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Portland Area Indian Health Service

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FY 2017 Budget Formulation Submission

*Budget and Narrative
DoubleTree-Hilton Hotel Seattle Airport
December 1-2, 2014*

Portland Area Budget Formulation Representatives

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Federal Responsibility to Provide Health Care for AI/AN

Northwest Tribal leaders believe it is important that the Indian Health Service (IHS) recognize that Portland Area Tribes are among those who signed treaties or entered into Executive Orders with the government of the United States of America that established the Federal responsibility to provide health care for Indian people. The Federal government has a unique ongoing moral and legal obligation to provide health care to Indian people—an obligation paid for with millions of acres of land and trillions of dollars in resources. This obligation has been affirmed many times through treaties, executive orders, legislation, and policy supported by Presidential administrations and Congresses of both parties.

Portland Area Tribal leaders and health directors also want to go on record in the wake of current deficit reductions efforts to state that IHS appropriations are not “discretionary” by their mere classification in the appropriations process. IHS funding is provided in fulfillment of the United States federal trust responsibility based on treaty obligations that the United States Congress entered into with Indian Tribes. This makes it appropriate to exempt IHS and BIA programs from sequestration.

The Administration and Congress should also exempt IHS funds under the Indian Health Care Improvement Act’s, Declaration of National Indian Health Policy, in which the Congress declares it the policy of the United States—in fulfillment of its special trust responsibilities and legal obligations to Indians—to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy.

Preliminary Process

On December 1-2, 2014, Portland Area Tribal leaders, health directors, representatives from the Northwest Portland Area Indian Health Board (NPAIHB) along with leadership of the Portland Area Office (IHS-PAO) met to discuss their recommendations for the FY 2017 Indian Health Services (IHS) budget. The meeting was held at the Doubletree-Hilton Hotel at the Seattle Airport.

The Portland Area budget formulation process followed required instructions issued by IHS headquarters. The session began with an orientation on the federal, HHS and IHS budget formulation process. A review of the instructions for the FY 2017 Budget Formulation process included a discussion on the recommended budget marks; Indian Health Care Improvement Act (IHCA) priorities; sequestration; Contract Support Costs (CSC); distributions for the Methamphetamine and Suicide Initiative (MSPI) and the Domestic Violence Prevention Initiative (DVPI); the Special Diabetes Program for Indians, and; identifying hot topics. The meeting agenda for our budget formulation session is included as an attachment to this report.

Portland Area Tribes also included a review of past year’s health priorities recognizing that setting health priorities are an important step in establishing budget priorities. Otherwise recommending budget marks without first identifying health priorities may result in allocating resources that may not respond to health care needs. Thus, Portland Area Tribes continue to restate their top ten health priorities consistent with past years’ budget

formulation meetings in order to address health disparities. The FY 2017 Portland Area health priorities are as follows:

1. Cancer
2. Behavioral Health (mental health, alcohol & substance abuse, suicide, and domestic violence)
3. Diabetes
4. Cardiovascular and Heart Disease, Stroke
5. Health Promotion/Disease Prevention Dental (Childhood obesity)
6. Elder Health – Long Term Care
7. Dental – child oral health
8. Injury Prevention
9. Maternal Child Health
10. Respiratory/Pulmonary

The Role of Budget Formulation

Budget Formulation is a Tribal consultation process designed to develop recommendations for the development and submission of the IHS budget. Past year's budget formulation meetings have not been well attended. This is attributed to the fact that the IHS budget has not received adequate budget increases during the years of the previous Administration. However this year's budget formulation process continues a trend of Tribal leaders and health directors to become reengaged in the budget formulation process.

The significant budget increases for the IHS during this Administration have reinvigorated interest in the IHS budget formulation process. This along with the budget austerity of the Congress to reduce the federal deficit and maintain the government debt ceiling has Tribes cautious to pay more attention to the IHS and federal budgets. Compound this with the challenge to balance IHS program increases with the new requirements to fully fund Contract Support Costs and avoiding funding one at the expense of the other.

These dynamics have Tribal leadership and health directors keeping a careful eye on the IHS budget process. Tribal leaders, Indian health programs, and ultimately Indian people lost \$228 million because of budget sequestration and do not want this to happen again.

The IHS budget formulation is very important consultative process for Tribal leaders and health directors to advocate for their health and funding priorities. It is a unique process among federal governmental entities to consult with Tribal governments. Tribal leaders support the process and acknowledge the IHS for conducting this very important process.

Summary of FY 2017 Budget Recommendations

The Portland Area Tribes submitted two recommended budget marks for FY 2017 at the 17% (\$787.8 million); and at the 5% (\$231.7 million) levels.

Portland Area Tribes did not recommend funding for Contract Support Costs (CSC) since the Agency is not obligated to fully fund these costs and this amount of funding should be reflected base budget line item for CSC. To provide a funding recommendation for CSC would erode the available funding for program increases. This should not be construed to mean that Portland Area Tribes do not support CSC funding. In fact, it is the opposite, and the IHS and United States has a legal obligation to fully fund self-determination contracts and compacts as a binding obligation.

The Portland Area Tribes recommended reductions to the Health Facilities Construction account and Staffing for New Facilities. The Health Facilities Construction funding does not equitably benefit tribes nationally and has an adverse impact on available funding for inflation, pay costs, and population growth. The effect of taking dollars off the top of the overall budget increase to fund staffing packages at new facilities for 1-5 Tribes is simply not fair to 500 or more Tribes that do not have an opportunity to compete for facilities construction funds. Portland Area Tribes' position on this issue is that the Administration has a legal and moral obligation to fund health services for all AI/AN people, and to recommend funds that benefit a select group is contrary to this legal and moral obligation.

Portland Area Tribes did not agree to submit budget recommendations to decrease the budget by 5% or to comply with sequestration instructions.

Top Five Budget Increases :

Portland Tribes continue to underscore the fact that IHS funded programs have had to absorb significant inflationary cost increases over the past twenty years. The IHS and tribal programs cannot continue to absorb the real resource loss associated with inadequate funding for inflation, pay act increases, contract support costs, and population growth. These mandatory costs must be the first consideration in the budget formulation process. To turn a blind eye to these mandatory requirements is indefensible since they are financed by cutting health services. This only serves to erode the base budget for the entire Agency and Tribes across the Country.

1. Fully Fund Pay Costs, Inflation and Population Growth

Portland Area Tribes support fully funding Federal and Tribal pay costs, Inflation, and Population Growth since funding would be adequate at the 5% and 17% levels. The fundamental budget principle for Portland Area Tribes is that these mandatory fixed costs must be funded in order to maintain the current levels of care—and employee satisfaction. Otherwise the Agency reduces services and stands to lose its workforce by not investing in them to a booming and vibrant private health care sector. Portland Tribes recommend \$154.4 million for current services as follows:

summary of Portland Area Budget Recommendations		
	17%	5%
Federal & Tribal Pay Cost Increases	\$18.2 million	\$18.2 million
Non-Medical Inflation	\$ 8.50 million	\$8.5 million
Medical Inflation	\$63.3 million	\$63.3 million
Population Growth	\$67.5 million	\$67.5 million
Program Increases	\$630.3 million	\$74.3 million
Contract Support Costs	* Fully Fund	* Fully Fund
Total Current Service & CSC Amounts	\$787.8 million	\$231.7 million

Binding Obligations:

The IHS electronic worksheet for budget formulation suggests funding increases of \$75 million for staffing, \$100 million for Health Facilities Construction and \$150 million for contract support costs. Portland Area Tribes do not support funding for facilities construction and related staffing because of the inequities of the facilities construction priority system that disadvantages tribes in the overall IHS resource allocation process. Because of this the Portland Area reduced the required facilities funding required for Binding Obligations and redirected this funding to cover program increases which is fair for all tribes nationally.

Portland Area Tribes support strongly Contract Support Costs (CSC) which is required for tribes to successfully manage their programs. Because the Supreme Court has ruled, and Congress has directed the IHS to fully fund CSC, Portland Area Tribes position is that CSC is now a function of current services and should not be categorized under Binding Obligations. As a consequence, the Portland Area did not recommend funding under this category recognizing the fact that the Agency is obligated to pay in full the amounts required under self-determination contracts and compacts and this amount should be reflected in the CSC base budget line item. If a funding recommendation is made under the Binding Obligation section of the worksheet, then it erodes the available resources that can be made available for program increases. Because CSC is now mandatory it should not compete with program increases and the electronic worksheet should be updated to address this fact.

Most importantly, because Portland Area Tribes did not provide funding for CSC increases, this should not be construed to mean that they do not support CSC funding. In fact, it is the opposite, and Portland Tribes position affirmatively is that the IHS and United States has a

legal obligation to fully fund self-determination contracts and compacts as a binding obligation and needs to pay them.

2. Increase Purchased & Referred Care Funding - \$391.4 million*

At the 5% level, Portland Area Tribes recommend a program increase for the Purchased and Referred Care (PRC) program of 74.3 million.

At the 17% level, Portland Area Tribes recommend a program increase for the PRC program of \$391 million. The PRC program is extremely important for Northwest Tribes since the Portland Area does not have any hospitals and must rely on the PRC program for all specialty and inpatient care. Other parts of the IHS system have access to hospitals for specialty and inpatient care. The PRC program makes up 35% of the Portland Area budget and when less than adequate inflation and population growth increases are provided, Portland Area tribes are forced to cut health services to absorb these mandatory costs. To address this funding disparity and to address the denied and deferred services at the national level, Portland Tribes recommend this additional \$391 million for the PRC program.

3. Fund ACA and IHClA Amendments (New Authorities) - \$187.3 million*

The Affordable Care Act included amendments to and a permanent reauthorization of the Indian Health Care Improvement Act (IHClA). Both the ACA and IHClA include many new authorities that are beneficial for IHS, Tribal, and urban Indian health programs. The IHClA includes authorities to carry out hospice care, long-term care, assisted living, and home and community based services in Tribal communities. The IHClA also provides authority to develop a grant program for technologically innovative approaches to assess/prevent/treat youth suicide.

At the 17% recommended increase level, Portland Area Tribes recommend \$115 million to further implement the ACA and carry out new IHClA authorities. For this purpose, this recommendation is broken down as follows: \$50 million for the H&C and \$50 million for the PRC line items to assist Tribes to purchase health premiums for their tribal members. The Portland Area Tribes also recommend the IHS to pursue legislation that gives the IHS authority to purchase health insurance premiums for Tribal members when beneficial to the program. \$15 million to be provided to the Urban Indian Health Program line item to allow them to also purchase insurance premiums for their users.

The IHClA Section 124 provides authority for IHS to carry out hospice care, long-term care, assisted living, and home and community based services in Tribal communities. The program and staffing needs of carrying this provision out are discussed above. However there is a need for facilities and to support infrastructure to support the program. For this purpose, the Portland Area recommends an additional \$30 million for infrastructure to support long-term care services and program needs.

At the 17% level, the Portland Area recommends \$17.3 million to develop long term care programs. This funding should be directed to develop staffing programs to carry out home and community based services that are reimbursable under Medicaid and through qualified health plans on the Insurance Marketplaces. This will allow these programs to become self-

sustaining and help to address the aging bubble that is cropping up on Indian health programs.

4. Restore Pay Act Increases - \$48.1 million

At the 17% mark, Portland Tribes recommend that an additional \$3.6 million to restore past year's pay costs that were not funded due to the federal moratorium on pay act increases. It was not fair for federal and tribal programs to not receive these increases while other members of federal personnel received such increases. Federal and tribal programs have a serious challenge to recruit and retain employees. This in part due to isolation and working conditions, which are attributed to IHS only being funded at 60% of its level of need. Often programs are under staffed and do not have state of the art medical equipment. This affects the employee morale and the ability to recruit and retain personnel. The IHS and tribes must continue to reward their employees in order to retain them otherwise the system will be in a mode to continually recruit and replace personnel that leave the system. For these reasons, Portland Area tribes recommend additional funding for federal and tribal employees.

5. Facilities - \$90 million

Portland Area tribes discussed at length the neglected need of existing facilities infrastructure. Portland Tribes acknowledged that past year's budgets have not included increases necessary to address the ongoing backlog of facilities infrastructure. For example, the Maintenance & Improvement (M&I) line item has not been increased in over seven years. While the M&I program received a \$100 million under the American Recovery and Reinvestment Act (ARRA), there was a backlog of over \$380 million of maintenance and improvement projects. The M&I line item also had its base budget eroded due to the sequestration in FY 2013. The Sanitation & Facilities program saw a serious reduction of \$16 million in FY 2012 and has never received an increase to restore the lost funding or an increase to address the growing backlog of projects. The Equipment line item has also been marginally funded over the last ten years. Because of these issues, the Portland Area recommends increases as follows: \$30 million for the M&I account; \$50 million for the Sanitation and Facilities program, and; \$10 million for Equipment.

Budget Reductions:

1. As discussed under Binding Obligations, the Portland Area budget recommendations include reducing completely funding for facilities staffing and construction. Portland Tribes are on record about the inequities of the current IHS facilities construction system. The staffing requirements for newly constructed health facilities have always been a concern for tribes in the Portland Area and other IHS Areas that are dependent on PRC funding to provide health care. The inequity of the facilities construction funding is that it provides a disproportionate share of funding to a few select communities. The significance of facilities funding, both for construction and staffing new facilities, is that it removes funds necessary to maintain current services (pay costs, inflation, and population growth) from the IHS budget increase. Unless current services can be maintained no funding for phasing in staff at new facilities should be provided.

2. Portland Area Tribes did not agree to submit additional budget reductions at the minus five percent level (-5%). Rather than making recommendations to cut budget line items, Portland Tribes recommend that the IHS Director find efficiencies to achieve cost savings in the IHS system by consolidating functions and realigning the Area Office system. This recommendation is consistent with the past House Interior Subcommittee recommendation contained House Report 112-151 concerning the FY 2012 IHS appropriation. The House Interior Subcommittee instructs the following:

“...the Committee directs... [Indian Health Service]... to provide with their annual budget submissions a list of field offices and their estimated FTE and budgets for the prior, current, and upcoming fiscal years. In an effort to achieve greater efficiencies and maintain funding for core programs, the Committee also directs the...[Indian Health Service] to submit not later than 120 days after enactment of this Act, a joint proposal to consolidate field offices or close offices with minimal staffing.”

The request by the House Interior Subcommittee acknowledges these tough budget times and anticipates that further budget reductions will need to be made. Rather than cutting the health services budget it would be more prudent to address such reductions through administrative efficiencies.

Additional Recommendations

- **IHCIA Priorities**

The Portland Area Tribe’s position is that the IHS has authority to implement many of the new authorities under the recent reauthorized IHCIA and that new appropriations are not necessary. Many of these new provisions are being implemented under Self-Determination contracts or Self-Governance compacts. These same authorities could be implemented on behalf of IHS direct service programs by reallocating resources and/or staff within federally operated service units. If Direct Service Tribes request new or expanded services authorized under the IHCIA, then the IHS should conduct Tribal Consultation with those Tribes to determine the health service priorities for that Tribal community and reallocate resources and staff as they recommend. IHS is the steward of those health care resources and the health service priorities should be determined by Direct Service Tribes. Portland Area Tribes recognize that the bureaucratic entrenchment of federal personnel may be reluctant to undertake such deliberations. Thus, Portland Area Tribes recommend that the IHS Director or Portland Area Director implement a formal initiative to address this on behalf of Direct Service Tribes.

- **Contract Support Costs in light of Ramah Decision**

Portland Tribes underscore that IHS has a legal and moral obligation to provide full CSC funding as discussed in other areas of this report (see above). Portland Area Tribes do not believe that this issue should be part of the Budget Formulation Process. Rather, the IHS-CSC Workgroup should provide recommendations to the IHS Director. The budget and policy issues related dealing with CSC issues is very specialized and requires subject matter expertise of the CSC Workgroup to address.

- **Special Diabetes Program for Indians**

Portland Area Tribes support continued funding of the SDPI and recognize that the funding or formula recommendations were developed during Tribal Consultation in cooperation with the Tribal Leaders Diabetes Committee (TLDC). Thus, obtaining funding or formula recommendations through the budget formulation process may be inconsistent with the recommendations obtained via the TLDC. IHS should use one or the other and not both processes to obtain recommendations. Portland Area Tribes are on record and stand by their recommendations submitted in past Tribal consultation letters submitted to the IHS Director.

Portland Area Health Priorities

1. **Cancer**

As life expectancy increases among AI/ANs, cancers of all types are becoming more prevalent. Cancer is now the second leading cause of death among AI/ANs in nearly all areas. Despite lower rates of cancers among AI/ANs than other races in most areas, AI/ANs have higher mortality rates than the general population from specific cancers and have more devastating outcomes after diagnosis. One factor contributing to this is the limited access to cancer screening. At least four cancers (cervical, breast, prostate and colorectal, accounting for about 50% of all cancers) have widely accepted standards of care for screening and early diagnosis that are an integral part of primary care services. However, limitation in access to these preventive services (such as mammograms and pap smears) is a major impediment to cancer prevention in Indian Country. The other major contributor to this increased mortality among AI/ANs is the lack of adequate resources to coordinate care and provide the sophisticated and specialized cancer treatment that is available to higher income populations. Unless budget attention is given to cancer prevention and cancer care, the occurrence of cancers and the rate of cancer patients who die will continue to increase among the AI/AN population.

2. **Behavioral Health (Mental Health, Alcohol/Substance Abuse, Suicide, Domestic Violence and Sexual Assault)**

This category summarizes the need for additional funds to support many programs that share the common goals of: healthy lifestyles and quality of life. This request identifies the need to improve programs' ability to reduce health-related complications, prevent the onset of unhealthy lifestyles, and educate our communities to deal with behavioral health issues. There is a need to enable the I/T/U programs to expand access to multiple programs for services and implement a comprehensive, coordinated network of care. Tribes are active in this area, but with the small funding increases, measurable improvements are predicted to occur slowly.

More needs to be done to address the circle of violence, depression, intergenerational violence, and sexual/domestic abuse in tribal communities. The cost for treatment of

alcohol and substance abuse is increasing at a rate that exceeds the availability of funds. Local tribal treatment centers and alcohol and substance abuse programs are forced to adjust priorities as a result. AI/AN communities are not receiving the latest information about “best practices” in the alcohol and substance abuse field. Without a system to share information from community to community, the development of effective models is more difficult. Tribes are active in this effort, but miniscule funding increases have made improvements difficult. Tribes want to address all forms of addictive behavior including gambling.

The use of methamphetamine is on the rise throughout Indian Country and is causing tremendous cost to the Indian health care system. Studies show that to be effective, Tribes need to pay for 180-day inpatient treatment, as well as follow up care. Currently, there are no programs in the Northwest to provide this type of adult treatment. Tribes have identified substance abuse funding as a high priority, yet the Board has not achieved the success it would like in obtaining funds for substance abuse treatment and mental health programs. Dual diagnosis patients needing a combination of mental health and alcohol treatment services would benefit from a larger appropriation for these services. Mental health programs are the best hope to reduce the epidemic of suicides in Indian country. The need for increased funding for follow up care is critical. Inter-agency transfers should be coordinated between the IHS and other HHS agencies that have responsibility for addressing alcohol and substance abuse issues.

Domestic Violence and Sexual Assault (DV/SA) against native women are the most pervasive human rights abuses and also the most hidden. AI/AN children have the second highest rate of maltreatment and 1 in 3 AI/AN women will be physically/sexually assaulted in their lifetime. DV/SA survivors often experience higher rates of PTSD, depression and physical symptoms that persist many years after the abuse had stopped, according to a new study. Compared with never abused women, women with a history of sexual intimate partner violence (IPV) had the worst overall health.

According to the US Department of Justice, AI/AN women are 2.5 times more likely to be raped or sexually assaulted than women in the USA in general; 34.1 percent of AI/AN women – or more than one in three – will be raped during their lifetime; it is widely accepted that these statistics do not accurately portray the extent of the sexual violence against AI/AN women. A survey of IHS facilities found that 44 percent lacked personnel trained to provide emergency services in the event of sexual assault forensic examination. In 2012, forensic equipment for sexual assault examinations was purchased for all IHS and Tribal hospitals, thus excluding IHS and Tribal clinic facilities from having the appropriate equipment for examinations. Sexual assault nurse examiners (SANEs) – registered nurses or health practitioners with advanced education and clinical preparation in forensic examinations of victims of sexual violence – are a new nursing specialty; yet given the statistics of sexual violence in Indian Country, the IHS has not prioritized SANE programs throughout its facilities. The online IHS Manual states that it is IHS policy to perform “only medically related care and treatment” in cases of rape. This raises concerns that survivors of sexual violence will not have access to a full sexual assault forensic examination if evidence collected is not deemed “medically related.”

Past trends for DV measures show stagnant rates through FY 2005 and then a significant increase in FY 2006 of 28 percent. In FY2007, the proportion of women who are screened for DV at healthcare facilities was 36 percent. The FY 2009 target was to maintain the FY 2008 result of 42%. Some reasons for the improved screening was increasing provider awareness, improved documentation, and improved efforts to better match targets with program performance.

Suicide is a sensitive issue, but one that is of great concern to many AI/AN communities. Data suggest that suicide is a significant problem throughout Indian Country, particularly among Native youth, males, veterans, and elders. From 2000-2005, the average suicide death rate was highest among AI/AN youth aged 15-24 (at 18.7 cases per 100,000, compared to 10.7 per 100,000 for White youth and 7.1 for Black youth). Nationwide in 2005, suicide was the second leading cause of death for AI/AN youth in that age range. The Portland Area has one of the higher suicide death rates for AI/AN among the IHS service areas. The IHS reported that, from 1996-1998, the age-adjusted suicide death rate for the Portland Area was 22.0 per 100,000, a rate that was exceeded only by Aberdeen, Alaska, Bemidji, and Tucson. The IHS must receive additional funding in order to reduce suicide rates among AI/AN and to increase tribal capacity to prevent suicide throughout Indian Country.

3. Diabetes

By now it is well known that diabetes is exploding in Indian Country. Depending on the region, American Indian/Alaska Natives (AI/ANs) are two to four times as likely, compared to all other races to have diabetes. There are many factors that contribute to the diabetes crisis; change in dietary choices and an increase in sedentary lifestyle are key factors that are driving obesity to record levels. The consequences of uncontrolled diabetes primarily effects chronic blood vessel damage, which can lead to heart attacks, strokes, kidney failure, blindness, and amputations. Although, heart disease was relatively uncommon in AI/AN populations, it is now the leading cause of death among AI/ANs. The sharp rise in diabetes prevalence unquestionably plays an important role in the increasing importance of heart and other cardiovascular diseases in Indian Country, both through blood vessel damage and through the close relationship of diabetes and obesity, high blood pressure and poorly controlled blood cholesterol levels. From a physiologic point of view, all of these problems cannot be reasonably separated and should be viewed as one reinforcing each other. AI/ANs are also becoming diabetic at a much younger age, making it more difficult to break the cycle of diabetes, obesity and cardiovascular disease. Budget priorities include funding for screening of younger populations for “pre-diabetes”, targeted interventions to reduce diabetes in all ages, as well as screening and aggressively treating high blood sugar, risk factors for cardiovascular complications of diabetes (like high blood pressure and poorly controlled cholesterol) and cardiovascular complications once they are identified.

4. Cardiovascular, Heart Disease, Stroke ¹

¹ Discussion on this item included with Priority No. 2: Cardiovascular Disease since the issues associated with these two health priorities are often related.

The prevalence of risk factors for cardiovascular disease (CVD) (i.e., hypertension, current cigarette smoking, high cholesterol, obesity, and diabetes) among AI/AN is significant, with 63.7% of AI/AN men and 61.4% of AI/AN women having one or more CVD risk factors. For example, the consequences of uncontrolled diabetes primarily affects chronic blood vessel damage, which can lead to heart attacks, strokes, kidney failure, blindness, and amputations. Although, heart disease was relatively uncommon in AI/AN populations, it is now the leading cause of death among AI/ANs. The sharp rise in diabetes prevalence unquestionably plays an important role in the increasing importance of heart and other cardiovascular diseases in Indian Country, both through blood vessel damage and through the close relationship of diabetes and obesity, high blood pressure and poorly controlled blood cholesterol levels. From a physiologic point of view, all of these problems cannot be reasonably separated and should be viewed as one reinforcing each other.

5. Health Promotion/Disease Prevention (Childhood obesity)

The main health challenges currently faced by American Indian and Alaska Native people are the increasing health conditions and chronic diseases that are related to lifestyles choices resulting in obesity, physical inactivity, poor diet, substance abuse, and injuries. Health promotion disease prevention (HP/DP) efforts can effectively reduce these health conditions. IHS recognizes the value of prevention and has named HP/DP as an agency priority for several years. National health reform efforts also recognize the financial benefits and improved quality of life by supporting prevention programs.

The goal of HP/DP Initiatives is to create healthier American Indian and Alaska Native communities by developing, coordinating, and implementing, effective health promotion and chronic disease prevention programs through collaboration with key stakeholders and by building on individual, family, and community strengths and assets. Improvements to the RPMS system have now allowed interventions to be tracked and measured, allowing for evaluation of effectiveness.

HP/DP efforts could help to eliminate our top six Portland Area Health Priorities; following is a partial list. Asthma is a chronic lung disease that affects 14-15 million people in the United States, with almost half a million asthmatics hospitalizations annually, and 5,000 die each year of the disease. Nutrition plays an integral part in many of our most prevalent diseases, including diabetes mellitus, heart disease, stroke, obesity, hyperlipidemia, hypertension, certain cancers (breast and colon, e.g.), and osteoporosis. Two in five AI/AN children are overweight and one solution is to support tribal communities in developing long-range, culturally competent, multidisciplinary, effective overweight and obesity treatments and preventative interventions for the diverse AI/AN population. Commercial tobacco use is one of the leading causes of Preventable Death nationwide and IHS recognizes that tobacco use is a major issue in AI/AN communities. Cardiovascular Disease in AI/ANs appear to be increasing significantly despite a fall in the general U.S. population mortality rates, quickly reaching incidence rates almost twice that of the general U.S. population. Behavioral health needs in Indian Country include depression, suicide, traumatic life circumstances including child abuse, neglect and domestic violence, addiction, and co-occurring disorders. The three greatest oral health problems facing the Indian Health Service (IHS) and the people it serves are high dental disease rates, poor access to dental care, and severe dental health workforce shortages

6. Elder Health – Long Term Care

The treatment and medication management that is unique to the elder population requires the development of specialized geriatric capabilities within the I/T/U health care system. The care of elders is a culturally inherent trait that provides an important part of maintaining our cultural knowledge and wisdom to strengthen our families and communities. It was the consensus of the group that with the expanded authority of Long Term Care under the Indian Health Care Improvement Act, this needs to be fully supported and funded.

- Elder care accounts for approximately 18% of ambulatory visits for acute complaints, chronic disease follow-up or hospitalization.
- There is a need for expanded inpatient and outpatient clinical services. Including basic primary and secondary tertiary care, increased recruitment and retention for gerontology specialists, nurse practitioners, and social workers with specialized training in elder care.
- The growth of the elder population has increased and will continue to grow as the baby boomers age.
- Long-term care is not funded nor is it a service that IHS currently provides.

7. Dental

Oral health is inextricably linked with overall health. AI/AN children in each age group have markedly higher rates of tooth decay (caries or cavities) and periodontal (gum) disease, and these rates appear to be increasing. Tooth decay among AI/AN children is as high as three to four times that of other races in the US. Over 80% of AI/AN children have tooth decay and over 90% of AI/AN adolescents have tooth decay that is untreated. A major factor behind this unacceptable state of dental health is the continuing crisis in access to dental care at facilities serving AI/AN populations. Significant and widespread shortcomings in dental facilities and staffing have resulted in long waiting lists of patients requiring even the most basic dental services. Often the inability to access routine services at the local facility results in the need for emergency room care, using up PRC funds in a highly inefficient manner.

A consensus emerged from the NIH Caries Management Conference in 2001 that identified an increase of varied methods to prevent tooth decay in children are needed, especially in Indian Country. These include fluoride varnishes and other sealants, aggressive educational programs (for instance, to reduce sugared beverages consumption), and experimental research protocols to prevent periodontal disease (including use of antibiotics and home oral hygiene regimens). However, one of the core preventive dental health measures that should be emphasized is fluoridation in Tribal water systems, necessitating coordination with the Environmental Protection Agency (EPA) to share the costs of this effort.

8. Injury Prevention

Injuries are the second leading cause of hospitalizations for AI/ANs. During 1981-1985, injuries accounted for approximately 7,950 deaths and more than 73,000 hospitalizations among AI/ANs. The age adjusted injury death rates for Native Americans served by the Indian Health Service (IHS) were approximately three times the U.S. all races rates for each

of the years 1981 through 1985. This discrepancy can be primarily attributed to a Native American poverty rate that is approximately two and one-half times the U.S. all races rate (the environment of poverty is a strong predictor for injury mortality) and the rural locations and associated disadvantaged proximity to emergency medical care within which a large proportion of Native Americans live. The leading causes of Native American injury death were motor vehicles (40%), homicide (13%), and suicide (13%) followed by drowning, fire/flames, and falls. For all injuries combined, the male to female ratio of death rates was three to one.

9. Maternal Child Health

Serious health disparities among pregnant AI/AN women and their children have been documented in numerous publications. American Indians/Alaska Natives (AI/AN) experience some of the highest disparities in infant mortality in light of current medical and public health interventions within the Pacific Northwest Region and across the countryⁱ. In the Northwest region, AI/AN are nearly twice as likely to die before their first birthday as White American, Non-Hispanic (WNH) infants. Causes of death and risk factors for infant mortality within this population include Sudden Infant Death Syndrome (SIDS), infections, injury, limited access to health care resources, and exposure to other socioeconomic factors.

In the Northwest from 2000-2004, AI/AN infants had the highest fetal and infant mortality rate of all races with 13.0 deaths per 1000 live births, while the reference group (white non-hispanic women >20 years of age and >13 years of education) experienced 5.7 deaths per 1000 live births and the entire regional population experienced 8.1 deaths per 1000 live births. Chronic maternal stress and acute life events during pregnancy may contribute to the racial disparity in infant mortality. AI/AN women experience a disproportionate number of stressful life events during pregnancy. In the 2002-2006 Washington state Pregnancy Risk Assessment Monitoring Survey (PRAMS), a greater proportion of AI/AN women reported each stressor in the PRAMS survey compared to white women, and were 2.6 times more likely to experience five or more stressful life events during pregnancy than white women.

The rates of fetal and neonatal death, low birth weight, and babies born with developmental problems are also far higher among AI/AN women than the general US population. All of these outcomes are heavily impacted by the health status of the mother and whether or not prenatal care has been received. Maternal complications that can be avoided or minimized include gestational diabetes, hypertension, placental hemorrhage, and pre-eclampsia. Complications for the baby that may be prevented by prenatal care are many, but include low birth weight, intrauterine infections (such as rubella), fetal alcohol syndrome (FAS) and cerebral palsy. There is good evidence to support the fact that woman who receive medical care during their pregnancy are healthier, have better outcomes for themselves and give birth to healthier children. The health status of pregnant and potentially pregnant AI/AN women is important not only because women of child-bearing age make up a large segment of the AI/AN population but also because their health is a predictor for the health of the next generation AI/ANs.

10. Respiratory /Pulmonary

Respiratory disease was among the most prevalent infectious disease group associated with hospitalizations for infants and has been previously described as an important contributor to

AI/AN infant morbidity and mortality. Some studies indicated that the rate for hospitalizations for the AI/AN infant population was more than double that for the general U.S. infant population. The disparity suggests a need for additional funding to identify risk factors for hospitalizations and potential prevention strategies among AI/AN infants. Previous studies have found that lack of breastfeeding and household crowding increased the risk of respiratory syncytial virus (RSV) hospitalization among Alaska Native children, and that cooking with a wood-burning stove was associated with hospitalization among some Indian children. Interventions such as the recently licensed pneumococcal conjugate vaccine, RSV monoclonal antibody for high-risk infants, and a vaccine for RSV when available may reduce the burden of LRTIs among AI/AN infants. The increase in the lower respiratory tract infection hospitalization rate among US infants is notable and might be explained by reasons discussed in an earlier study regarding a similar increase of bronchiolitis-associated hospitalizations among US infants.

In contrast to the rates for the other infectious disease groups as well as the overall infectious disease hospitalization rate for AI/AN infants, the rate of hospitalization for the kidney, urinary tract, and bladder infections group increased by almost 50% during the study period. Among US infants, the rate for these infections increased 94%. Infections of these types are often suspected when an infant presents with a fever without other symptoms. It is not clear whether the increase in hospitalization rates for these types of infections reflect improved detection by physicians or represents a real increase among infants.

Conclusion

It is important to reiterate the consensus of the Portland Area tribes' effort to address all of the health priorities that continue to impact the service population in their budget request. The priorities and budget requests outlined in this document represent a consensus building process that began many years ago.

The Portland Area's budget request clearly demonstrates a commitment to maintain the health programs by funding current services. Our recommendations fund an initiative to eliminate the health disparity that exists for AI/ANs. Portland Area Tribes believe that health care needs and national priorities should be tied to performance outcome measures like GPRA and considered in budget formulation. The Area's Tribes feel that there are many ancillary costs associated (with such things as organ transplants and long term care) that do not categorically fit our Health Priorities but are reflected in PRC and CHEF budget line items. The Portland Area feels there needs to be a better method of tying health priorities and GPRA to the budget structure.

Portland Tribes recommend that the IHS continue to address equity issues associated with providing consistent levels of health care across the IHS system. Health reform will bring many new patients with health coverage into the IHS system, however for those Areas that do not have the staffing capacity to provide services (PRC dependent) to these new patients with health coverage, they will continue to be reliant on the PRC program as it continues to be grossly under-funded. This will continue to perpetuate the inconsistent levels of care provided across the IHS system. Portland Area Tribes recommend that this issue be address by the IHS Director as part of bring *reform* to the Indian Health Service.

It is the Portland Area's goal to support Northwest Tribes in their efforts to improve health care for their people. Fully funding the budget will further the goal of the IHS and the Portland Area to elevate the health status of AI/ANs.

INDIAN HEALTH SERVICE
FY 2017 Budget Worksheet: +17% Level
AREA RECOMMENDATION

(Dollars in Thousands)

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Total Amount to meet \$5,421,987 17%
(\$5,421,987)

NOTE: At each % Level, funding recommendation to include, first, Current Services & Binding Obligations, and then Program Expansion. Left to spread \$0

% x Plng Base = \$787,810

INDIAN HEALTH SERVICE																												
FY 2017 Budget Worksheet: +5% Level																												
AREA RECOMMENDATION																												
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SERVICES																												
Hospitals & Health Clinics	1,821,550	1,790,904	(3,000)	(16,973)	0	1,862,501	2,130,312	1,442	3,817	6,452	2,287	21,154	33,581	68,733	0	0	0	0	68,733	0	0	0	0	0	1,931,234	68,733	3.7%	
Dental Services	166,124	165,290		(30)	0	175,654	192,627	171	537	533	59	1,672	3,028	6,000	0	0	0	0	6,000	0	0	0	0	0	181,654	6,000	3.4%	
Mental Health	78,344	77,980			0	82,025	136,268	58	187	303	47	880	1,438	2,913	0	0	0	0	2,913	0	0	0	0	0	84,938	2,913	3.6%	
Alcohol & Substance Abuse	186,582	186,378			0	193,824	243,325	37	119	1,096	34	2,843	3,535	7,664	0	0	0	0	7,664	0	0	0	0	0	201,488	7,664	4.0%	
Purchased/Referred Care	878,575	878,575			0	929,041	1,127,289	0	2	0	17	32,466	15,814	48,299	0	0	0	0	48,299	74,269	0	0	0	0	1,051,609	122,568	13.2%	
Total, Clinical Services	3,131,175	3,099,127	(3,000)	(17,003)	0	3,243,045	3,829,821	1,708	4,662	8,384	2,444	59,015	57,396	133,609	0	0	0	0	133,609	74,269	0	0	0	0	3,450,923	207,878	6.4%	
Public Health Nursing	71,373	70,909		(80)	0	76,353	78,728	62	212	230	21	713	1,281	2,519	0	0	0	0	2,519	0	0	0	0	0	78,872	2,519	3.3%	
Health Education	17,077	17,001		(75)	0	18,263	24,338	7	26	85	2	237	318	675	0	0	0	0	675	0	0	0	0	0	18,938	675	3.7%	
Comm. Health Reps	58,345	58,345		(450)	0	59,386	64,832	1	4	399	0	917	1,110	2,431	0	0	0	0	2,431	0	0	0	0	0	61,817	2,431	4.1%	
Immunization AK	1,826	1,826			0	1,855	1,931	0	0	13	0	29	35	77	0	0	0	0	77	0	0	0	0	0	1,932	77	4.2%	
Total, Preventive Health	148,621	148,081	0	(605)	0	155,857	169,829	70	242	727	23	1,896	2,744	5,702	0	0	0	0	5,702	0	0	0	0	0	161,559	5,702	3.7%	
Urban Health	40,729	40,729			0	41,375	57,973	3	10	181	65	646	775	1,680	0	0	0	0	1,680	0	0	0	0	0	43,055	1,680	4.1%	
Indian Health Professions	38,466	33,466	(5,000)	(5,000)	0	38,466	40,217	4	11	0	744	0	0	759	0	0	0	0	759	0	0	0	0	0	39,225	759	2.0%	
Tribal Management	2,442	1,442	(1,000)		0	2,442	2,542	0	0	0	49	0	0	49	0	0	0	0	49	0	0	0	0	0	2,491	49	2.0%	
Direct Operations	67,894	67,894		(2,000)	0	68,065	69,131	105	318	127	566	0	0	1,116	0	0	0	0	1,116	0	0	0	0	0	69,181	1,116	1.6%	
Self-Governance	5,727	4,727	(1,000)	(500)	0	5,727	5,765	4	11	0	78	0	0	93	0	0	0	0	93	0	0	0	0	0	5,820	93	1.6%	
Contract Support Cost	547,788	587,376	10,000	25,108	0	617,205	669,144	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	617,205	0	0.0%	
Total, Other Services	703,046	735,634	3,000	17,608	0	773,280	844,772	116	350	308	1,502	646	775	3,697	0	0	0	0	3,697	0	0	0	0	0	776,977	3,697	0.5%	
Total, Services	3,982,842	3,982,842	0	0	0	4,172,182	4,844,422	1,894	5,254	9,419	3,969	61,557	60,915	143,008	0	0	0	0	143,008	74,269	0	0	0	0	74,269	4,389,459	217,277	5.2%
FACILITIES																												
Maintenance & Improvemen	53,614	53,614		0	0	53,614	70,082	0	0	0	989	0	967	1,956	0	0	0	0	1,956	0	0	0	0	0	55,570	1,956	3.6%	
Sanitation Facilities Constr.	79,423	79,423		0	0	79,423	96,033	0	0	0	980	0	1,432	2,412	0	0	0	0	2,412	0	0	0	0	0	81,835	2,412	3.0%	
Health Care Fac. Constr.	85,048	85,048		0	0	85,048	180,907	0	0	0	1,308	0	0	1,308	0	0	0	0	1,308	0	0	0	0	0	86,356	1,308	1.5%	
Facil. & Envir. Hlth Supp.	211,051	211,051		0	0	220,585	228,011	248	777	570	1,244	973	3,730	7,542	0	0	0	0	7,542	0	0	0	0	0	228,127	7,542	3.4%	
Equipment	22,537	22,537		0	0	23,325	29,493	0	0	0	20	788	406	1,214	0	0	0	0	1,214	0	0	0	0	0	24,539	1,214	5.2%	
Total, Facilities	451,673	451,673	0	0	0	461,995	604,526	248	777	570	4,541	1,761	6,535	14,432	0	0	0	0	14,432	0	0	0	0	0	476,427	14,432	3.1%	
TOTAL, IHS	4,434,515	4,434,515	0	0	0	4,634,177	5,448,948	2,142	6,031	9,989	8,510	63,318	67,450	157,440	0	0	0	0	157,440	74,269	0	0	0	0	74,269	4,865,886	231,709	5.0%
\$ Change over prior year						199,662	814,771	\$157,440						\$157,440						\$231,709								
% Change over prior year						4.50%	17.58%	0						3.40%						5.00%								

																	Total Amount to meet					\$4,865,886		5%
																						(\$4,865,886)		
NOTE: At each % Level, funding recommendation to include, first, Current Services & Binding Obligations, and then Program Expansion.																	Left to spread					(\$0)		
																	% x Plng Base =					\$231,709		

HOT TOPICS – PORTLAND AREA

Prepared: January 16, 2015

ISSUE: Autism

BACKGROUND: Autism is a developmental disability significantly that affects verbal and nonverbal communication and social interaction. Other characteristics of autism are engagement in repetitive activities and stereotyped movements, resistance to environmental change or change in daily routines, and unusual responses to sensory experiences. Autism adversely affects a child's educational performance and ability to learn. A recent report issued by the State of Oregon indicates that 84,707 kids are in special education as a consequence of autism. The report shows that since 2008-09, the number has risen by 2,727 kids -- a 3.3 percent growth rate, which is faster than Oregon's population growth of 2.6 percent in that period.¹ Systems will soon be stretched to capacity to respond to the growing population who may require additional support services. Tribal leadership has reported that the effects of autism are starting to impact Tribal communities. While autism has been present in the Tribal system, it more recently is starting to become a greater concern, and also having a financial impact on Tribal education and health budgets.

RECOMMENDATION: IHS and BIA need to collaborate to provide resources to screen on all AI/AN children for Autism Spectrum Disorder (ASD) by their second birthday, and use consistent process for the identification evaluation. Promote the training of personnel throughout I/T/U agencies. Support increased funding for Early Intervention/Early Childhood Special Educations by providing additional resource for the BIE and state agencies need to do more to assist Tribes.

ISSUE: Uranium contamination on reservations

BACKGROUND: The Midnite Mine, located on the Spokane Indian Reservation in Eastern Washington State was operated by the Dawn Mining Company under a lease from the Spokane Tribe from 1954 until 1981. In addition to radioactive contamination from uranium, heavy metals such as arsenic, cadmium, and manganese have been identified in local surface and groundwater (ATSDR, 2007, 2009). In addition to the Midnite Mine, another mine located on the reservation, Sherwood, and a uranium ore mill site just across the reservation boundary, the Ford Mill, both employed a large number of tribal members, potentially contributing both direct occupational exposure as well as secondary exposure of employees' family members and community members. Trucks hauled ore from the mines to the mill using roads that passed through the most populated areas of the reservation. The Spokane Tribal leadership continues to be concerned about the health effects of this mine on its tribal population and wants IHS to do more about it.

RECOMMENDATION: IHS and CDC should use health data to determine the impact and address this health issues with other federal agencies (i.e. EPA, CDC, IHS, BIA, etc.). The Spokane Tribe has long been interested in pursuing funding for a RESEP clinic in the Northwest. The IHS and other federal agencies should fund a RESEP clinic that is central accessible by patients from Northwest Tribes most affected by uranium mining-related exposure including Nez Perce and Coeur d'Alene Tribe (ID), Confederated Tribes

¹ Oregon Statewide Report Card, An Annual Report to the Legislature on Oregon Public Schools 2013-14, Oregon Department of Education, p.78, www.ode.state.or.us

of the Umatilla Indian Reservation and Confederated Tribes of Warm Springs (OR) and Yakama and Confederated Colville Tribes (WA).

ISSUE: Public Health Emergencies

BACKGROUND: While Tribal health programs have public health and medical care infrastructure it is often underfunded and may lack the capacity to respond effectively to health, natural, and manmade disasters. Too often population density is often a primary consideration in the allocation of emergency preparedness resources, it is important to recognize that public health emergencies and disasters can and do occur on Indian reservations and in rural areas in proximity to Tribes, and that the impact of these emergencies can be felt on all Americans regardless of geography. One need only consider the far reaching impacts of natural disasters, agricultural blight, and infectious diseases to realize the interconnectedness of our reservation, rural and urban citizens.

The recent public health emergencies dealing with the Ebola outbreak in the United States is yet another example. Tribes expressed concerns regarding the cost of deployment of IHS Commissioned Corp officers to combat Ebola, protecting AI/AN communities from exposure to the Ebola virus, and communications with Tribal leadership. While IHS facilities may have established infection control procedures IHS facilities are not equipped to deal with the Ebola virus. IHS and Tribal facilities in most cases do not have isolation rooms, full body protective gear, and other things necessary to contain the Ebola virus.

Recommendation: In order to ensure the readiness of the Tribal governments in times of crisis, an important consideration is that, while the federal and state governments need to be financial partners in this endeavor, resources and implementation must also occur at the local Tribal level.

ISSUE: Heroin use

BACKGROUND: Opioids are a class of drugs chemically similar to alkaloids found in opium poppies. Historically they have been used as painkillers, but they also have great potential for misuse. Repeated use of opioids greatly increases the risk of developing an opioid use disorder. The use of illegal opiate drugs such as heroin and the misuse of legally available pain relievers such as oxycodone and hydrocodone can have serious negative health effects. [Nearly 17,000 overdose deaths in 2011](#) were related to prescription opioid medications. In 2013, among persons aged 12 or older, the rate of current illicit drug use was 3.1 percent among Asians, 8.8 percent among Hispanics, 9.5 percent among whites, 10.5 percent among blacks, 12.3 percent among American Indians or Alaska Natives, 14.0 percent among Native Hawaiians or Other Pacific Islanders, and 17.4 percent among persons reporting two or more races.²

RECOMMENDATION: Portland Area tribal leaders have noticed that heroin use is on the rise in their communities and stress the importance of prevention and treatment funding to address this growing issue. There is a tremendous need to increase culturally competent treatment and supportive services by providing additional funding to Youth Regional Treatment Centers.

² Results from the 2013 National Survey on Drug Use and Health: Summary of National Findings, U.S Department of Health and Human Services Substance Abuse and Mental Health Services Administration Center for Behavioral Health Statistics and Quality <http://www.samhsa.gov/atod/opioids>

ISSUE: Providers limiting/refusing Medicaid patients

BACKGROUND: With an increased enrollment of individuals now eligible for Medicaid, Indian health providers have noticed an increase demand for services. With respect to specialty care and dental care Tribal health programs have also noticed an increase in providers refusing to serve Indian patients because they are at capacity or do not take Medicaid (dentists). One program in Washington has surveyed dentists within a 60 mile radius and could only find two dentists that took Medicaid and one of those programs was the tribe itself.

RECOMMENDATION: Portland Area Tribes recommend that CMS require states to pursue options with Medicaid managed care providers to ensure that they must offer contracts to Tribal health programs using a Indian addendum similar to the Part D and QHP addenda. This will assist to make referrals for specialty care. Portland Tribes also recommend that IHS support and pilot alternate approaches for providing oral health delivery similar to the Alaska DHAT model.

ISSUE: Hepatitis C drugs

BACKGROUND: Hepatitis C Virus (HCV) affects an estimated 150 million persons worldwide, and about 5 million in the United States. In the US, an estimated 75% of HCV occurs among persons born between 1945 and 1965, most of whom do not know they are infected. Recent data from The Department of Veteran Affairs (VA) showed that 10% of veterans born 1945-1965 were confirmed positive with HCV, a rate that was seen among American Indian and Alaska Native (AI/AN) veterans as well.³ Based on these and other national data, there are many tens of thousands of HCV patients in Indian Country with a high proportion of them undiagnosed. Most persons exposed to HCV will develop a chronic form of the infection, which can have no symptoms for decades. HCV leads to highly elevated risk of death from liver disease, including cirrhosis, liver cancer, end-stage liver disease, chronic liver disease (CLD) and other complications. AI/AN have much higher rates of deaths from Chronic Liver CLD, including premature cirrhosis and liver cancer. The CLD death rate among AI/AN was 3.5 times higher, cirrhosis was 4 times higher, and hepatocellular cancer was 2.5 times higher than that of Whites.⁴ HCV is the leading cause of liver transplants in the US.

HCV Treatment

Past treatment for HCV lasted several months, presented severe side effects, required consistent injections, and had high failure rates. Within the last year, treatment for the four HCV genotypes found in the United States has improved dramatically – with three new treatment regimens being recommended. The new regimens can be taken orally, have few side effects or contraindications, and have treatment times shortened to a range of 8 to 12 weeks for almost all patients. Sustained virologic response (SVR; patient effectively ‘cured’) has consistently improved with new treatments, and the

³ Backus, Lisa I., et al. (2013). Hepatitis C Virus screening and prevalence among US veterans in Department of Veterans Affairs Care. *Journal of the American Medical Association, Internal Medicine*, 173.16: 1549---1552.

⁴ Suryaprasad, Anil, et al. (2014). Mortality caused by chronic liver disease among American Indians and Alaska Natives in the United States, 1999–2009. *American Journal of Public Health*, 104.S3: S350---S358

latest regimens are resulting in SVR rates of > 90% according to current data. Obtaining HCV SVR has been cited as reducing liver failure by 90% and liver cancer by 70%^{5,6}

New Drugs called Direct Acting Agents (DAAs) including harvoni, sofosbuvir, simeprevir, and ledipasvir, are approved – with more DAAs expected in the near future. These drug regimens represent a revolution in treatment that is shorter, more effective and less toxic than the previous generation of HCV treatment options. These regimens are oral-only, last 8-24 weeks, have few side effects, and have shown cure rates of 76 percent to 99 percent. The shorter treatment times, low toxicity, and high success rates of these drugs make HCV largely manageable at the primary care level for many HCV patients if there is specialist support available at key junctures such as intake and determination of treatment regimen.

The Cost Barrier

The new treatment regimens are extremely expensive. Of note, two of the new HCV medicines cost over \$1,000 per pill, making a 12-week regimen over \$100,000. Insurance companies, state Medicaid programs, the VA and Indian Health Service (IHS) cannot afford the high cost of treatment for large numbers of patients, which has resulted in only those patients with the most severe liver disease qualifying for HCV treatment, although earlier treatments would have prevented fibrosis and cirrhosis. So far, IHS has successfully accessed various pharmaceutical companies' patient assistance programs (PAPs). Although PAPs carry a heavy paperwork burden for both the patient and the provider, they obtain some or all of the needed HCV drugs for free.

The national response to HCV has begun with an emphasis for scaled up screening and treatment. Currently only a handful of IHS, Tribal, or Urban Indian health (I/T/U) sites are treating HCV patients. Relying upon PAPs does not represent a scalable or sustainable solution to meeting outstanding HCV treatment needs in Indian Country. The high costs of the new regimens and the perceived cost barriers are serving as a strong disincentive for I/T/U sites to initiate broader screen and treatment programs.

Potential Budget Impact

In the last 12 months, IHS has spent \$1.2 Million on HCV medications through the Pharmaceutical Prime Vendor. Of this total, \$1 million was spent on Sofosbuvir alone. The cost for treatment averages approximately \$72,000 per patient. The cost for treating 25,000 patients would be \$1.8 billion. Separately, Human Resources impacts and costs are projected but have not been formally assessed. These include:

- Clinical training/lab burden.
- Paperwork burden to secure medications via patient assistance programs.
- Routine appointment to monitor patients.

RECOMMENDATION: Portland Tribes recommend that I/T/U sites receive the clinical and administrative support related to diagnosis and treatment for HCV patients. Even if a clinic treats only a small cohort of patients at a time, many lives will be saved. While it is difficult to project the current and future rate of HCV-related deaths and complications, available data shows the impact of HCV is high, and growing. A

⁵ Lok, Anna S., et al. (2012). Preliminary study of two antiviral agents for hepatitis C genotype 1. *New England Journal Of Medicine*, 366.3: 216---224,

⁵ Ghany, Marc G., et al. (2009). Diagnosis, management, and treatment of hepatitis C: An update. *Hepatology* 49.4: 1335---1374.

⁶ Van der Meer, Adriaan J., et al. (2012). Association between sustained virological response and all-cause mortality Among patients with chronic Hepatitis C and advanced hepatic fibrosis. *Journal of the American Medical Association*, 308.24: 2584---2593.

recent IHS study showed that HCV hospitalizations more than tripled in recent years.⁷ CLD mortality has been significantly increasing from 1999-2009. One prominent study estimated CLD to be the 4th leading cause of death among AI/ANs, a rate that is nearly three times higher than the AI/AN mortality rate for diabetes.

ISSUE: Tulalip shooting

BACKGROUND: Youth violence refers to harmful behaviors that can start early and continue into young adulthood. The young person can be a victim, an offender, or a witness to the violence.

Youth violence includes various behaviors. Some violent acts—such as bullying, slapping, or hitting—can cause more emotional harm than physical harm. Others, such as robbery and assault (with or without weapons), can lead to serious injury or even death.

Deaths resulting from youth violence are only part of the problem. Many young people need medical care for violence-related injuries. These injuries can include cuts, bruises, broken bones, and gunshot wounds. Some injuries, like gunshot wounds, can lead to lasting disabilities.

Violence can also affect the health of communities. It can increase health care costs, decrease property values, and disrupt social services.⁸

A number of factors can increase the risk of a youth engaging in violence. However, the presence of these factors does not always mean that a young person will become an offender.

Risk factors for youth violence include:

- Prior history of violence
- Drug, alcohol, or tobacco use
- Association with delinquent peers
- Poor family functioning
- Poor grades in school
- Poverty in the community

Among 10 to 24 year-olds, homicide is the leading cause of death for African Americans; the second leading cause of death for Hispanics; and the third leading cause of death American Indians and Alaska Natives.⁹ (http://www.cdc.gov/violenceprevention/youthviolence/schoolviolence/data_stats.html)

RECOMMENDATION: IHS should develop better internal systems to develop crisis plans and supply mental health providers in emergency situations like the shootings at Tulalip and Red Lake. Often Tribes do not know that such plans may even exist (if they do), or what the protocols are for seeking IHS assistance. IHS should also conduct training and technical assistance to IHS and Tribal health programs about these plans and protocols so that Tribes are better equipped to respond to emergency situations.

⁷ Byrd, K. K., et al. (2011). Changing trends in viral hepatitis---associated hospitalizations in the American Indian/Alaska Native population, 1995–2007. *Public Health Reports*, 126.6: 816.

⁸ Centers for Disease Control and Prevention. Youth risk behavior surveillance—United States, 2011. *MMWR, Surveillance Summaries* 2012;61(no. SS-4) Behaviors that Contribute to Violence on School Property Fact Sheet, CDC

⁹ Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). [cited 2012 Oct 19] Available from www.cdc.gov/injury. Understanding Youth Violence Factsheet, CDC

ISSUE: Human Trafficking

BACKGROUND: Human trafficking is a serious federal crime with penalties of up to imprisonment for life. Human trafficking involves a person to perform commercial sex related acts, labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery. In comparison to other racial and ethnic groups, Native women remain the most frequent victims of physical and sexual violence in the U.S. and in Canada. In the U.S., their rate for sexual assault and rape in 2000 was 7.7 per 1,000 women versus 1.1 for White women, 1.5 for African American women, 0.2 for Asian women, and 0.6 for Hispanic women. Over 30% of Native women have experienced an attempted or completed rape in their lifetimes, versus 17.9 % of Whites, 18.8% of African Americans, and 6.8% of Asians (Tjaden & Thoennes, 2006)."

There are several common risk factors among victim's poverty, young age, limited education, lack of employment opportunities, homelessness, run-away, history of substance abuse. Native women and children are often target because they are desperate to meet their survival needs. In many case Tribal communities are not prepared to recognize or provide services for those individuals who are being trafficking. The following recommendations are from the Alaska Native Task Force on Sex Trafficking:

RECOMMENDATION: Tribes need assistance to begin to address this issue. IHS should coordinate with other federal agencies that have jurisdictional responsibilities for dealing with the effects of human trafficking (i.e. SAMHSA, DOJ, BIA, FBI, etc.) so that responsibilities are more clearly defined. Resources are also need to implement prevention and prosecution activities.

ISSUE: Cost for Outreach and enrollment into ACA

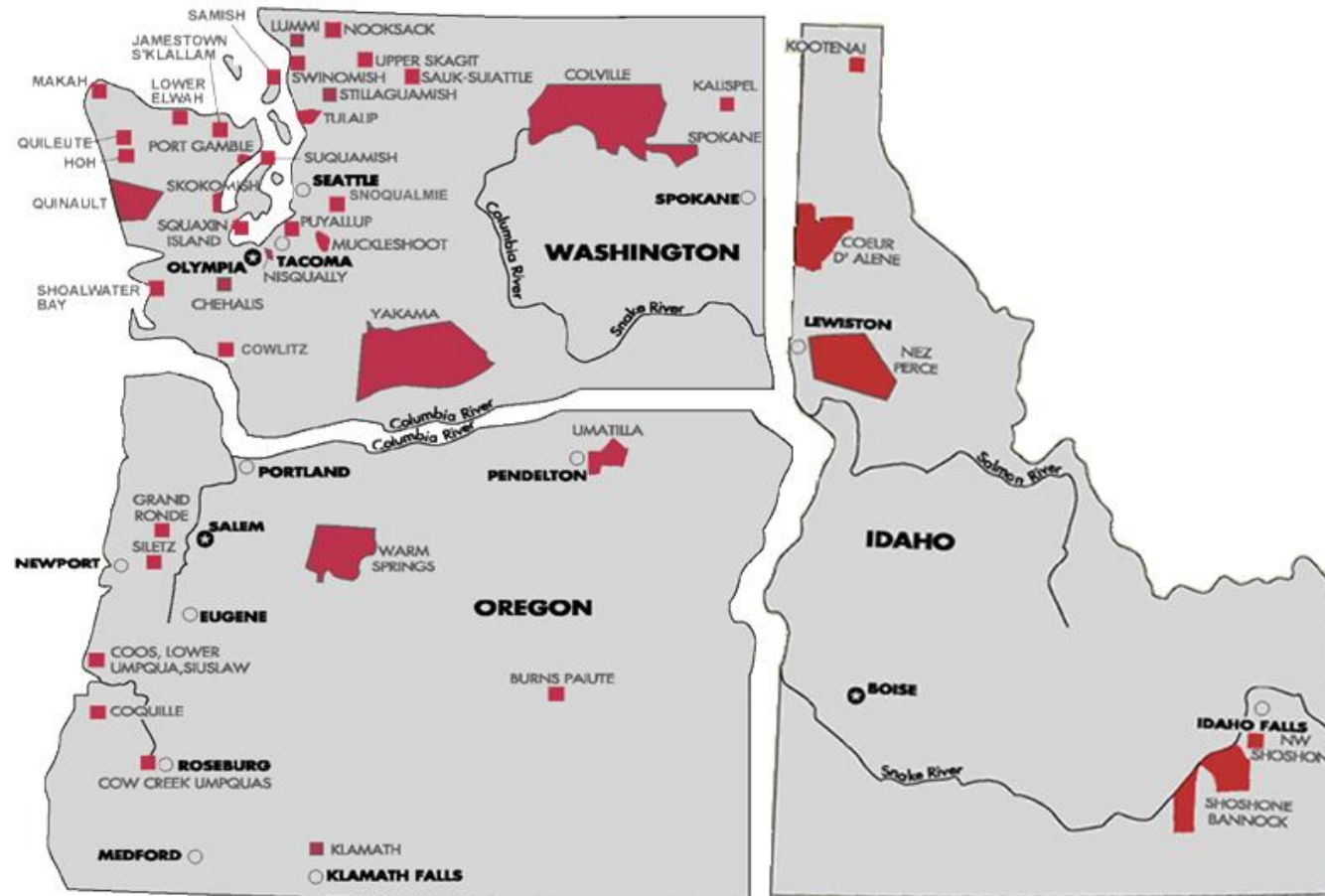
BACKGROUND: Portland Area Tribes are concerned that they had to perform many administrative activities related to education, outreach and enrollment for Medicaid and the Insurance Exchanges. In most instances in the private sector, these costs were accommodated by funding organizations to conduct such services or performed by the State itself. Tribes were funded very little if at all to conduct such activities yet had their tribal personnel carry out this work. This disrupted patient care as tribes had to shift resources away from carrying out direct health care and other associated administrative activities. Often the state outreach and education assistance is inadequate to address or respond to the questions and needs of Indian people. Tribal health programs are in best position to do this however they lack the necessary capacity to do the jobs they are financed to do (provide direct health care) and also carry out the responsibilities of the state and federal government.

RECOMMENDATION: IHS and CMS need to find a mechanism to directly fund these administrative costs for Tribes. The states get reimbursed for such activities and Tribes should too, as to not infringe on patient care.

FY 2017 Indian Health Service Budget Recommendations from *Portland Area*

PRESENTED BY [INSERT NATIONAL BUDGET FORMULATION REPRESENTATIVES]

Service Area and Geographic information



Service Demographic information

- ▶ *Serving American Indian/Alaska Native residents of Oregon, Washington and Idaho.*
 - ▶ *Approximately 150,000 users*
 - ▶ *43 Tribes*
 - ▶ *6 - Federal Health Facilities*
 - ▶ *23 - Title V Tribal Contracts*
 - ▶ *24 - Title I Tribal Contracts*
 - ▶ *3 - Urban Clinics*
 - ▶ *1 - Youth Regional Treatment Center*

Area Top 5 National Budget Priorities

1. Priority 1 – Fully Fund Current Services
2. Priority 2 – Increase Purchase and Referred Care Funding
3. Priority 3 – Fund ACA and IHClA Amendments (New Authorities)
4. Priority 4 – Restore Pay Act Increases
5. Priority 5 – Increase Facilities (M&I, Sanitation Facilities, Equipment)

Summary of 5% recommendations:

- ▶ \$231.7 million to fund:
 - ▶ \$18.2 million Federal and Tribal Pay costs
 - ▶ Non-Medical Inflation \$8.5 million
 - ▶ Medical Inflation \$63.3 million
 - ▶ Population Growth \$67.5 million
 - ▶ Program Increase of \$74.3 million reprogrammed from Binding Obligations for facilities staffing and construction
 - ▶ Contract Support Costs: Full funding is law and function of current services. No funding included in worksheet. Does not mean Portland Tribes do not support.

Summary of 17% Recommendations:

- ▶ \$787.8 million to fund:
 - ▶ Same current services at the 5% level.
 - ▶ Program increases for the following:
 - ▶ Increase PRC \$391.4 million
 - ▶ Fund ACA and IHCI Implementation \$187.3 million
 - ▶ Restore Past Year's Pay Act Increases \$48.1 million
 - ▶ Increase M&I, S&F Construction, and Equipment \$90 million

Area Hot Topics

1. Autism
2. Uranium contamination on reservations
3. Public Health Emergencies
4. Heroin use
5. Providers limiting/refusing Medicaid patients
6. Hepatitis C drugs
7. Tulalip shooting
8. Human Trafficking
9. Cost for Outreach and enrollment into ACA