sufficient funds not yet appropriated.
VIII. MISCELLANEOUS	**9% of provisions not yet fully implemented**	
Sec. 808A. North Dakota and South Dakota as Contract Health Service Delivery Areas	Provides that North Dakota and South Dakota shall be designated as a contract health service delivery area.	IHS has not yet implemented citing lack of funds.

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