

WINNEBAGO TRIBE OF NEBRASKA

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TESTIMONY REGARDING S. 1250, “RESTORING ACCOUNTABILITY IN THE INDIAN HEALTH SERVICE ACT OF 2017”

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GREAT PLAINS AREA REPRESENTATIVE, NATIONAL INDIAN HEALTH BOARD**

BEFORE THE UNITED STATES SENATE COMMITTEE ON INDIAN AFFAIRS

June 13, 2017

Good afternoon Mr. Chairman and Members of the Committee:

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

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

The Winnebago Tribe and national Tribal advocates support the efforts of Congress to address the ongoing challenges for health delivery at the IHS-operated facilities. We appreciate the commitment of the Senate Committee on Indian Affairs to find real change. Legislative efforts to address these issues should be conducted in tandem with increased oversight and scrutiny over the administration of the delivery of care at service units operated by the Indian Health Service. The legal current framework for IHS provides much of the necessary guidelines for the operation of the agency.

While we appreciate the speed at which the Senate is considering the legislation given the critical situation going on in the Great Plains region, we need to make sure we get this right. It is true, our people need help. Some of the quality of care issues found at my Tribe and elsewhere in the Great Plains region cannot go on any longer. However, it is also important that these changes are accompanied by input from tribes across the country to ensure the best possible outcome and product. We think legislation is needed and would have appreciated an opportunity for the Winnebago Tribe and other tribes across the county to review any draft legislative language before S. 1250 was introduced. NIHB is ready and willing to lead a legislative consultation on this bill and we intend to do so in throughout the coming weeks and months. This step must happen first before anything can be enacted.

Winnebago IHS Hospital

For those of you that may not know, the Winnebago Tribe is located in rural northeast Nebraska. The Tribe is served by a thirteen (13) bed Indian Health Service operated hospital, clinic and emergency room located on our Reservation. This hospital provides services to members of the Winnebago, Omaha, Ponca and Santee Sioux Tribes. It also provides services to a number of people from other tribes who reside in the area. Collectively, the hospital has a service population of approximately 10,000 people.

As I have shared in previous testimony before this Committee, since at least 2007 the Winnebago IHS Hospital has been operating with demonstrated deficiencies which should not exist at any hospital in the United States. The Centers for Medicare and Medicaid Services (CMS) deficiencies were so numerous and so life-threatening that in July 2015 the IHS Hospital in Winnebago became what still is, to the best of our knowledge, the only federally operated hospital ever to lose its CMS certification. Other IHS facilities in the Great Plains Region have been experiencing similar quality of care issues throughout this time and are also under threat of decertification by CMS.

Nearly two years have passed since the Winnebago Hospital lost its certification and IHS has yet to submit the application to CMS for recertification. Initially, the target date to apply for recertification was scheduled for October 2015. Since then, the date for submitting the application has been repeatedly delayed. It is an extremely frustrating situation and it is unacceptable that such a bad situation should take so long to correct. While the staff at the facility have been working hard to prepare for recertification and corrective action plans have been implemented, including multiple mock surveys, staff training and necessary policy changes, the fact remains that the facility continues to lack critical resources necessary to move forward.

Senior officials at IHS have said that recertification at Winnebago is a top priority, but for some reason the practical resources to achieve this have not reached the ground level. The inability to generate necessary revenue from all third party sources has caused serious budget issues. The financial constraints in addition to staffing challenges have kept the facility in a dire situation. The Hospital Governing Body finally decided last month that the Hospital was ready for

recertification. However, the application has not been submitted due to key staff vacancies including the CEO, Director of Nursing and Lab Supervisor. The fact that these vital positions are vacant is a huge indicator that the hospital is not adequately staffed to be ready for CMS review.

Many of the situations that led to the Hospital losing its certification in the first place have also played a role in the delay to submit the application for recertification. For example, the Great Plains Region has operated under an Acting Regional Director for nearly one and a half years. At Winnebago, the hospital also operated with a series of Acting CEO's until a permanent hire was made approximately 6 months ago. Both the Omaha and Winnebago Tribes have been very pleased with the progress he has made at the facility. Unfortunately, due to personal reasons, he is now resigning as the CEO and the position will be vacant once again later this month.

These important leadership roles need to be filled by permanent, qualified and dedicated employees who have a vested interest making improvements. There have been instances where the IHS has continued to hire key personnel without any input from the Tribe and/or "recycled" employees who were found to be unacceptable at other IHS hospitals in the Great Plains Region. A multi-million dollar staffing contract was awarded to a company previously used by IHS that had placed unsatisfactory employees in many of the Great Plains IHS hospitals. Finally, the federal hiring freeze implemented earlier this year caused great delays in filling critical positions. While waivers were eventually obtained for many positions, it is our understanding that some positions necessary for CMS certification remain under a freeze status. The hiring freeze is detrimental to the needs of our tribal members and others who rely on IHS for their healthcare.

Many missteps could have been avoided by getting input from the Tribes and actually acting on that input. The Governing Body for the Winnebago Hospital was basically non-functional around the time of the loss of the CMS Certification. Although the Governing Body appears to be meeting more often, the tribal representatives have since lost their seats on the Governing Body since IHS deemed that the non-IHS members (Tribal Council representatives from the Winnebago Tribe and the Omaha Tribe) have no oversight over IHS and therefore should not be on the Board. This is ridiculous and counter-intuitive. Perhaps Tribal Council members have no "authority" over IHS, but they know their own communities and are more likely to have an interest in holding management accountable if their actions are not conducive to patient care or a well operated medical facility. We have already learned that IHS officials in the Great Plains region were not using their authority to police each other, which was another reason that led to the decertification in the first place.

Although some IHS regions around the country seem to function better than others, the Great Plains Region has been problematic for years, despite several reports conducted by Congress and U.S. Government agencies. Many provisions contained within this proposed legislation are designed to correct some of the issues that plague the Winnebago Hospital and other IHS Hospitals within the region. I will now provide more specific comments on S. 1250 and how certain provisions will help the situation in Winnebago or how it might be amended to meet our specific needs.

Comments on S. 1250

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

The Winnebago Tribe is working its way toward self-governance, a status many other tribes throughout the country already have. In fact, about 60 percent of the IHS budget is delivered directly to the tribes through contracts and compacts. The proposed legislation does not do an adequate job of stating which provisions of the legislation pertain to self-governance tribes and which do not. The legislation provides a “Savings Clause” that appears to ensure that the legislation does not interfere with tribal contracting or compacting. Yet the provision at 607(e) of the proposed legislation is not clear on what provision or provisions that Savings Clause language pertains. Since we hope to be a self-governance tribe in the reasonably near future we would certainly appreciate some clarity regarding the application of this provision. The Winnebago Tribe and NIHB are happy to work with you on the drafting of that provision.

The Winnebago Tribe and NIHB support the intent to make a streamlined system for licensed health care professional credentialing procedures, including volunteers, as outlined in Section 102. However, we note that these provisions should not be considered a substitute or final step for increasing available providers to the IHS and tribes throughout the country. For example, NIHB and the tribes fully support the expansion of the dental therapy model, which was first brought to the United States by tribes in Alaska in 2004. It is a highly effective way to provide reliable, safe, and quality dental care providers to underserved areas. We urge the Committee to consider models such as these to address the chronic staffing shortages in the Indian health system.

Section 105 addresses Improvement in Hiring Practices. While we certainly agree that hiring practices need drastic improvement we are not completely comfortable with the language in the proposed legislation. First, this provision indicates that the Secretary has direct hire authority, which in and of itself is not a bad idea. However, the Winnebago Tribe and NIHB want to make sure that Tribal Preference is not ignored in the direct hire authority. This provision of the proposed legislation goes on to note that the Secretary shall notify each tribe in the service area prior to the direct hire taking place. While notice is appreciated, it would be useful if tribes could file objections to any hire, especially if the new hire is somebody who has been recycled through the system previously and has not performed well with other tribes in the Region, which has been

a common practice at IHS. Lastly, this provision provides that the Secretary may seek waivers to Indian preference from each Indian tribe concerned if certain criteria are met. We understand that when there are no qualified “Indian” candidates or the Indian candidates have not performed well in the past, it may be appropriate to hire a non-Indian candidate. However, Tribes are concerned about diminishing Indian preference in the hiring process. This path should only be used in the most extreme circumstances and should be initiated by the Tribe(s) served by the facility in question.

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

The Winnebago Tribe finds Section 108 regarding training programs in tribal culture and history to be of utmost importance. Meaningful cultural training can do nothing but help IHS employees as they learn the history and culture of the people they are serving on a daily basis. We think this training should be mandatory and it should include all IHS employees from headquarters to all staff at the service unit facilities, who have daily interaction with Native American people. It would be even more useful if the training involved and was tailored specifically for the tribes in the service area.

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

Fiscal accountability is never a bad thing as laid out in Section 202, but the provision in subsection (b) that addresses the prioritization of patient care is somewhat troubling in its specificity. This section explains that IHS should only use certain dollars for patient care directly and limits their use to essential medical equipment; purchased/ referred care; and staffing. While

we certainly appreciate the need for more scrutiny, we worry that the criteria may end up being too constraining on the programs. IHS should consult with the Tribes in their service area before they make decisions on what can be done with the funds pertaining to this section. With consultation, the money can go to the most needed programs in a particular service areas.

Most of Title III of the proposed legislation deals with a variety of reports. The one report that drew our attention was the Inspector General reports on patient care in Section 304. We definitely agree that reports on the quality of care and patient harm at IHS are necessary. However, we want to draw attention to the fact that many tribal members end up receiving their care outside of the IHS system through the purchased and referred care program. For example, in South Dakota, approximately 70% of care referred outside of IHS facilities. It would be useful to also have information on quality of care once a patient has left the IHS facility and is care for in an outside facility. We suggest that another subsection be added to Section 304 in order to address this issue.

Overall, we think this proposed legislation is necessary and once again thank the Committee for its genuine interest in trying to alleviate problems within IHS. It is clear that management, recruitment, accountability and transparency are all still issues that need to be addressed, most of which are covered in the proposed legislation. Nearly two years has passed since the CMS certification was terminated at the Winnebago Hospital and our CEO, Director of Nursing and Lab Director positions are once again vacant. As we have stated at prior hearings, real change and the rebuilding of the hospital cannot happen without permanent qualified personnel and the funding necessary to carry out the mission.

Mr. Chairman, the Winnebago Tribe supports the passage of this legislation once the issues listed above are addressed and after thorough comment and review by Indian Country. As I stated last year at a hearing and this bears repeating, while everything in this bill is needed, legislation alone will not solve our problem. Proper training of hospital staff costs money, new equipment costs money, and recruitment under these circumstances is also going to cost money. We would consider the passage of this legislation an initial solid first step and implore you not to abandon us after this bill is passed. Correcting this situation is going to require a continuous team effort, additional resources, and consistent Congressional oversight of IHS activity.

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