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State of Indian Health Facilities

U.S. Senate Committee on Indian Affairs
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Good morning, Chairman Dorgan, Vice-Chair Murkowski and Members of the Committee. Quyana (thank you) for the opportunity to testify today about the state of Indian health facilities.

I was privileged to work for seven years for the Yukon-Kuskokwim Health Corporation, the tribal health program that serves 58 federally-recognized tribes in a region roughly the size of Oregon, of which Bethel is the hub. I am now honored to work for over 2 years for the Alaska Native Tribal Health Consortium, a statewide tribal health program that serves all 229 tribes in Alaska, co-manages with Southcentral Foundation the Alaska Native Medical Center (ANMC), the tertiary care hospital for all American Indians and Alaska Natives (AI/ANs) in Alaska, and carries out all non-residual Area Office functions of the IHS that were not already being carried out by Tribal health programs as of 1997. With me today is Rick Boyce, Director of Health Facility Support, for the Alaska Native Tribal Health Consortium. Mr. Boyce also serves as the Alternate Alaska Representative to the Facilities Appropriations Advisory Board.

The deplorable health status of AI/ANs is clearly understood by this Committee as evidenced by your commitment to modernizing the Indian Health System through your recent efforts to advance the Indian Health Care Improvement Act (IHCIA). We thank the Committee for your efforts in highlighting the unmet needs in Indian Country and congratulate you on your successful passage of the bill in the Senate and its transmittal to the House.

We look forward to the day when we can take advantage of these modern advances. In the meantime, we know that in order to make headway on health disparities, we need to put adequate resources toward improving access to care. In addition to providing resources for direct care, we also need to focus our efforts and resources on building facilities where they do not exist, and improving facilities that are in disrepair because the maintenance and improvement needs have not been sufficiently funded.

For those of you who have not visited Indian country or seen a tribal health facility first hand, I will try to paint a picture. It will be incomplete. It is impossible to understand the diversity and challenges faced by Tribes without visiting a number of them. However, not everyone can visit. So today, I hope to help you understand why adequate health facilities are so important to the Indian health system.

The stories I will tell you come from my experience in Alaska, and from the experience of other tribes across the country, where tribal members experience the same difficulties accessing health care, and tribal governments and clinics experience the same pain of having to deny health care to people in need because there just isn’t enough money to pay for it, and because there are just not enough resources to provide adequate facilities.

We specifically recommend that Congress adequately fund the full range of facility construction and operational needs, including primary health care needs, Long-Term Care Skilled Nursing and assisted living facilities, residential alcohol and substance abuse facilities, and our huge unmet sanitation facilities needs.

I. The Indian Health Service System

The federal government has a duty – acknowledged in treaties, statutes, court decisions and Executive Orders – to provide for the health and welfare of Indian Tribes and their members.[1] In order to fulfill this legal obligation to Tribes, it has long been the policy of the United States to provide health care to American Indians and Alaska Natives through a network made up of the Indian Health Service programs, tribal health programs and urban clinics.

The Indian Health Service (IHS), directly and through tribal health programs carrying out IHS programs under the Indian Self-Determination and Education Assistance Act, Pub. L. 93-638, as amended (ISDEAA), provides health services to more than 1.9 million American Indians and Alaska Natives. We are members of 562 federally-recognized tribes in the United States, located in 35 different states. According to the IHS, these services are offered from the following facilities:[2]

	IHS Directly Operated	Tribally Operated
Hospitals	33	15
Health centers	54	229
Health stations	38	116
Alaska Community Health Aide (CHA) clinics	0	162

There are also 34 urban Indian health programs funded by IHS under Title V of the IHCIA that provide care to approximately 600,000 AI/ANs.[3] When health care cannot be provided through these facilities, IHS and tribal programs use funding to purchase "Contract Health Services" from providers outside of the IHS system.

The number of facilities does not really tell the story though. The Indian health system is a real system of care. It is reflected in the IHCIA, which addresses health provider workforce

[1] See Federal Basis for Health Services, January 2007 (info.ihs.gov/Files/ BasisForServices-Jan2007.doc).

[2] Indian Health Service Fact Sheet, IHS/OD/PAS January 2007 (info.ihs.gov/Files/IHSFacts-Jan2007.doc).

[3] Indian Health Service Year 2007 Profile, January 2007 (info.ihs.gov/Files/ProfileSheet-Jan2007.doc).

issues, and a full range of health care services from preventive health care services to critical inpatient care, from prenatal care and deliveries to services needed at the end of one's life.

The IHCIA also encompasses services that have been woefully inadequate or simply unavailable like nursing home services and behavioral health, including a continuum of mental health and substance abuse services. In addition, the IHCIA addresses those critical infrastructure issues that are so easily overlooked when a suffering patient and her family require immediate attention – the facilities that are needed to provide this vast array of services and basic public health services like safe water and sanitation.

There is a desperate need for additional resources even with reliance on supplemental funding through Medicaid, Medicare and SCHIP. The system simply cannot remain viable without adequate facilities.

II. State of Indian Health Facilities

The unmet need for health facilities for the IHS and tribal health system is $6.5 billion. This includes only the highest priority need for inpatient hospitals, health centers, staff quarters, and youth regional treatment centers. It does not include adult treatment centers, residential long-term care facilities, nor sanitation facilities, which are sorely needed.

Currently, the average age of an IHS facility is 32 years. Even more startling is that there are 17 installations throughout the IHS where the facility age is between 40 and 66 years.

The state of individual health facilities in Indian Country varies greatly. They range from a few "newer" health facilities to the more common old, poorly maintained facilities that are in desperate need of repair. Even more striking is that entire IHS Areas do not have certain kinds of health facilities at all.

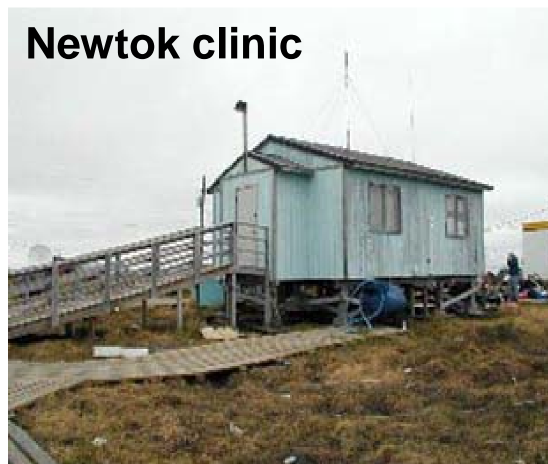
An example of a newer inpatient hospital facility is the Alaska Native Medical Center (ANMC), jointly operated by Southcentral Foundation and ANTHC. Although it was constructed over ten years ago, it is considered a very new facility in the Indian Health System. The planning documents for this facility were completed 10 years before the facility was constructed. In the meantime, it languished on a very long "facilities list" along with other crucial but unfunded projects. The ANMC facility is a significant improvement over the previous hospital that was constructed in 1953, but it is clear that the facility is not large enough to keep up with population growth. This is a common occurrence when limited construction funds are available to meet the need for facilities that have been sitting for years on the IHS facility list.

The more typical IHS inpatient hospital is old and dilapidated. For example, the Nome hospital was constructed in 1948 with an addition in the 1970s. A replacement facility has been on the IHS priority list since 1991. Another Alaskan facility, the Samuel Simmonds Memorial Hospital in Barrow was constructed with wood frame construction in 1964. Although wood framed buildings are short-lived, the Barrow hospital has been on the IHS priority list since 1991.

This hospital in Barrow, Alaska has been on the IHS facility list since 1991 and is in desperate need of replacement.

Some areas, like the Portland Area (representing Washington, Oregon, and Idaho) and the California Area, have no inpatient hospital facilities at all. Because there is no hospital for AI/AN patients in their respective IHS Area, these facilities depend on Contract Health Services (CHS) funds. In fact, despite the population shifts to the west and east coasts of the United States, there are very few IHS inpatient hospitals in the western United States. Likewise, there are very few IHS inpatient hospitals located on the east coast. There is clearly a need for additional inpatient hospitals.

Like inpatient hospitals, health centers are also in various stages. For example, health clinics in the Portland Area are an average of 40 – 50 years old. One clinic on the Colville Indian Reservation is over 70 years old. Other clinics in the Portland Area make do with mobile homes.[4]



This clinic in Newtok, Alaska has no running water

[4] Testimony of Linda Holt, Chairperson, Northwest Portland Area Indian Health Board, before the Senate Finance Committee, March 22, 2007.

The continuing "pause" on facility construction has delayed attempts to address the aging health care facilities within the IHS system. We strongly recommend that Congress appropriate more resources for the construction of desperately needed health facilities and to take advantage of other opportunities for innovation. At a minimum, we recommend that the 2010 budget restore funding to $93.6 million, allowing the IHS to replace its high priority healthcare facilities with modern facilities, and to significantly expand capacity at its most overcrowded sites.

III. Innovations in Facility Development

We have seen the benefit of pursuing and leveraging additional resources in the construction of sanitation facilities. Between 1986 and 1990 project contributions from other sources to IHS sanitation facilities construction projects averaged $55.7 million annually. After the Sanitation Deficiency System (SDS) was established, annual average contributions for the five years following (1991 - 1995) averaged $105.6 million.[5] This resulted in a $50 million annual increase in contributions from other sources. Thus, contributions almost doubled as a result of SDS.

We anticipate that these same opportunities can be replicated in making additional resources available to address the unmet need for health facilities by increasing appropriations for two successful programs and providing additional resources to implement the FAAB recommendations. Because of the limited amount of funds available for health facility construction, tribes worked with Congress to develop two innovative programs, the Joint Venture Program (JV) and the Small Ambulatory Program (SAP), to leverage other funds to get projects completed. Another opportunity yet to be realized is the FAAB's recommendation for the Area Distribution Program.

Tribes have built approximately three times more health care space than the IHS has been able to with limited funds through the Joint Venture Program and the Small Ambulatory Program.

The **Joint Venture** program was developed to help assist tribes with their unmet facilities needs. This competitive program provides the medical equipment funds and the complete staffing package for a selected facility that is constructed with tribal resources so long as it meets IHS planning requirements.[6]

The **Small Ambulatory Program** (SAP) also assists tribes with their unmet facilities needs. This competitive program provides the construction funds, facility maintenance costs, and medical equipment costs, while the tribe provides the staffing package.[7]

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[5] The Indian Sanitation Facilities Act, P.L. 86-121, authorizes the IHS to provide essential sanitation facilities, such as safe drinking water and adequate sewerage systems, to Indian homes and communities.

[6] The Joint Venture program was enacted as an amendment to the IHCIA under Section 818 and authorizes Congress to appropriate recurring funds for increased staffing, operation and equipment for new or replacement facilities constructed with non-IHS funding acquired by tribes.

[7] The Small Ambulatory Program is only available to tribes who contract or compact to operate a facility under the Indian Self-Determination and Education Assistance Act, Pub. L. 93-638.

One recommendation from the FAAB is the creation of an **Area Distribution Program** (ADP). The ADP is intended to provide funds to each IHS area to fund projects on the national priority list that are high priorities for the Area but don't rank high enough to receive direct Congressional funding in the near future. Thus, it provides a methodology for allocating funds to Area Offices to address the highest priority projects within the Area. These funds can be used to match other local, state, and federal funds to complete a project that would take many more years to complete if they were limited to using IHS funds.

The ADP would be initiated only when Congress appropriates funds for this purpose, the fund would be another line item in the facilities appropriation just as Joint Venture, Small Ambulatory Clinic, Dental, and Priority List Construction are separate line items now.

The ADP proposal would require these funds to be distributed to the highest priority Area Office facilities where the Area and Tribes agree that only limited new staffing is required. Upon completion of ADP projects, the facility will be allocated only about 40% of the additional staffing and operational funds usually allocated to new facilities. As proposed by the FAAB, the ADP funds would be allocated as follows:

- In a given year, the Area Offices may not participate in the ADP if the line-item amount in the Facilities Appropriation exceeds 20% of the total appropriations for facilities construction.
- Those Areas that receive 20% or less of the annual line-item facilities appropriation are allocated a portion of the Area Distribution Program funds using a formula based on Area user population and location cost adjustments.

The benefit of this process is every IHS Area is able to participate. Other matching funds can be used to build, renovate, and expand a facility; and some staffing is provided. Each Area can complete a high area priority project, and M&I funds can now be used for code and infrastructure type projects like boilers, chillers, pumps, air handlers and life-safety code issues. More projects addressing the overall unmet needs are completed more quickly and at a lower costs since non-IHS partners like private foundations and other granting agencies contribute funding for some of the staffing and/or construction costs.

Some Areas have expressed concern about projects identified back in 1991 that are now on the national priority list. They question whether the Area Distribution Funds may dilute the facilities appropriation and further delay funding for their projects. However, the Joint Venture and SAP funding lines are already in place on the facilities appropriation and Congress has continued to provide funding to these programs along with funding individual projects on the priority list. We ask that Congress continue this practice with the Area Distribution Program so that it provides another option for Congress to allow more tribes to participate in what has been a closed priority system since 1991.

There have been 7 Joint Venture projects and 27 Small Ambulatory Program projects awarded since 1998. The JV program and the SAP are examples of the best available opportunities to leverage funds to get desperately needed facilities constructed in Indian Country, but the funds available have been very limited. We recommend that Congress increase Joint

Venture funding and Small Ambulatory Program funding and add new appropriations for the Area Distribution Program to accelerate the completion of needed facilities.

IV. Facility Operational Needs

When addressing facility needs, it is important to look beyond new construction. In order for existing facilities to remain functional and provide maximum use, it is also important to adequately fund Medical Equipment Replacement, Facility and Environmental Support Funding, Maintenance & Improvement and the Village Built Clinic Lease Program. Adequate funding for these programs will ensure that the facilities we build today will be available for continued use into the future. Thus, we recommend adequate funding for these needs as more specifically described below.

A. Medical Equipment Replacement

In order to assure patient safety, medical equipment should be replaced on an average of every 6 years. Unfortunately, current funding levels cover only one-third of the level of need. Thus, equipment that should have been replaced after 6 years may continue to be used for 18 years or longer. Medical equipment maintenance and replacement presents obvious patient safety issues, and some tribes may divert funds from direct patient care to make up this gap.

The annual medical equipment funding is $21.3 million, when the annual need is actually $64 million. We urge Congress to increase IHS appropriations to this line item to ensure that neither patient safety nor direct patient care is compromised.

B. Facility and Environmental Support Funding

Facility and Environmental Support (FES) funding provides for the maintenance staff and basic operations of health facilities, including utilities. These funds also pay for Area office programs, like core staffing for health facilities, environmental health, and sanitation construction.

The level of funding has stayed relatively flat or received small increases (less than 2%). With the rising cost of salaries and double digit annual increases in energy costs, this funding line is not keeping pace. In fact, the FY 09 President's budget proposes no change from FY 08 even though it allocates $25 million out of the base funding for staffing and operational costs for new facilities opening in FY 09. Historically, new funds were made available to meet these additional FES costs for new facilities in addition to any necessary nationwide programmatic increases. However, the effect of the President's FY 09 budget recommendation is that new facility needs are being funded at the expense of existing programs.

We recommend that Congress increase this appropriation by $4.2 million annually to meet the current national need. We also recommend that Congress appropriate an additional $25 million recurring need for new staffing requirements associated with new facilities opening in FY 09.

C. Maintenance & Improvement

Maintenance & Improvement (M&I) funds are used to maintain facilities so they can continue to be used in the future. Unfortunately, the level of M&I funding is substantially lower than what is needed. It is estimated that the base M&I funding needed to just sustain the facilities in their current condition should be funded at $80 million annually. Because funds have not kept pace with the need, there is a tremendous backlog of maintenance needs. The IHS estimates $371 million is needed just to get caught up. The FY 08 M&I funding level of $52.9 million is grossly insufficient to sustain the facilities. It fell far short of the estimated $120 million needed to address the backlog.

Failing to maintain existing facilities will only hasten the need for new construction. Health programs with existing facilities have tremendous and growing maintenance and improvement needs especially those with older facilities. We recommend that the Maintenance and Improvement appropriation be substantially increased to sustain existing facilities and to address the $371 million backlog of maintenance and improvement issues.

D. Village Built Clinic Lease Program

The Village Built Clinic (VBC) Lease Program funds rent, utilities, insurance, janitorial, and maintenance costs of healthcare facilities in rural Alaska communities.[8] Despite an increase in the number and size of clinics throughout Alaska as well as the rapidly increasing fuel costs, funding for the VBC Lease Program has barely increased since 1996. Village clinics have also incurred more costs in recent years due to increases in the scope and level of medical services provided, expanded village healthcare programming, new technology, and accreditation standards. Current lease funding covers only approximately 55% of the current operating costs and those costs are expected to continue to increase sharply as energy costs continue to skyrocket in rural Alaska.

Without additional funding for the VBC Lease Program, Alaska villages are forced to subsidize the day-to-day operating costs of their clinics and defer long term maintenance and improvement projects. Therefore, without an increase in funding to the VBC Lease Program, village clinics will be increasingly forced to reduce clinic operations, and these clinics will continue to fall into disrepair. This situation reduces the health care available locally to village residents and threatens the almost 200-million-dollar investment in these facilities by the federal government, Alaska villages, and the regional tribal health organizations in the Alaska Native health care system.

Thus, we recommend an increase of $5.8 million in funding for the VBC Lease Program to the current program base of the VBC Lease Program. These funds are required immediately to sustain the program, covering the expected operating costs in FY 09 as well as establishing funding for long-term maintenance and improvement. Without this funding, many of Alaska's

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[8] Reprinted from The Village Built Clinic Programs: Village Clinics in Crisis, Alaska Native Health Board, May 2007.

villages will not be able to continue supporting local clinics, eventually leading to serious consequences for the health and safety of Alaska Native people.

V. Impact of the Lack of Funding for Facilities & Facility Operational Needs

The biggest impact of inadequate facilities is decreased access to care, which in turn exacerbates health disparities. While we have provided a snapshot of the unmet primary health care needs, we would be remiss if we did not highlight for the Committee the lack of other types of facilities like Long-Term Care, Skilled Nursing and assisted living facilities, residential alcohol and substance abuse facilities, and our huge unmet sanitation facilities needs.

Most AI/ANs do not have access to Long-Term Care services, including skilled nursing and assisted living services. For example, in the Alaska Tribal Health System which has a relatively comprehensive range of services, there are currently no assisted living facilities and only one long term care skilled nursing facility. Public health measures, such as childhood vaccinations and improved sanitation in rural Alaska, have increased the life expectancy of Alaska Natives and we are now living longer than we ever have. From 1950 to 1997, Alaska Native life expectancy rose from 46 years of age to 68 years of age.[9] As our population is aging, there are no facilities to provide desperately needed community-based health care. For instance, if I were an elder living in Bethel, Alaska, and my family could not provide the medical care I needed at home, I would have to be sent to a nursing home in Anchorage, hundreds of miles and hundreds of dollars away from my family, community, and culture in order to get the care I need. Our elders make the daily choice to forego this care because such a separation is unconscionable in our communities. Unfortunately this situation occurs throughout the Indian health system because there are only a handful of long term care facilities to meet this need.

Many AI/ANs still do not have access to behavioral health services despite the clear need. An integrated health system requires availability of qualified and trained behavioral health providers in every community. Prevention and treatment approaches to behavioral health must be provided in a seamless integrated fashion, use best and promising practices; and they must start at the community level. The full implementation of this vision is only possible with resources that ensure services are available in the right place and the right time to prevent escalation of the need for more intensive and costly services.

Specifically, there is an overwhelming shortage of residential alcohol and substance abuse facilities for AI/AN throughout the country. Without sufficient facilities to meet this need people continue to be turned away at the door of existing residential treatment programs or wait listed for extended periods of time at the crucial moment in their addiction where they acknowledge they have a problem and are seeking help. Unfortunately, the current reality is that AI/ANs who need residential alcohol and substance abuse services, can expect to wait 6 months to a year for services. For many, treatment is simply not available. The consequences are profound. Again, to use Alaska as an example, 1 in 11 Alaska Native deaths is alcohol-induced;[10] Alcohol contributed to 85% of reported domestic violence cases and 80% of reported

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[9] Status of Alaska Natives Report, Institute of Social and Economic Research, 2004.
[10] Alaska Bureau of Vital Statistics.

sexual assault cases between 2000-2003;[11] and, Suicide among Alaska Natives remained steadily at 2 times the non-Native rate from 1992-2000.[12] Many AI/ANs still do not have access to behavioral health services facilities despite the overwhelming need. An integrated and modern health system requires not only the services but the facilities in which to provide those services.

Inadequate sanitation continues to plague much of Indian Country and is especially problematic in Alaska where 26% of Alaska Native homes lack adequate water and wastewater facilities. It is 2008 and, despite the fact that we know that people live longer, healthier lives in communities with water and sewage systems, there are over 6,000 homes in rural Alaska without safe drinking water and about 14,000 homes that require upgrades or improvements to their water, sewer, or solid waste systems to meet minimum sanitation standards. Increased sanitation facilities will improve these statistics and the health of these communities, as well as contribute to increasing the Alaska Native life expectancy, as discussed previously.

Funding for these services have been sorely lacking even though we know that improvements in these areas can result in significant improvements in health status. For example, infants in communities without adequate sanitation facilities are 11 times more likely to be hospitalized for respiratory infections and 5 times more likely to be hospitalized for skin infections when compared to all U.S. infants.[13]

In addition, the lack of facilities also increases costs to other IHS budget line items. For example, tribes who are served in an IHS area in which there is no hospital to refer patients to are become dependent on Contract Health Services (CHS) resources and pay private facilities premium rates for care that is too often culturally insensitive. The CHS line item is already substantially under-funded without adding facilities inadequacies into the equation. In order to provide necessary patient care, IHS and Tribal providers are forced into "robbing Peter to pay Paul" in life and death situations. We also know that when facility needs are not adequately funded, these funds necessarily come out of direct patient care dollars especially when life-safety issues are involved, like the replacement of medical equipment. Chronic under-funding of the IHS facilities line items contributes to the lack of adequate facilities, the overburdening of the other budget line items, and rationed health care on a systemic level.

VI. Efforts to Update the Healthcare Facilities Construction Priority System

In FY 2000, Congress recognized the significant and growing unmet facility needs, and directed the IHS to consult with Tribes and the Administration to revise the Healthcare Facilities Construction Priority System (HFCPS). Congress highlighted the need "to reexamine the current system for construction of health facilities" and to develop "a more flexible and responsive program…that will more readily accommodate the wide variances in tribal needs and capabilities."[14]

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[11] Status of Alaska Natives Report, Institute of Social and Economic Research, 2004.
[12] Alaska Bureau of Vital Statistics.
[13] Impacts of Water and Sewer Service on the Health of Infants, American Journal of Public Health, In Press, May, 2008.
[14] Conference Report, HR 2466, FY00 Interior Appropriations, Congressional Record – October 20, 1999.

Over the course of 8 years, the IHS, working with tribal leaders, undertook a major overhaul of the facilities priority system. Although the resulting proposal is a vast improvement over the current process, it has not yet been implemented by the IHS. We describe the planning process and resulting system below. We recommend that Congress direct the IHS to implement this new system and that Congress provide additional appropriations to ensure the new system is fully effective.

In early 2001, the Facility Appropriations Advisory Board (FAAB)[15] established an IHS Facility Needs Assessment and Priority Criteria Workgroup (Workgroup) to develop specific recommendations to improve the IHS construction priority system. The Workgroup, comprised of 19 tribal leaders, health directors, planners, urban health directors and regional tribal associations, worked on specific recommendations regarding:

- Criteria to be used for establishing and annually reviewing the need for facilities construction need in Indian Country;
- Criteria (and their relative weight) to prioritize competing projects of the same type; and
- Strategies for prioritizing needs of different construction programs (inpatient facilities; outpatient facilities; dental units program; Joint Venture Program; Small Ambulatory Program; the proposed Loan Guarantee Program; etc.).

The Workgroup's recommendations, IHS Facility Needs Assessment and Priority Criteria Recommendations, were forwarded to the FAAB and to the IHS in February, 2002 and became the foundation for the final recommendation for the new priority system.[16]

The FAAB spent the next two and a half years refining the Workgroup's recommendations. Extensive tribal consultation began in June 2004 when the IHS sent out a "Dear Tribal Leader" letter in June 2004 with a draft copy of the FAAB priority system proposal. The IHS received 80 responses from 11 IHS Areas containing over 1200 total comments. The FAAB spent the next two years incorporating comments and working with IHS and tribal leaders on the final recommendation. The final recommendation was forwarded to the U.S. Department of Health & Human Services in November, 2007.

VII. The New Healthcare Facilities Construction Priority System

The new Healthcare Facilities Construction Priority System (HFCPS) is more robust than the current system in that it is very orderly and uses reliable data. It is also based on the master plan concept which ensures that service needs of the local population are used for facility planning. It also provides for a tremendous amount of tribal involvement throughout all phases of the process. Among the highlights are the development of a Master Planning process that recognizes the needs of smaller communities, and an Area Distribution Program.

[15] The 14 member FAAB is comprised of a tribal representative of each of the 12 IHS Areas plus 2 IHS members.
[16] IHS Facilities Needs Assessment and Prioritization Criteria Workgroup Report on Findings and Recommendations, February, 2002.

A. Area Health Services and Facilities Master Plan (Area Master Plan)

The Master Planning process is central to the new priority system. Using the IHS "Health System Planning" (HSP) software/model, the services and facilities required in individual service areas are determined nation-wide. Based upon these community-specific or service area specific HSP analyses, a community specific Master Plan would be generated to quantify the costs associated with the potential construction of expanded, replaced or new facilities.

From there, these data can then be integrated at the Area level to produce a State-wide Health Services and Facilities Master Plan. A Master Plan will help establish relative priority within an Area for construction and development of new services and support decision-making consistent with the Area-wide service delivery system, which in turn, will provide the basis for an integrated Area-wide Master Plan.

The key to this approach to master planning is facility planning and construction decisions will be based on accurate factual information about the system-wide health service needs in each Service Unit and Area. As the area wide service delivery plan is developed decisions will be made about where and how each service will be provided. Then, the discussion will move on to deciding what the facility need is and how best to meet the need. Effectively, tribes engage in an analysis of whether renovation and expansion of an existing facility or whether construction of a new facility is warranted and what will best serve their population's needs.

B. HFCPS Ranking Methodology

Once the facility requirements of each area have been identified in the Area Master Plans, these projects will then be scored according to the HFCPS. The HFCPS ranking is implemented in two phases. Phase I is designed to assess all of the facility needs through the creation of the Comprehensive National Listing of Facility Need (Unmet Needs List). Phase II is designed to further refine the application and allow innovative solutions to be applied to the scoring criteria. This two-phased process allows the IHS and the Tribes to use limited resources to both identify all of the facility needs (phase I), and to allocate the necessary time and resources for concentrating analysis on those facilities that have the opportunity to move forward to receive full funding within 5 years.

1. Process Overview

In Phase I, all health care facilities in IHS Area Healthcare Services and Facilities Master Plans are evaluated and scored by IHS Headquarters using a HFCPS formula. Facilities on this list are categorized according whether they are an inpatient hospital, health center, small clinic, or other health facility, ranked and compiled into the "Comprehensive National Listing of Facility Need."

In Phase II, facilities selected from the Comprehensive National Listing of Facility Need are reviewed by the HFCPS Validation Committee.[17] The IHS will apply the HFCPS Phase II Formula to data about these proposed facilities to develop the Priority List. Facilities are selected from the Comprehensive National Listing of Facility Need. The method for selecting facilities for Phase II review differs based on the requirements of the specific facilities construction funding program.

Six evaluation factors are employed to evaluate and score facility projects over two phases. The evaluation criteria are:

	Phase I	Phase II
• Facility Resources Deficiency	400 points	400 points
• Health Status	200 points	200 points
• Isolation	100 points	100 points
• Barriers to Care		50 points
• Facility Size	150 points	150 points
• Innovation		100 points
Total	850 points	1000 points

2. Implementation of Phase I

Implementation of Phase I should take approximately 6 months. Phase I scores will be recalculated every five years to maintain a relatively up-to-date Comprehensive National Listing of Facility Need. All Area Health Services and Facilities Master Plans will be updated 24 months before Phase I is recalculated.

The data required for completion of Phase I are:

- User population from the IHS National Patient Information Reporting System;
- Existing facility size, age, and condition from the IHS Facility Data System;
- The following indicators from the Federal Disparity Index (FDI):
  - The Birth Disparities Indicator,
  - The FDI Percent of the population over 55 years old,
  - The Composite Poverty Indicator, and
  - The Disease Disparity Indicator
- The distance from the proposed facility to the nearest emergency room.
- The size of the new/expanded facility from the Area Master Plan

Validation of the data used is obtained from existing IHS databases or will be verified by qualified professionals, e.g., certified professional engineers, architects, etc.

[17] The Healthcare Facilities Validation Committee is a standing committee consisting of seven individuals appointed by the Director of IHS. Membership may include but not be limited to IHS Headquarters and Area Offices, Tribal, and other health oriented professionals.

3. Implementation of Phase II

The entire Phase II process should take approximately 1 year to complete. Phase II of the HFCPS will be recalculated every year that funding is available for one or more facilities construction program to assure an up to date list of high priority projects.

The Phase II list will reflect the changes in funding status of each project. The criteria for Phase II will be implemented and applied slightly differently for each of the congressionally authorized facilities construction programs.[18] The basic formula will remain the same, but other factors, identified in law and regulations, will be used to select projects for Phase II review. Data for the scoring is developed from the approved Program Justification Document (PJD).

For Validation purposes, each PJD is approved by the Director, Office of Environmental Health and Engineering. The HFCPS Validation Committee will review the documentation supporting Innovation and Barriers to Service proposals along with any Tribal facilities information that is not included in the Facility Data System (FDS).

The IHS applies the HFCPS formula to the approved and validated data. Finally, facilities under consideration, are prioritized according to their scores and placed on the Priority List in rank order.

Clearly the new process is based on more reliable data and improved needs based planning. It also allows greater tribal involvement throughout all phases of the process. We applaud the FAAB and the IHS on the development of the new model and implore them to implement it expeditiously. It is one more example of the opportunities in innovation that arise when the IHS and tribes work collaboratively in addressing our facilities needs. However, in order for the new system to be successful more resources are necessary. To realize the full potential of the new facilities priority system, and we urge Congress to provide such funding.

Conclusion

For those of you who deal with the size and complexities of a variety of appropriation needs a regular basis, the improvements we seek here may seem inconsequential. That could not be farther from the truth. As American Indians and Alaska Natives, we are a people with painful legacies of forced removal – to boarding schools, to cities, to faraway hospitals – and rampaging epidemics that disrupted families for generations. Despite this, we still have very strong ties to our communities.

We know from experience, that as resources get tighter, individual AI/ANs and the IHS facilities that provide their care will feel the impact more than any other. Why? The highest rates of unemployment are in Indian Country. We have some of the lowest income levels; some

[18] These programs include the line-item program authorized under Section 301 of the Indian Health Care Improvement Act (IHCIA), Public Law (P.L) 93-437; the Small Ambulatory Program, authorized under Section 316; the Joint Venture Program authorized under Section 818, etc.; and projects considered under the Area Distribution Program within each Area.

of the poorest health status; and we are primarily rural where access to care is a problem. There is a high cost of providing care, and a high cost of living where limited incomes get stretched even more. What this means is that, when our people do finally get the care they need, they have traveled farther with money they simply don't have, are sicker than the average person, and are seen in clinics/hospitals that have fewer resources than most other facilities in the country. Also, because of their rural nature, our facilities have a higher cost of providing care.

As one of the younger members of my Tribe, with the privilege and opportunity to work in our health programs, it is my duty to try to overcome this history and to assure that no AI/AN will have to make the choice to forego medical care due to a lack of facilities or to receive culturally insensitive care because we are buying care from others that we can provide for ourselves. It is my duty to be sure that we protect the health status improvements that have been made and that we accomplish more. We must leave a better health system for our children and grandchildren than we inherited. It is for that reason that I am here today to testify before you.

The strategies we are discussing today will authorize many important steps toward the goal of quality health care in our home communities and in ways that respond to our needs and respect our way of life. I know that we cannot knock down all of these barriers overnight, but these recommendations will make a significant improvement.

In closing, I want to thank the Committee again for all your work and leadership in addressing these critical issues.