Portland Area
Indian Health Service

FY 2019 Budget Formulation Submission

Budget and Narrative

Portland Area Budget Formulation Representatives

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Federal Responsibility to Provide Health Care for American Indian and Alaska Native (AI/AN)

The Portland Area 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.

Preliminary Process

On November 29, 2016, Portland Area Tribal leaders, health directors, representatives from the Northwest Portland Area Indian Health Board along with leadership of the Indian Health Service - Portland Area Office met to discuss their recommendations for the FY 2019 Indian Health Service (IHS) budget. The meeting was held at the Embassy Suites Portland Airport.

The session included an overview of the federal, HHS and IHS budget formulation process and 2016 Government Performance and Results Act (GPRA) results. The meeting agenda for is included as an attachment to this report.

Summary of FY 2019 Budget Recommendations

The Portland Area Tribes submitted two recommended budget marks at the national-level for FY 2019: 33% ($1.5 billion) and 42% ($2.0 billion). Portland Area Tribes recommend a 42% increase in FY 2019 to fall in line with an IHS need-based budget.

For the pilot spreadsheet, Portland Area Tribes submitted an area-level budget recommendation worksheet at the 33% level. National budget recommendations at the 33% level were applied on a pro-rata distribution to the area spreadsheet. This provided consistency for budget recommendations at both the national and area levels.

Summary of Portland Area National Budget Recommendations		
	National +33%	**National +42%**
Federal & Tribal Pay Cost Increases	$19.9 million	$19.9 million
Non-Medical Inflation	$10.4 million	$10.4 million
Medical Inflation	$70.0 million	$70.0 million
Population Growth	$68.7 million	$68.7 million
CSC Binding Obligation	$100 million	$100 million
Program Increases	$1.3 billion	$1.8 billion
Total Current Service and Program Increases	**$1.5 billion**	**$2.0 billion**

CURRENT SERVICES

Fully Fund Pay Costs, Inflation and Population Growth: +$169M
Portland Area Tribes continue to underscore the fact that IHS funded programs have had to absorb significant inflationary cost increases over the past twenty years, stressing that IHS and tribal programs struggle to absorb the real resource loss associated with inadequate funding for inflation, pay act increases and population growth. Therefore, Portland Area Tribes believe these mandatory costs must be the first consideration in the budget formulation process.

Portland Area Tribes support fully funding federal and tribal pay costs, inflation, and population growth. 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 tribes are concerned that the agency may reduce services and lose its workforce by not investing in them.

BINDING OBLIGATIONS

H&C Staffing for New Facilities & HFC Healthcare Facilities: +$0.00 / CSC Need: +$100M
The IHS electronic worksheet for budget formulation suggests funding increases of $75 million for staffing, $100 million for Health Facilities Construction. Portland Area Tribes do not support funding for facilities construction and related staffing under the premise that the facilities construction priority system disadvantages Portland Area Tribes in the overall IHS resource allocation process. Additionally, the funding does not equitably benefit tribes nationally and has an adverse impact on available funding for inflation, pay costs, and population growth. Portland Area Tribes reduced the facilities funding in Binding Obligations and redirected this funding to cover program increases. Portland Area supports the binding obligation CSC need of +$100M.

PROGRAM INCREASES

Purchased & Referred Care Funding: +$861.1M

At the National 33% level, Portland Area Tribes recommend a program increase for the Purchased and Referred Care (PRC) program of $861.1 million. The PRC program is extremely important for Portland Area Tribes since the Portland Area IHS does not have hospitals and must rely on the PRC program for specialty and inpatient care. The PRC program makes up 35% of the Portland Area budget. When less than adequate inflation and population growth increases occur, Portland Area Tribes must make difficult decisions about cutting health services to absorb these mandatory costs.

Fund ACA and IHCIA Amendments & Long Term Care +$334.7M
The Affordable Care Act included amendments to and a permanent reauthorization of the Indian Health Care Improvement Act (IHCIA). Both the ACA and IHCIA include many authorities that are beneficial for IHS, Tribal, and Urban (I/T/U) Indian health programs. The IHCIA includes authorities to carry out hospice care, long-term care, assisted living, and home and community based services in tribal communities. The IHCIA also provides

authority to develop a grant program for technologically innovative approaches to assess/prevent/treat youth suicide.

At the National 33% level, Portland Area Tribes recommend $248.7 million to further implement the ACA and carry out new IHCIA authorities. For this purpose, $88.9 million for H&C and $88.9 million for the PRC line items would assist tribes to purchase health premiums for their tribal members. The Portland Area Tribes also recommend the IHS pursue legislation that gives the IHS federally operated programs authority to purchase health insurance premiums for tribal members when beneficial to the program. $46 million to be provided to the Urban Indian Health Program line item to allow them to also purchase insurance premiums for their users.

The IHCIA 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.

At the 33% level, the Portland Area recommends $86 million to develop long term care programs with funding 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. The Portland Area Tribes believe this will allow these programs to become self-sustaining and help mitigate future pressures on the system as the user population continues to age.

Restore Pay Act Increases: +$84.1M

At the 33% mark, Portland Area Tribes recommend an additional $84.1 million to restore past-years' pay costs that were not funded due to the federal moratorium on pay act increases. The IHS and tribes must continue to reward their employees in order to retain them, otherwise the system will be in a cycle to continually recruit and replace personnel that leave the system.

Facilities: -$15.9M

Portland Tribes acknowledged that past-years' 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 $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 realized a 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: $53.5 million for the M&I account; $25 million for the Sanitation and Facilities program, and $12.2 million for Equipment.

Regional Referral Center: +$53.6M

The tribes recommended a $53.6 million increase in Portland Area for a specialty center and staffing package. The current IHS Health Care Facility Priority system does not provide a mechanism for funding specialty referral centers. The Portland Area Facilities Advisory Committee recommends that the first specialty referral center be constructed as a demonstration project under the new authorities in the Indian Health Care Improvement Act.

Portland Area Health Priorities

The FY 2019 Portland Area health priorities are as follows:

1. Cancer

   American Indian and Alaska Native (AI/AN) 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. Another major contributor to this increased mortality among AI/ANs is that most receive their care through limited primary care facilities that lack adequate resources to coordinate care and provide the sophisticated and specialized cancer treatment that is available to the wider 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.

   Tribes are effective in sharing information from community to community, yet the development of effective models is more difficult due to the lack of significant funding increases. Tribes want to address all forms of addictive behavior from substance abuse to gambling.

   The use of methamphetamine 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. This highlights the need for increased funding for follow up care.

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% 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. Tribes emphasized the need for tribal clinic facilities to have funding for personnel specifically trained to provide treatment for this population.

Tribes reported that past trends for domestic violence measures show stagnant rates through FY 2005 and then a significant increase in FY 2006 of 28%. In FY2007, the proportion of women who are screened for domestic violence at healthcare facilities was 36%. 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. The Portland Area has one of the higher suicide death rates for AI/AN among the IHS service areas. The Tribes strongly encourage IHS to provide additional funding to reduce suicide rates among AI/AN and to increase tribal capacity to prevent suicide throughout Indian Country.

3. Diabetes

Depending on the region, 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. 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.

4. Cardiovascular, Heart Disease, Stroke

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. Although, heart disease was once 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 rates 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 comorbidities.

5. Health Promotion/Disease Prevention (Childhood obesity)

   AI/AN people are challenged with 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.

   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.

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 cultural knowledge and wisdom to strengthen families and communities. It was the consensus of the Portland Area Tribes 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. 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. Portland Area Tribes support increased use of fluoride varnishes and other sealants, aggressive educational programs (for instance, to reduce sugared beverages consumption), water fluoridation and expansion of the Dental Health Aide Therapist (DHAT) program to stretch limited resources.

8. Injury Prevention

   Injuries are the second leading cause of hospitalizations for AI/ANs. The age adjusted injury death rates for AI/ANs served by the 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 an AI/AN 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 AI/ANs live. The leading causes of AI/ANs 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. AI/ANs experience some of the highest disparities in infant mortality in light of current medical and public health interventions within the Portland Area and across the country. 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.

   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. Another challenge facing AI/AN programs is the higher incident of infants born with opioid addiction resulting in higher costs for initial care and potential for negative health outcomes in the future. 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.

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.

11. Auto-Immune Disease

Auto-immune disease is a broad category of many diseases (sometimes also termed rheumatic diseases), which includes conditions such as rheumatoid arthritis, lupus, ankylosing spondylitis, Sjogren's syndrome, etc. Certain subpopulations of Tribes have a much higher incidence of certain autoimmune diseases. For example AI/AN women in one Washington Tribe have a rate of rheumatoid arthritis of 3.4% (compared to 0.5-1.0 % in the US population).

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. The Portland Area Tribe's recommendations fund an initiative to eliminate the health disparity that exists for AI/ANs.

Portland Area Tribes suggest that health care needs and national priorities should be tied to performance outcome measures like GPRA and considered in budget formulation. The Portland Area Tribes are aware 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.

Portland Area Tribes encourage the IHS to continue addressing issues associated with providing consistent levels of health care across the IHS system. Fully funding the budget will further the goal of the IHS and the Portland Area Tribes to elevate the health status of AI/ANs.