

S. HRG. 114-522

**IMPROVING ACCOUNTABILITY AND QUALITY OF
CARE AT THE INDIAN HEALTH SERVICE
THROUGH S. 2953**

FIELD HEARING

BEFORE THE

COMMITTEE ON INDIAN AFFAIRS

UNITED STATES SENATE

ONE HUNDRED FOURTEENTH CONGRESS

SECOND SESSION

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FRIDAY, JUNE 17, 2016

U.S. SENATE,
COMMITTEE ON INDIAN AFFAIRS,
Rapid City, SD.

The Committee met, pursuant to notice, at 10:30 a.m. in the Central High School Auditorium, Hon. John Barrasso, Chairman of the Committee, presiding.

[Opening prayer, by Robert Flying Hawk spoken in Lakota.]

OPENING STATEMENT OF HON. JOHN BARRASSO, U.S. SENATOR FROM WYOMING

The CHAIRMAN. Well, good morning, everyone, and welcome to this oversight legislative hearing on improving accountability and quality of care at the Indian Health Service, and we have a piece of legislation to do that. I'm John Barrasso. I'm a physician from Wyoming. I'm also the United States Senator from Wyoming and Chairman of the Senate Indian Affairs Committee, and I'm delighted to be here with Senator Thune, Senator Rounds, and Congresswoman Noem, who have worked tirelessly on this effort and I'm so happy that you've all joined us today.

The first order of business this morning is to recognize the tribal leaders here today. I'd like to thank all of them for your continued leadership and your dedication to making your people stronger and healthier. The progress we've made so far is a direct result of your hard work and the feedback, and I greatly appreciate the important role you've played in this entire process.

So I look forward to working with each and every one of you to improve the legislation that's before us today and to move it forward for the betterment of Indian health in this region and for the entire country.

Now, I know our work isn't finished, and I'd also like to thank, obviously, the congressional delegation of South Dakota for its significant dedication to Indian health and providing us with a warm welcome here in Rapid City today. And, of course, we want to thank our friends here at Central High School for hosting us.

Today the Committee is basically examining one specific piece of legislation called S. 2953, the Indian Health Service Accountability Act.

So let me just stop there and ask if you or your family relies on the Indian Health Service for medical care, please stand.

[Members of the audience stood.]

This is why we are here today. This is why we're here today. For everyone standing, for all of the IHS patients, we must get this right. We cannot accept failure or complacency, and, as a doctor, I know that quality health care is about putting the patient first. This is the mentality we need to see at every level of the Indian Health Service, and I thank each and every one of you for being here today.

So on May 19th Senator Thune and I introduced a piece of legislation, S. 2953, the Indian Health Service Accountability Act. Senator Rounds is also a cosponsor. Congresswoman Noem is also working on similar legislation in the House.

This Committee held an oversight hearing, a listening session, on February 3rd. We examined what we saw as substandard quality of Indian health care in the Great Plains Area. Many of you were part of that hearing, the listening session we held in Washington D.C.

What was clear from listening to each and every one of you was the tremendous amount of pain and frustration that you have had with the Indian Health Service. You shared many tragic stories, tragic events with the Committee that day, and the sad reality is that many of these problems were identified, that we identified earlier this past year, were also identified in 2010 when Senator Dorgan from North Dakota was chairman of the Committee and he did his report. So some of these problems I believe have gotten worse, new issues have developed over time, and, as you all recall his words, the services provided by the Indian Health Service as malpractice, and I stand by those words.

As a physician for more than 20 years I know this can only be rectified by significant improvements in delivering medicine, accountability, transparency and compassion for patients. And I see people on the panel shaking their head yes. So the bill that Senator Thune and I introduced does just that.

This bill, the Indian Health Service Accountability Act, is the critical first step on the road to reform because it targets the issues we believe are at the core of the dysfunction of the Indian Health Service. It will lay a sound foundation for the Indian Health Service to actually deliver the health care that tribal members need and deserve.

Now before going any further, I want to emphasize that this bill will basically bring together what we've heard from you, the problems that you say are there and the solutions that you've all shared as ways to fix them. All the provisions in this Indian Health Service Accountability Act are tied directly to the feedback that we have already received from you. So this bill is really a series of solutions designed to solve specific problems.

For example, the Indian Health Service Accountability Act will provide expanded removal and disciplinary authority for the Indian Health Service to ensure that it has all the tools it needs to address problem employees. This expanded authority enhances accountability and transparency within the Indian Health Service to better reporting mechanisms and increased compliance. We've also

heard the Indian tribes describe a lack of basic tribal consultation. We heard it then and we heard it this morning in our listening session. We heard it yesterday. This legislation will increase consultation between the Indian Health Service and tribes and require this consultation be meaningful and timely. It would also ensure that the basic budget and spending information is available to the tribe. We heard about that this morning. And also available to Congress so the Indian Health Service funds are spent on patient care instead of union settlements that you brought up today.

To address severe staffing shortfalls, this legislation would enhance the Indian Health Service's ability to recruit and retain qualified employees by offering more incentives to work in Indian country. The bill will also reward employees who deliver quality care and innovative ideas to the tribal communities that they serve.

The bill includes a number of provisions that will help determine housing needs and staffing needs in the agency so that we are all in a position to make informed decisions about what resources are needed and how they should be spent.

The Indian Health Service Accountability Act will increase patient safety through quality measures and monitoring, and requires regular oversight by other Health and Human Services agencies. Among other things, it would help ensure that cases don't fall through the cracks by requiring HHS's Inspector General to investigate suspect patient deaths.

This bill will also help ensure that Indian Health Service employees who see something wrong feel comfortable coming forward to report problems. Increasing accountability and transparency will help ensure the problems are resolved rather than repeated and covered up. That's what we need to do to improve patient safety and quality of care.

So this legislation of the Indian Health Service Accountability Act is a step in the right direction. Too many lives have been lost that could have been saved, and it's my hope the administration listens and responds to testimony today so that one day these tribes can trust and again seek services from a well-functioning Indian Health Service hospital in all areas of the country.

So the feedback we receive today will help the Indian Health Service Accountability Act and will make it stronger before we consider it in our Committee in Washington.

I would also like have it known the Human Services Deputy Secretary, Mary Wakefield, made the trip to South Dakota. Dr. Wakefield, I know you had a scheduling conflict earlier and you cleared the calendar so you could be here to attend the hearing today and I'm grateful you've done that.

So I appreciate your attention to this important matter, and thank you for coming here to testify, but also I want to take a break from me talking and turn this over to Senator Thune for an opening statement.

Senator Thune.

**STATEMENT OF HON. JOHN THUNE,
U.S. SENATOR FROM SOUTH DAKOTA**

Senator THUNE. Well, thank you, Mr. Chairman, for holding this important hearing in South Dakota, and I want to speak out to the commission and those who are affected most by the Indian Health Services and those who are part of the communities. I also want to thank Chairman Barrasso, who has been terrific on these issues, and, as he mentioned, we had a hearing back in February. This is a follow-up hearing to that, but, most importantly, right here in South Dakota where we will hear directly from people who are impacted.

And it's nice having someone like Senator Barrasso chairing the Indian Affairs Committee as a neighbor of Wyoming so he understands our issues. He also, as he said, is a physician, an orthopedic surgeon, so those of us in our 50s who are always looking for medical advice in the Senate turn to him quite often. He doesn't do surgery—

The CHAIRMAN. Free advice.

Senator THUNE. Yes, that's right. That's the best type of advice.

He doesn't do surgeries in the cloak room, and a lot of times I'm told, take two aspirin.

But, anyway, it's great to have somebody with his background and expertise addressing issues to health care.

The reason that we're doing this, and, you know, we held, what I feel, was a very necessary oversight hearing back in February regarding the chronic failures of the IHS, failures that, frankly, are just unacceptable; and, you know, we heard some pretty stunning stories, and at that time I think you, Mr. Chairman, heard the same stories, and Senator Rounds participated in that hearing along with us heard, and you continued that oversight into an agency that seemingly just doesn't have accountability to anyone.

CMS's findings, as terrible and horrific as they were, brought forth evidence of reprehensible practices that were occurring at the Indian Health Service. Practices that did not match information that was provided to members of Congress, including myself. CMS's findings have, once again, provided a public window in these facilities to view the substandard care that's being delivered to our states by its citizens. The stories have been detailed time and again, and it's time to take action.

After these reports were released in the hearing in February, Chairman Barrasso and I immediately began to explore ways to reform the agency. The result of our efforts, combined with tribal input, culminated with the introduction of the IHS Accountability Act of 2016, which attempts to tackle this crisis from all sides.

Senator Rounds was very active in that process and is also a co-sponsor of the legislation. The legislation which we are here to discuss today increases accountability, improves hiring practices, enhances recruitment and retention, protects whistle-blowers, increases fiscal accountability and creates greater transparency of the agency.

In an effort to improve accountability, the legislation provides the Secretary of Health and Human Services with a streamlined ability to remove underperforming managers and executives. As I've said many times, leadership starts at the top, and if IHS lead-

ers are a barrier to delivering quality care, then they should look for another job, not simply be moved to a different area.

While we need strong leadership, it is also no secret that providing care in remote rural locations is difficult, which is why we have included provisions to streamline hiring demands and incentivize improvement of providers. One of the largest fears of change currently plaguing IHS is the lack of transparency. Unfortunately, IHS is simply unable to answer straightforward questions regarding funding allocations and outlays.

For example, the agency estimates that it spends \$50 million a year in the Great Plains Area on temporary, non-full-time staff. What the agency does not know is whether that number is accurate and how much it would save IHS if they were able to achieve permanent staffing, and full-time employees.

What's even more troubling is the question of where the agency is taking this money from in order to paper over this problem. This brings me to our bill's next point, fiscal transparency and long-term planning. Our legislation requires IHS to issue spending reports to tribes and to Congress and requires the agency to release a staffing plan. Creating a spending plan is essential to understanding exactly how IHS allocates funding, not only nationally, but within each area.

Last, and most importantly, we want to ensure increased tribal consultation when IHS hires senior staff. One of the major complaints that we hear constantly from tribes is the lack of meaningful consultation.

I hope to continue discussions regarding what meaningful consultation means to our tribal members and what we can do to improve it. While there's no doubt that more oversight is necessary and will be conducted, today's hearing allows us the opportunity to explore changes to this failing agency, and provides us with chance, with input from our clients, to change the status quo.

I'd like to acknowledge and thank the administration's willingness to work with us and to engage with us on these issues and look forward to continued collaboration.

I also want to thank, particularly, our tribal leaders, tribal representatives, and the individuals who reached out with their concerns and solutions for IHS. Your continued input and suggestions are still needed, and I am committed, along with the delegation, Senator Rounds and Congresswoman Noem and others who want to take on this battle with us to working with you to bring forth positive solutions.

So thank you, Mr. Chairman, for being here in South Dakota. Thank you for bringing the Indian Affairs Committee to this state and to giving intense focus to the issue, and, frankly, to something that has become and reached, I think, a crisis stage and desperately demands a solution. Thank you.

The CHAIRMAN. Thank you, Senator Thune, for your thoughtful leadership.

Senator Rounds.

**STATEMENT OF HON. MIKE ROUNDS,
U.S. SENATOR FROM SOUTH DAKOTA**

Senator ROUNDS. Thank you, Mr. Chairman. First, let me just say to the Chairman, I most certainly appreciate you taking the time to hold today's field hearing in South Dakota where our tribal members are all too familiar with the failures of the Indian Health Service. I'd also like to thank Senator Thune and Congresswoman Kristi Noem for their tireless work to address the problems plaguing IHS.

In South Dakota we know all too well of these ongoing problems. Nearly every week, if not every day, our newspaper headlines tell the tale of new problems. Let me just read you some of the headlines that we've seen in just the last month: IHS Hospital in Immediate Jeopardy; Feds Deal Blow to Rosebud IHS Hospital; Man Won't Return to, As He Quotes, Death Hospital; Tribal Leaders Say They Were Left Out of IHS Call For Help; Health Care Crisis Hits South Dakota Reservations.

I can spend my entire time reading headlines, but it's important to understand the impact that it's having on real people, our tribal members. The Great Plains Area IHS, which covers South Dakota, North Dakota, Nebraska, and Iowa, has the second highest mortality rate among all IHS regions. We also have the highest diabetes death rate. It's five times the U.S. average, almost double the average among all IHS regions. Our life expectancy rate is the lowest of all IHS regions at 68.1 years. Compare this to the U.S. average of 77.7 years.

It is clear the IHS is failing our tribal members who are suffering and even dying due to this inadequate and disgraceful care. As we all know, Rosebud has had its emergency department on diversion status for 195 days as of today, meaning tribal members are having to drive over 50 miles to receive emergency care. The same is true with their OB and surgical departments as well. These circumstances are going to continue to occur until we demand thorough review and reform of IHS. We need an independent audit.

I had the opportunity to deal with the Great Plains Tribal Chairman's Association in April. We discussed an in-depth analysis on IHS and my office researched in an attempt to seek answers and gain a better understanding. We talked about the administrative imbalance, that there are 15,000 employees at IHS, only 750 doctors, yet nearly 4,000 are administrative medical billers.

We also found that IHS employees and administrators can't explain or don't understand their own budget. After reviewing the data with me, the Great Plains Tribal Chairman voted on a resolution that supported an audit of the IHS. The IHS needs major reform. More taxpayer money won't solve the dysfunction because what IHS lacks is an efficient system and accountability.

Consider this: If the President proposed and Congress supported doubling the IHS budget, based on IHS's current template, they would have 20,000 administrative employees, 7,400 bureaucrats billing Medicaid, and still only 1500 doctors. The imbalance and priorities would still exist, just at a greater level.

From my standpoint, investing more taxpayer money in a dysfunctional system will only compound the problem. This is a seri-

ous issue that requires tangible solutions, not mandates. There are significant administrative management, financial management, and quality of care issues that must be addressed. Today's hearing will help us better understand where the problems lie and steps forward to fix these problems.

Once again, we need the audit. Ultimately, today's hearing is to fix the poor quality of health care for our people. IHS will never be able to deliver quality timely care the federal government has a trust responsibility to deliver without broad reforms.

I want to take this opportunity to thank Chairman Barrasso, Senator Thune, and Representative Noem for being here today, and also their ongoing work to address these issues. Thank you, Mr. Chairman.

The CHAIRMAN. Well, thank you, Senator Rounds, for your leadership and for your intense focus on this. We're very grateful.

Now Representative Noem.

**STATEMENT OF HON. KRISTI LYNN NOEM, U.S.
REPRESENTATIVE FROM SOUTH DAKOTA**

Congresswoman NOEM. Thank you, Chairman Barrasso, and the Committee, and I appreciate your input today and this opportunity to attend today's hearing. I'm a member of the House, and, obviously, this is a Senate Committee Hearing, so it is very humbling to be a part of this process and to be invited to join the group at the table today and listening to our testimony that we'll hear.

I also thank Senators Thune and Rounds for being great partners in having ongoing monitoring of HHS, IHS, CMS as we've gone through this crisis and over the years as we've dealt with this before, as well.

Thank you all for coming here to testify today. Mr. Bear Shield, you've been very candid with me and you always speak with great truthfulness, and I know that the words that you speak are factual and very helpful to me when I've been dealing with drafting legislation and hearing the testimony of your tribe. The frank analysis that you gave me is extremely helpful.

And, Dr. Wakefield, I do appreciate you making this a priority. It certainly is for all of us here at the table, and the fact that you came here today means a lot.

Ms. Stabler, Ms. Blue Shield, Ms. Bohlen, thank you, as well, for coming. It's just wonderful. And, Ms. Smith, thank you for being here, as well. I wasn't quite sure that you'd make it, and I'm glad that you have. It means the world to me that you recognize how important this is.

And I'm grateful that we're all here today to shed some light on the ongoing tribal health care crisis that we have going on in South Dakota, but, frankly, throughout Great Plains regions with tribes that include Nebraska, as well. We need comprehensive reform, and, frankly, I'm just going to put it very simply, I believe that IHS should get out of the hospital business. I think they're terrible at it. I don't think they know what they're doing.

[Audience applause.]

I believe this for two different reasons. First, as everyone in this room is aware, the medical care that we receive at IHS in the Great Plains region is like getting health care in a third-world

country. The mismanagement of fiscal stability that is lacking in the area and the agency have just completely eliminated my confidence in the agency.

We found that the agency is devoid of transparency and openness. We found it keeps patients and tribal leaders in the dark. It's extremely discouraging to me and it's incredibly difficult to get answers to the simplest questions.

For example, IHS told us that it needs more people. We asked them how many employees the IHS needs and were told by the agency that it has no way of finding out this information. How do you make a request without knowing what you're requesting?

And if you're a tribal leader, timely and accurate information is even harder to come by. To give one recent example, IHS notified Great Plains Tribal Leadership of an important conference call regarding the contracting problem by attending a Microsoft Outlook meeting invitation 1 hour before the call was to begin.

Now we all describe the term "tribal consultation" differently, but I tell you that is certainly not it.

On my most recent visit down to the Rosebud hospital, which was just a couple weeks ago, every single conversation that I had, those people are sick and tired of the decades of corruption, the mismanagement, and the life-threatening care provided by Indian Health Services. They're done with the bureaucratic mess, and that they are tired of watching underperforming employees risk their lives of brothers and sisters and family.

Enough is enough, and that's what we're here to talk about today. What do we do when enough is enough? For years IHS has been asked to make improvements. Congress has increased the agency's funding nearly every year that I've been in office, and yet the situation is as bad as it's been. And let me be very clear, I do believe that Native American health care is underfunded, but I also believe that money is not going to fix the broken management system that we have in the Great Plains region. So let's talk about solutions.

I thank the Chairman and the Senators for introducing the IHS Accountability Act in the Senate. Like the bill that I introduced in the House, this legislation attacks serious personnel problems that are flooding IHS, including the agency's hiring, firing, and disciplinary practices. It also includes many incentives for improvement and retention of high-quality employees.

My bipartisan Health Act that I've introduced in the House has many sponsors on it already. We'll be having a hearing in the coming weeks, but it also takes a similar approach, but I also added something that is a third rail of delivering high-quality health care to people in Indian country. It's the Purchase/Referred program, and we've already talked about that today when we had some questions from tribal leaders. Don't get sick after June has become a common phrase in Indian country. And it's because purchase referred care program runs out of money in June every year, and after that the only way that you're going to get any kind of treatment or care is if you're dying or losing a limb in Indian country. It's unacceptable. It's jeopardized tribal members' lives, personal well-being, as well as their financial health.

The reforms in my bill ensures that funding is fairly distributed among tribal communities and ensures that South Dakotans can get the care that they need.

So, Mr. Chairman, I am encouraged by the fact that we've already got broad agreement between the House and the Senate on solutions that remediates these problems. I'm looking forward to working with you and my delegation colleagues in the House, Natural Resources Committee, the Energy and Commerce Committee, Ways and Means Committee in uniting to approach this and unite to find a solution so we can put it on the President's desk. And that's what I fully intend to do is to get solutions signed into law so we can fix this problem. I yield back and I want to thank you again for allowing me to participate today.

The CHAIRMAN. Thank you, Congresswoman Noem. Ladies and Gentlemen, there are 100 United States Senators. You've got three of us here. There are 435 members in the House of Representatives and I will tell you, people of South Dakota, you are looking at somebody who shows incredible leadership and a very forceful voice in the House of Representatives. Thank you very much, Congresswoman Noem.

Now our witnesses. We are going to start with Mary Wakefield, who is also a Ph.D., but also a registered nurse. She's the acting Deputy Secretary of the U.S. Department of Health and Human Services from Washington D.C. I just want to remind all witnesses that your full written testimony will be made part of the hearing record, so we want to please keep your statements to 5 minutes or less so that we may have time for questioning.

And I look forward to hearing your testimony. Let's us start with you.

**STATEMENT OF MARY WAKEFIELD, PH.D., R.N., ACTING
DEPUTY SECRETARY, U.S. DEPARTMENT OF HEALTH AND
HUMAN SERVICES; ACCOMPANIED BY MARY SMITH,
PRINCIPAL DEPUTY DIRECTOR, INDIAN HEALTH SERVICE**

Dr. WAKEFIELD. Thank you very much, Mr. Chairman, Senator Thune, Senator Rounds, Congresswoman Noem. Thank you for the opportunity to participate in today's very important hearing on the IHS Accountability Act of 2016.

I wanted to say at the outset of this hearing that we, in the administration, certainly share the goals reflected in your legislation. Your focus on accountability, strengthening the workforce, and improving the quality of our native communities that we serve are extremely important and we share those goals. Each goal that's reflected in your bill is important, as we confront acute and chronic problems like those that we are facing right now in some of our facilities here in the Great Plains Area, which are, in no small part, due to the product of longstanding issues.

Today, under our current leadership, it is not business as usual at Indian Health Service, and with support from the Department of Health and Human Services we are doing critically important work on moving aggressively to strengthen the delivery of quality care at IHS facilities long term, while at the same time working to address immediate short-term needs.

Four months ago Secretary Burwell created the Executive Council on Quality Care, and she asked me to lead this effort. I come from the Great Plains. I'm from North Dakota, which I say softly here in the Great State of South Dakota. But I have some firsthand knowledge of the challenges facing Indian Country, and I view the responsibilities the secretary gave me as incredibly important and as an opportunity to make meaningful and needed changes.

The council, the executive council, includes some of HHS's top management and program experts, and together we are taking a deep look at longstanding obstacles like workforce retention, providing housing, care quality, and even the organization structure of the IHS, itself. With executive council engagement and support, IHS is applying a five-part strategy to create lasting change.

First, we're focusing on surfacing problems and addressing them as quickly as we can with the resources that we have. One effort underway is IHS's system-wide survey initiative that includes all of its direct service hospitals.

Second, we are focused on strengthening health care services to patients and communities. Recruiting and retaining health care providers is one of our biggest challenges. In the short-term we have already deployed more than two dozen U.S. Public Health Service Commissioned Corps clinicians to the Great Plains area. And right now, for example, we have the National Institute of Health helping IHS implement innovative nursing recruitment strategies.

In addition, I do want to mention today that it is through the work of the Executive Council that we have identified an additional approximately \$50 million in funding for Indian Health Service to help strengthen service delivery, the second goal over the long term. About 30 million of those dollars will support much-needed projects right here in South Dakota. This funding will be applied to some of the biggest needs, such as construction for provider housing. Lack of housing is a longstanding obstacle to recruiting and retaining staff.

IHS will also be able to purchase equipment to make much needed IT upgrades, including to enhance hospital telehealth in historically hard to access specialties.

As part of a long-term strategy we are working to find new ways to recruit and train more individuals with connections to the communities that IHS serves, and also connecting those with demonstrated commitment to service.

For example, we're now recruiting committed U.S. clinicians to the Peace Corps, as well as a Global Health Services program. It's a new initiative.

Third, we're focused on strengthening area management through a number of strategies, from improving recruitment efforts for area directors to IHS's recently announced consultation around the organization and structure of the Great Plains Area office.

Fourth, we are infusing substantial quality expertise into the IHS system. IHS has joined with CMS supported hospital engagement network which shares approaches that we know improve care quality. Going forward CMS is in the process of contracting this fall for the first quality improvement organization that will focus exclusively on strengthening quality of care within IHS hospitals.

And, fifth, we're working to collaborate with local resources. Local communities are valuable sources of expertise and collaboration. We plan to work with leaders from tribal colleges to other academic institutions, as well as regional health providers to further develop health care workers and services.

We also know that the health of communities is tied to the health of the local economy, and that's why we're committed to doing what we can to advance the success of small businesses in the tribal communities. I've asked our HHS Department Office of Small and Disadvantaged Business working in cooperation with the U.S. Small Business Administration to coordinate technical assistance events for small businesses that are owned by Native American Indian Tribes and the native community at large. One of these is planned to occur here in South Dakota.

As I mentioned, we know the health of our community is tied to the health of our local economy.

IHS and all of HHS are committed to working hard to make meaningful and measurable progress. We've taken significant steps since the last hearing, and there is much more work ahead, including intense work ongoing now to strengthen and stabilize the hospitals in South Dakota and Nebraska.

We look forward to addressing these challenges and making meaningful progress in partnership with you and the tribal leadership. Thank you.

[The prepared statement of Ms. Wakefield follows:]

PREPARED STATEMENT OF MARY WAKEFIELD, PH.D., R.N., ACTING DEPUTY SECRETARY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; ACCOMPANIED BY MARY SMITH, PRINCIPAL DEPUTY DIRECTOR, INDIAN HEALTH SERVICE

Introduction

Good morning. Chairman Barrasso and Members of the Committee, thank you for the invitation to join you today here in Rapid City, South Dakota and to testify on S. 2953, the IHS Accountability Act of 2016. We would like to start by thanking you and Senator Thune for your leadership on the Committee and for elevating the importance of delivering quality care through the Indian Health Service. This Committee, IHS, and HHS share a common goal of providing consistent, quality health care to the American Indian and Alaska Native communities we serve. The Administration has concerns with some provisions in S. 2953 as drafted and looks forward to working with the Committee to improve the bill as it moves through the legislative process.

Earlier this year, we strengthened and refocused our resources within the Department as part of an aggressive strategy to improve the overall quality of care in the Great Plains Area, and across the country. HHS and IHS are working to instill a culture of quality care and accountability across the agency. We are committed to hearing directly from you and the communities we serve to focus sharply on how to best improve access to quality health care and most importantly improve the health status of American Indian and Alaska Native families and communities.

To be clear, the acute problems we are seeing right now are largely tied to chronic, longstanding issues, often spanning decades. Recognizing that, the focus of our work this year is to move aggressively to develop both systemic changes even while we're addressing immediate, short-term needs. We have significant efforts underway on both fronts.

With new leadership at IHS, we are not accepting business as usual. IHS's Principal Deputy Director, Mary Smith, has made it crystal clear that change is the new status quo at IHS. And the leadership at HHS is reinforcing and amplifying that message. Under her leadership, IHS is changing the way it approaches long-standing challenges. IHS is working to reengineer its human resources, create an organizational structure that supports sustained improvement and accountability, and is focused on strengthening its financial management infrastructure.

To ensure that dependable, quality care is delivered consistently across IHS facilities, three months ago, Secretary Burwell created the Executive Council on Quality Care and asked Acting Deputy Secretary Wakefield to lead it. This council includes senior executives from across HHS and thus draws on expertise from across the Department. We have some of HHS's top managers, clinicians, and program experts taking a fresh look at long-standing obstacles like workforce supply, housing, challenges to delivering quality of care, and addressing key operations issues. The council ensures that we are leveraging all the resources we can on behalf of American Indian families and communities.

Through the work of this Council, in tandem with IHS, for the past two months, we have been engaging our work through a five-prong strategy to address these challenges—many of the same obstacles like sufficient workforce, personnel issues, and care quality, that your legislation seeks to address. With this strategy, IHS and the Department are working to (1) surface existing problems so that we can work to resolve them; (2) improve service delivery; (3) strengthen IHS Area management; (4) infuse quality expertise; and (5) engage with local resources.

Surfacing Problems

First, we are assessing and surfacing problems so that we can work to resolve them. We are taking a very close look at the quality of care delivered through direct service hospitals at IHS facilities across the Great Plains Area as well as throughout across Indian Country. We want to affirm and support facilities that are delivering quality care and work closely with facilities that need improvement. It is important that IHS leadership from headquarters to Area offices work closely with both tribal leadership and direct service hospitals in a transparent way that encourages open information exchange about improvement opportunities. We know from decades of experience across the health care continuum, that problems that are not acknowledged and fixed put even more patients at risk. For the past 20 years, health care systems across the nation have been embracing new models of improvement, and it is that orientation that we are working to further strengthen with in IHS through the assets of IHS and other divisions in HHS.

For example, IHS is beginning a system-wide mock survey initiative at all 27 of its hospitals to assess compliance with CMS Conditions of Participation and readiness for re-accreditation. These mock surveys will be conducted by survey teams from outside each respective Area to reduce potential bias. The new mock survey initiative is being coordinated through the IHS Quality Consortium as a unified effort to reinforce standardization of processes. We are beginning in the Great Plains Area with assessments and, when appropriate, interventions through the provision of on-site assistance to hospital staff. Although some direct service hospitals currently conduct self-assessments, IHS is standardizing and improving this process so that all Direct Service hospitals receive an assessment within the next three months and performance data tracked, not just at individual facilities but across all facilities.

Through this and other targeted strategies, IHS will move from being reactive to proactive in identifying and addressing performance issues early. Our first efforts were piloted May 10, 2016, at the Rosebud Hospital and we will continue to do quality surveys at all direct service hospitals, excluding those that have been surveyed in the past year or are scheduled to be formally surveyed through other mechanisms during this timeframe. When our survey teams identify problems, we will work swiftly to address these local problems and work to put systems changes in place to resolve the problems. Additionally, best practices that are identified will be shared across IHS facilities.

Another example of surfacing and addressing problems is IHS' enhanced drug testing interim policy. This policy was released on June 6th and focuses on drug testing based on reasonable suspicion, and expands the HHS drug testing policy that already applies to IHS employees. The interim policy provides guidance to supervisors and managers on drug testing based on a reasonable suspicion of drug use. This effort was informed by tribal leaders' calls for additional IHS administrative actions in this area.

Improve Service Delivery

Second, we are working to improve service delivery by focusing on workforce and clinical support infrastructure.

Workforce

The IHS continues to face significant workforce challenges with a chronic shortage of health care providers. While we have immediate steps to address some local shortages and are in the process of adding more, such as telemedicine, these long-standing challenges require building up and expanding the training and deployment

pipelines and full use of innovative approaches to delivering care. In the near-term, with Secretary Burwell, Deputy Secretary Wakefield, and the U.S. Surgeon General's support, over two dozen Commissioned Corps clinicians have been deployed for temporary placements into the Great Plains hospitals with CMS findings. In addition, NIH has been helping IHS deploy strategies it has used to recruit nurses into its clinical program. These include providing new recruitment language and accessing web-based resumes of South Dakota nurses for the IHS, as well as using new web-based places to advertise. IHS is also revising position descriptions and deploying more comprehensive recruitment plans around key positions, in an effort to recruit a greater number of qualified candidates. IHS is also deploying Title 38 pay increases for high-demand clinicians and has established eligibility for payment of relocation expenses for GS-12 and lower graded clinical positions. However, even with these and a number of other strategies that have been deployed during the past two months or that are in development right now, there is still much more work that needs to be done to attract and retain an adequate health care workforce. Some of these changes will require legislative action. In addition, we are working with OPM, OMB, and other affected agencies to explore ways to enhance our current flexibilities. We are also combining efforts that leverage collaboration between tribal, public, and private academic institutions.

One of the most challenging areas to support is the availability of emergency services, particularly in the Great Plains Area. Because of this, on May 17, 2016, IHS initiated a new strategy through a contract award to provide both emergency department staffing and operations support and management services at three hospitals: Rosebud Hospital and Pine Ridge Hospital in South Dakota and Omaha Winnebago Hospital in Nebraska. This will provide health care in these hospital emergency rooms while IHS reviews the administrative and clinical operations of its facilities across the region to develop long-term solutions. IHS's leadership both in the hospitals and at headquarters have direct oversight of this contractor and is responsible for holding this contractor accountable for providing consistent quality health care. However, because this is a new approach to Emergency Department staffing and management combined, a team of clinicians and attorneys, as well as the CEOs of the facilities, are tracking this initiative weekly to ensure that performance expectations are met.

As part of a longer term strategy, we are reexamining the scholarship and loan repayments program to make sure that we are maximizing their impact and we are introducing other new strategies as well. We are working with the Peace Corps' Global Health Services program that fields clinicians to areas of critical workforce needs and most immediately, we are building communication channels about service to Indian Country to 60 returning volunteers. By the end of this month for example, 60 returning volunteers will be learning about opportunities to work in direct service IHS hospitals even as we are engaging other longer term communication strategies with the broader Global Health Services program. Additionally, the U.S. Public Health Service Commissioned Corps has prioritized new officers to IHS with a particular focus on the Great Plains Area.

On a related front, on June 1st, IHS proposed to expand its community health aide program and is slated to engage consultation with tribal leaders over the next months on this expanded effort. This important proposed change would bring more health workers directly into American Indian and Alaska Native communities.

Infrastructure

In addition to addressing workforce challenges, the IHS is trying to lessen the loads on our emergency departments by establishing alternative avenues of care, such as urgent care clinics and telehealth services. IHS is working aggressively to reopen the Rosebud Emergency Department as soon as it is safe for the patients. In the meantime, in order to fill the temporary gap, the IHS has re-purposed existing ambulatory care space into an Urgent Care clinic staffed with emergency department and ambulatory providers. Given the types of illnesses that individuals present with to the Rosebud Emergency Department, the Urgent Care clinic can manage the majority of these non-emergent care needs.

Specialty services like behavioral health, cardiology, and diabetes care can be difficult to find in rural areas. IHS will also be using telehealth contracts to bring specialty services into the communities where individuals live so they do not need to travel. IHS issued a Telemedicine Request for Proposal on May 5, 2016. Proposals were originally due June 6, 2016; however, at the request of prospective bidders for more time to prepare comprehensive proposals, IHS extended the deadline to respond by 30 days.

Strengthening Area Management

Third, we are working to strengthen area management. While we support the workforce at each hospital, we are also taking a broader view to strengthen Great Plains Area management through the temporary deployment of high-quality managers from within other areas of IHS as well as deploying HHS experts to both IHS headquarters and the field to assist with finance, contracting, and management functions. IHS also established a Human Resources (HR) Steering Committee, which provides oversight and guidance on the implementation of system-wide HR improvements in IHS.

As part of these efforts, Rear Admiral Kevin Meeks spent three months leading the Area Office. Captain Christopher Buchanan joined the Great Plains Area leadership team in May and is serving as the Acting Director of the Great Plains Area Office. Captain Buchanan has extensive expertise working with complex health systems which are IHS directly-operated facilities as well as tribally-managed programs assumed under the authority of the Indian Self-Determination and Education Assistance Act. In the longer term, the IHS is actively looking to find the best possible candidate for the Great Plains Area Director position. We revised technical qualification requirements for the position description in order to attract a broader pool of well qualified candidates. We have also implemented a stronger search committee process for recruiting highly qualified managers and executives. This committee is charged with candidate outreach, assessment, and vetting. IHS is also more widely advertising vacancies through federal, state, and non-profit partners, and is actively seeking additional venues to help attract a broad and diverse applicant pool. Additionally, going forward, we have expanded tribal participation in filling vacant Area Director positions and members of a tribe from each area will, for the first time, play a role in these search committees at the outset of the hiring process on these key positions.

Finally, IHS recently announced conducting a 90-day consultation with Tribal leaders to discuss the organization and operation of the Great Plains Area Office, to, in partnership with the Tribes, identify new approaches to better support patients and tribal community health in the Area.

Infusing Quality Expertise

Fourth, we are infusing substantial quality expertise into informing and improving care quality in direct service facilities. In partnership with CMS, we have launched a Hospital Engagement Network (HEN) to provide evidence-based efforts in quality improvement. As we announced on May 13, 2016, the Premier HEN is now available to all IHS direct service facilities and focuses on quality improvement methods intended to reduce avoidable readmissions and hospital acquired conditions (e.g. central line blood infections, pressure ulcers, falls, etc.). Hospitals in the network share successful practices and lessons learned to accelerate learning and change. The HEN will prioritize working with the three Great Plains Area hospitals and is currently working with each hospital to schedule onsite meetings.

Additionally, we are bringing in targeted quality improvement assistance through CMS' Quality Improvement Organization (QIO) infrastructure (QIO). Among other support and training functions, QIOs assist with root cause analysis of identified problems, assists with the development of improvement plans, establish baseline data, and monitor data to ensure improvement plans are successful and improvements are sustained over time. Also through Secretary Burwell's Executive Council on Quality Care, HHS is deploying quality experts, as needed, from throughout the Department to consult with and help our IHS direct service hospitals that are currently out of compliance with CMS Conditions of Participation and to monitor progress as the facilities come into compliance.

Engaging Local Resources

And fifth, we aim to engage more robustly with local resources. We know that, in addition to our strong partnerships with Tribes and their leadership, local academic and health systems organizations can be valuable sources of expertise and partnership. We intend to strengthen our relationships with local and regional health care systems, local colleges and universities and tribal colleges, direct service hospital leadership and tribal leadership to build stronger academic pipelines and health care connections to ensure we are working collaboratively and effectively to produce health related workers and health care services.

We also recognize that the health of communities is tied to the economic health of communities. Rates of unemployment and poverty matter. Consequently we are committed to advancing the success of small businesses in tribal communities. The Department's Office of Small and Disadvantaged Business Utilization, in collaboration with the U.S. Small Business Administration, is working to coordinate meetings

with tribal leaders and small businesses owned by Native Americans, Indian Tribes, and the Native American community at large.

Our team plans to have these meetings in or near the 12 Indian Health Service Area Offices and the events will focus on how to effectively pursue contract opportunities with HHS, IHS, and other Federal Agencies.

Strengthening IHS

We have been working to address challenges using new approaches on our end. First, we appreciate the authority we already have to use the pay flexibilities under chapter 74 of title 38. We are working with OPM, OMB, and other affected agencies to explore ways to enhance our current authorities to provide more tools to recruit and retain high quality staff.

Second, we are seeking tax treatment, similar to the treatment provided to recipients of National Health Service Corps (NHSC) and Armed Forces Health Professions scholarships. Currently, IHS loan repayment/scholarship awards are taxable, reducing their value. In contrast, participants in the NHSC scholarship program and Armed Forces Health Professions may exclude scholarship amounts used for qualifying expenses from income, and participants in the NHSC loan program may exclude any loan amounts repaid on their behalf from income. We recommend adopting the Administration's Fiscal Year 2017 Budget proposal which would conform the tax treatment of IHS repayments/scholarships to the tax treatment for NHSC and Armed Forces Health Professions repayments/scholarships.

Third, the Indian Health Care Improvement Act requires employees who receive IHS scholarships or loan repayments to provide clinical services on a full-time basis. However, the Affordable Care Act permits certain NHSC loan repayment and scholarship recipients to satisfy their service obligations through half-time clinical practice for double the amount of time or, for NHSC loan repayment recipients, to accept half the loan repayment award amount in exchange for a two-year service obligation. We would like similar flexibility.

Being able to access resources is key to amplifying our work. It is critically important that we receive the funding the President requested in his Fiscal Year (FY) 2017 Budget, which includes: an increase of \$159 million above FY 2016 to fund medical inflation, pay costs, and accommodate population growth for direct health care services; an increase of \$20 million for health information technology to fund the development, modernization, and enhancement of IHS' critical health information technology systems; \$2 million to create a new program which will focus on reducing medical errors that adversely affect patients; and \$12 million specifically for staff quarters at current facilities, in addition to staff quarters associated with new facilities.

Conclusion

Our entire Department is committed to making meaningful and measurable progress in the way that IHS delivers care. While the Administration has concerns about this bill, we look forward to working with the Committee to improve it as it moves through the legislative process. Thank you, and we are happy to take your questions.

The CHAIRMAN. Thanks so much for your testimony. I appreciate you being here and making the trip. Thank you.

Let me just now turn to the honorable William Bear Shield, who is the Chairman of the Rosebud Sioux Tribal Health Board of South Dakota.

STATEMENT OF HON. WILLIAM BEAR SHIELD, CHAIRMAN, ROSEBUD SIOUX TRIBAL HEALTH BOARD

Mr. BEAR SHIELD. Good morning. Thank you, Chairman Barrasso. Good morning, Senator Thune, Senator Rounds, Representative Noem. Thank you for the kind words.

First of all, I want to say [phrase in Lakota.] Welcome to the Hesapa Senate Indian Affairs Committee. It is the home of the great Sioux nation; Mount Rushmore; and, more importantly, Crazy Horse monument, which is our fierce warrior.

As Chairman Barrasso has said, I'm also a member of the Rosebud Sioux Tribe. I serve as our chairman of our health board com-

mittee there. I'm also the chairman of Unified Tribal Health Board here for people that utilize Sioux San Hospital. I'm also vice chairman of the Great Plains Tribal Chairman's Health Board here.

As you're aware, Rosebud IHS hospital has been the subject to multiple CMS findings that have left our hospital without emergency rooms since December 15, 2015 resulting in a CMS notification to terminate the hospital's provider agreement effective March 16, 2016, and as recently as this past week we learned that our tribal members who need surgical and health care services are now required to be diverted to other facilities.

I would like to thank you for your commitment and your actions in assisting the Rosebud Sioux Tribe, and not only other tribes of the Great Plains to address these issues. Many of you visited Rosebud and have shown a sincere interest in finding a solution, and we can only do that working as a team.

We believe in the IHS Accountability Act, along with Senator Rounds calling for an internal audit, and Representative Noem's bill to accept tribes from the ACA employer mandate are important steps towards improving health care for Indian people in the Great Plains.

The IHS Accountability Act of 2016 calls for fiscal accountability. We ask that the legislation includes a prohibition of the IHS from using the third-party revenue to settle any types of litigation.

Recently IHS used over \$900,000 of Rosebud IHS third-party billing to pay a national labor claims settlement. Additionally, we ask this Committee's support and of the Great Plains tribes' requests to IHS for a comprehensive budget of the area office, including tribal shares so that the Great Plains tribes, with the assistance of the Great Plains Tribal Chairman's Health Board can begin developing an alternative model to the area office.

We also believe that fiscal accountability must include adequate funding to ensure success. The Rosebud Sioux Tribe is currently teamed with capable health care management to pursue the sole source contracting of the Rosebud Indian Health management positions. However, when we informed IHS headquarters of this intent, we were told that the tribe could not sole source the proposed contract. When, in fact, didn't they do the same thing when they awarded the contract for the ED?

We ask this Committee to recognize that Rosebud and other tribes that want to assume programs right now are working under a handicap because the funding stream from third party have been disrupted and the costs have gone due to increased efforts to assume compliance.

Furthermore, we also need meaningful and productive consultation, which is currently absent.

We ask that Congress support and encourage tribal assumptions by creating a pool of funds to offset these challenges immediately so that the tribes do not have to use its own resources to overcome the deficits IHS causes.

Funding will also be needed to support increased recruitment and retention. They should also be able to have the tribes utilize and assume IHS programs since they are affected. We are aware that there is no changing the past, but we hope that the proposed legislation supported by adequate funding, we can all move forward

in a positive way to provide quality health care as our ancestors envisioned upon signing of our treaties.

Thank you again for your efforts on behalf of the Rosebud Sioux tribe and other tribes of the Great Plains. We look forward to continuing participation and partnership to drive these changes forward.

The CHAIRMAN. Thank you for your testimony and sharing that with us.

We're next going to turn to Wehnona Stabler, who's the Tribal Health Director from the Omaha Tribe of Nebraska.

STATEMENT OF WEHNONA STABLER, CEO, CARL T. CURTIS HEALTH AND EDUCATION CENTER, OMAHA TRIBE OF NEBRASKA

Ms. STABLER. Yes, good morning. I'd like to say thank you to my Tribal Council this morning that has accompanied me, and my nephew who said a little prayer this morning. I want to thank him.

I'm not here representing the council, though. I'm here representing the many patients that suffer, and one recently who has died. A 40-year-old that went to the Omaha Winnebago hospital, 9 miles up the road. We were promised in the treaty that's provided, and she went in and she was a diabetic. It was clearly recorded. Nobody ever checked her blood sugar. Sent her home, next day she came in with 1,500 and she died.

So in February when I testified, I wanted to relay the suffering; and yesterday I had to cry at the end of the day. It was one after the other after the other. And so, this morning I wanted to have the right words to say to you, but it's very difficult because these are people that I know. These are relatives that I'm going to watch these children grow up without a mother. Her daughter just graduated from high school. I almost sent it to all the IHS people, you should have seen what she wrote. I'm not sharing this with my mother, and it was a simple finger stick. And they're spending \$6 million to buy a central monitoring system for our ER's, but if the people aren't there to push the buttons and to do the readings, this is what's happening today still in our hospitals.

And I left the Indian Health Service after 31 years because I could not be a part. I could not be a part of a system that was failing my people. And I see this every day. And we're trying our best, and I have to thank CMS for doing their job. It seemed like they were trying to go around the systems. They were trying to figure out ways to not comply, instead of just giving us what we deserve and what we've already paid for, and what has been promised to the Omahas by the treaty.

We have five treaties with the government. We are the indigenous tribe there. We've always been a very peaceful tribe on the river, never declared the government as an enemy, but I am right now doing that because I've been in this battle for a long time, and we're losing it. We're losing it.

And the reality is they want the tribes to take it over, but the Omahas have done this for 38 years. We have a public law 93-638 contract. We've done everything except ER and inpatient care. Those are the two services, ER and inpatient care, that we rely on IHS for and they've failed us miserably.

So I do thank CMS for doing their job. And it is not a mission impossible, you know. I run three hospitals for IHS and numerous clinics when I was at the Pine Ridge service unit recently, like three and a half years ago we removed the immediate jeopardy. But it takes a CEO that will go into the ER. And I had a new area director tell me in February CEO's should not have to go into the emergency room.

I'm sorry. That was a necessity for me to do that to make sure those contract doctors, which are still in our ER's, give our patients the care they deserve. Nurses won't do it. Other staff won't do it. Doctors won't listen to people.

Doctor, you know we were sent a dentist when we were failing. A dentist from Pine Ridge as our medical officer.

You, as an orthopedic surgeon, know that there's no board certified ER doc that's going to listen to a dentist. That is the reality, but yet they argued with me every meeting and said it was legal. But we don't care if it's legal. We want the right thing to be done for us.

So today I'm here representing those people that have not had a voice, or just take that care and never say anything. Sit all day and wait in those hospitals for care, and then sent home with Motrin. Those are the people that I'm here for today.

And I have to say that this is a start, that you are building a beginning. Because you know what? When you asked that question, I stood up; chairman stood up; Ardell stood up; but none of the IHS people stood up. They don't get their care from IHS.

As a CEO, that's the first thing I did, I made a chart. I thought if I'm going to be the CEO of this hospital or clinic, I need to get my care here. I need to be satisfied. If I go there, then I know what's happening in that facility. And I expect the best for the patients that I serve.

This is why I'm sitting here today. I'm from Nebraska, and I don't have a representative at this table, so I'm depending on this Senate Committee investigation to move our voices forward. The bill is great. It's a start. There are some missing pieces, though, and I would just like to ask you to consider, including telemedicine, because the states are trying to figure out how to bill and how to set things up. But telemedicine would be an answer to these remote areas, and we would have access to board certified ER physician if we had telemedicine, rather than mid-level contractors or mid-level M.D.'s that they're contractors for a reason, you know. Otherwise they'd be in full-time positions somewhere. They all have their quirks.

Also, quarters, even though we've given up our quarters at Omaha Winnebago hospital, we need them to recruit. Consider funding that. So that's a part of your bill, but broaden it for the ones that have given up their quarters. Give us a second chance to rethink that for recruitment efforts.

We need authorities like the V.A. has, two-year funding. And president Steele talked about that this morning. We're still suffering from the shutdowns. We shouldn't have been shut down. We shouldn't have been included in that. All these things that the V.A.—we're the first Americans and they're our veterans and we have high, high rates, and there's veterans still in my tribe and so,

oftentimes, I send them to the V.A. because, unfortunately, they get better care there. That should not be the case. Our vets and us should be on the same playing field, I believe all the authorities that the VA has, we should too.

So what's the next step? I think the audit, because we need to know where our money is. We don't know. They don't share that information with us. There is no transparency when you start talking about funding. Those old accounts, those old discretionaries, where are they? We see things that the money is allocated, but they're not even in existence, so we know there's money available.

So the audit would be the next step, and then include us throughout these processes. The tribes have been left out. We're the patients. We're the stakeholders. Include us through the whole. So I think that would be the next step.

And then I'm going to start to close my comments, but I have to say I have to put it back on Congress, if Congress would fund us at 100 percent. We're only funded at 50, 40, 30 percent. You can go to any facility, they don't have 100 percent funding.

[Applause.]

Thank you.

This is why we're having to deal with CMS. If we were funded at 100 percent, you know, we would not have to do third-party billing. But, again, I thank CMS for being here and keeping us accountable for patient care issues. But fund us at 100 percent and uphold our treaty rights. I ask HHS and IHS, please uphold our treaty rights.

[Applause.]

Keep us, the patients, at the center of all your decisions and actions. Keep us in mind. We're real people.

Yesterday the man could barely stand. Did you see him? He was sweating and he just got out of the hospital, but he felt so strongly. He stood there for almost 20 minutes at the podium relaying his barriers and all the things that went wrong with his care. And I thought for sure he was going to pass out, but that's the kind of passion, and I think I even have PTSD from running three hospitals for a little bit. This is why we get so passionate, and if we cry and we carry on it's because we have that inside us, you know. We give up a lot for this. We're just asking. And so I thank you all for the opportunity today and may God be with you.

[The prepared statement of Ms. Stabler follows:]

PREPARED STATEMENT OF WEHNONA STABLER, CEO, CARL T. CURTIS HEALTH AND
EDUCATION CENTER, OMAHA TRIBE OF NEBRASKA

Good morning esteemed members of the Senate Select Committee on Indian Affairs. My name is Wehnona Stabler and I am the Chief Executive Officer of the Omaha Tribe of Nebraska's Carl T. Curtis Health Center and an enrolled member of the Omaha Tribe.

We operate Indian Health Service (IHS) programs, which are crucial to our tribal members. In addition to providing needed services, these programs offer sorely needed employment for both Indian and non-Indians. These programs are offered 365 days a year using federal funds and our limited tribal income, with very little assistance from the State of Nebraska. Current and past IHS funding has never met our full basic needs and that leads me into my initial, general comments about the matter at hand.

I understand that the IHS Accountability Act does not include more funding for our troubled facilities in the Great Plains Region. But it should. In sum, for too long, faced with federal shortfalls, IHS has leaned on the states and CMS to fund its op-

erations. And while I appreciate the intent of the Accountability Act—and will speak to its provisions—I believe Congress needs to be held accountable too. So let's not stop here.

Turning to the Accountability Act, I will begin with Section 3, regarding removal of IHS employees based on performance or misconduct. As a former employee of IHS, I personally welcome—and my Tribe welcomes—this language that fast tracks IHS' authority to fire or demote underperforming employees while also not allowing an individual transferred to a general schedule position or a reduction in pay grade to be placed on administrative or paid leave unless they're performing a primary or alternative primary duty. However, I submit that for the sake of transparency, Notice of the Personnel Action and of the results of employee appeals should also be submitted to the Tribes within the respective IHS service area.

Section 4 concerns improvements in hiring practices. Here, the proposed direct hiring authority is welcome, so too, are the provisions requiring tribal consultation. However, with regard to the required GAO report relating to staffing needs, I note the report to be submitted by the Comptroller General includes an assessment of the use of independent contractors instead of full time equivalent employees, yet lacks any required analysis of the fiscal impact of such use of independent contractors. In my experience, the expense of hiring independent contractors is far more than use of FTE. Accordingly, such analysis should be included.

Moreover, based on experience with the Omaha-Winnebago Hospital, I have concerns regarding what I will call the "recycling" of the independent contractors. For example, "AB Staffing" recently entered into a contract with IHS to run the Emergency Department at the Omaha-Winnebago Hospital. This is the same company that was at the helm when the hospital was terminated by CMS. In fact, their role has been expanded to include nursing. Why bring back a company that was part of the problem?

Section 5 regards Incentives for Recruitment and Retention. My comments concern the requirement that the GAO provide a report on IHS professional housing needs and the housing plan to be submitted by the Secretary based on that report. The draft bill proposes that the GAO has up to a year to provide the report and up to another year for the housing plan to be submitted to Congress. Given that Congress may take another year—if not years—to act, I suggest the respective reports should have a deadline of six months; that is, the report by IHS is due within six months of the passage of the bill and the subsequent report to Congress should be due within six months of the GAO report.

Next, I turn to Section 9: Fiscal Accountability. Section 9 (c) calls for status reports to be provided by the Secretary each quarter of a fiscal year describing the expenditures, outlays, transfers, reprogramming, obligations, and other spending of each level of the Service, including the headquarters, each Area office, each Service unit, and each facility to governmental entities, including tribes. I suggest this report should include a report detailing when, how, and for what purposes funds were diverted from one service unit to another. For example, additional funds were diverted to the hospitals with CMS issues in the amount of \$60 million: O/W Hospital, Pine Ridge and Rosebud. But instead of consulting with the Tribes, IHS decided to purchase a Central Monitoring Unit for the Emergency Departments at each hospital. The question the Omaha's have is "Will this machine do finger sticks?" and the answer is "NO". We ask that question because we had a 40-year-old Diabetic die and no one ever checked her blood sugar. We do not need new gadgets if we have no qualified staff to operate them; we need permanent Board Certified, compassionate providers and staff to take care of us. The O/W Hospital is all we have.

Finally, Section 10 addresses Transparency and Accountability for Patient Safety. This section requires the Secretary to post surveys, reports and other CMS materials relating to patient safety on websites of IHS operated hospitals and clinics. Section 10 (b) makes CMS responsible for conducting surveys at least every two years to assess the compliance of each hospital or skilled nursing facility of IHS and publish the results on the same websites. The Omaha Tribe strongly suggests that CMS should further be responsible for immediately publishing to those websites any citations issued by CMS to an IHS facility stating that the facility is in "Immediate Jeopardy".

Thank you for allowing me this time to speak. The Omaha Tribe will continue to stand ready to improve IHS as a partner to see the Quality of Care finally realized.

The CHAIRMAN. Thank you so much, Ms. Stabler. You started by saying that yesterday, as we were listening, that you hoped you

would be able to find your words, and I think we all agree that you have most certainly found your words.

Next we're going to hear from Ms. Ardell Blueshield, who's the Tribal Health Director from the Spirit Lake Tribal Health in North Dakota.

**STATEMENT OF ARDELL BLUESHIELD, HEALTH DIRECTOR,
SPIRIT LAKE TRIBE**

Ms. BLUESHIELD. Good morning, Mr. Chairman, and members of the Committee. I am honored to be here today to discuss the Spirit Lake Tribe's recent assumption of the Spirit Lake Health Center in Fort Totten, North Dakota from Indian Health Service.

We are proud to be the first tribe in the Great Plains Area area to exercise our self-governance rights to provide for our people's health care. In response to patient concerns and after conducting a patient survey and numerous community meetings, the tribe decided, in 2015, to assume operation of the Spirit Lake Health Center. The tribe and IHS concluded negotiations in early May, and the compact and funding agreement became effective June 1st of this year.

I want to add that the complaints that we received, the responses of them were long waiting times, they wanted more providers, there was no patient transportation, and they wanted more services at the clinic. But it fell on deaf ears.

So the council, the Tribal Council, and the people were tired of it, so they wanted to do this. They wanted to take the health care into their own hands. For a smooth transition, the tribe offered IHS employees the option to continue to work at the health center under the interpersonal agreements with IHS, and 48 IHS employees are detailed to the health center under these agreements.

The tribe hired a chief executive officer and is working hard to fill the 24 vacancies inherited from IHS. The tribe is actively recruiting, including a job fair held just this week. The tribe's goal is to have a single integrated system of care for its tribal citizens using the flexibility of self-governance to tailor health programs to address the specific needs of our communities. The tribe has only begun its journey over its health care and its future, but it is excited about the opportunities and promise afforded by self-governance to improve health care for its people.

The tribe would like to express its gratitude to Indian Health Service in the Area Office, and the Office of Tribal Self-Governance for their technical assistance and cooperation as the tribe gathered information and negotiated the agreement. The tribe looks forward to a collaborative relationship for the future to provide the highest quality health care for our people. We deserve it. We deserve everything that everybody else has.

I offer a few reflections based on the tribe's experience to date. The Spirit Lake Tribe found a tribal survey to be a useful tool to learn about patient experiences at the Spirit Lake Health Center. The Tribe intends to continue the use of surveys in order to evaluate the health care programs and services that it provides. We recommend that IHS increase its use of surveys.

The tribe also recommends that IHS expand its efforts to interact with tribal government of the communities which it serves through

regular meetings, consultations, and a tribal liaison function at the service unit level.

At the time when we took it over, that we have that and it needs to be stronger in all Indian Country. The provisions in Section 4 of S. 2953 requiring consultation with affected tribes regarding certain IHS personnel decisions are consistent with this recommendation and the tribe's experience. Enhanced communication between IHS and tribal government will improve accountability, IHS responsiveness to local needs, and the quality of care.

The tribe also believes that Section 5, provisions for incentives for improvement and retention of IHS employees would be beneficial.

The reasons for the tribe's decision to assume the Spirit Lake Health Center includes the tribe's greater ability, compared with IHS, to develop packages of compensation and other employment terms to attract and retain quality medical providers and other staff. Section 5 appears to improve IHS's flexibility in this regard as well.

I thank the Committee for inviting me to give testimony this morning today. Thank you.

[The prepared statement of Ms. Blueshield follows:]

PREPARED STATEMENT OF ARDELL BLUESHIELD, HEALTH DIRECTOR, SPIRIT LAKE TRIBE

Chairman Barraso, Vice-Chairman Tester and Members of the Committee,

I am honored to be here today to discuss the Spirit Lake Tribe's recent assumption of the Spirit Lake Health Center in Fort Totten, North Dakota from Indian Health Service. On June 1 the Tribe assumed the Health Center under the self-governance provisions in Title V of the Indian Self-Determination and Education Assistance Act. We are proud to be the first Tribe in the Great Plains Area to enter into the Indian Health Service Tribal Self-Governance Program and to exercise our sovereign rights to provide for our people's health care under self-governance.

The people of the Spirit Lake Tribe are Dakota. The Spirit Lake Reservation is comprised of approximately 405 square miles in eastern North Dakota and has four districts: Mission District (St. Michaels), Woodlake District (Tokio), Fort Totten District, and Crowhill District. The total population of the Reservation is 4,238 of whom 3,794 are tribal members. The total tribal enrollment is 7,839. According to recent census data, the economic conditions on the Reservation are difficult, with per capita income totaling only 37 percent of the statewide average and 35 percent of the national average, and 47.8 percent of reservation residents and 57 percent of children on the reservation living below the poverty level. The Spirit Lake community faces a number of health care challenges, including a high rate of diabetes. A 2015 community assessment found health care needs were eight of the community's top ten needs, in particular behavioral health issues and chronic disease.

The Spirit Lake Health Center is an outpatient facility on the Spirit Lake Reservation with over 70 staff positions serving IHS beneficiaries. Until June 1 IHS operated the Health Center. In recent years the Tribe noticed an increase in dissatisfaction among patients of the Health Center. In early 2015 the Tribe began evaluating whether it should assume administration of the Health Center under the Indian Self-Determination and Education Assistance Act. The Tribe conducted numerous community meetings in 2015 and 2016 to receive input from tribal members about the care provided at the Health Center and to discuss possible tribal assumption of the Health Center. The Tribe developed a patient survey and circulated it among patients. The results of that survey confirmed dissatisfaction with customer service and the care provided at the Health Center. The survey results also reflected concerns about the number of physicians and other providers available at the Health Center to serve patients and limited patient transportation services. In addition to the patient complaints, the Tribe was concerned about the high vacancy rate among IHS staff of the Health Center.

For many years, the Spirit Lake Tribe has operated a number of health programs under Title I of the Indian Self-Determination and Education Assistance Act, includ-

ing programs addressing mental health, diabetes, women's health, alcohol and substance abuse, public health, community health, environmental health, and emergency medical services. Assuming the Health Center would facilitate integration of the Tribe's programs with care provided at the Health Center.

The IHS Office of Tribal Self-Governance confirmed that the Tribe was eligible for self-governance, and the Tribe determined to assume the Health Center. The Tribe and IHS concluded negotiations in early May 2016, the Compact and Funding Agreement for the Tribe's existing Title I programs and the assumption of the Health Center was approved later in the month, and they became effective June 1, 2016.

In order to ensure the smoothest possible transition, the Tribe offered the current IHS employees the option to continue to work at the Health Center under Intergovernmental Personnel Act agreements or Memoranda of Agreement (for Commissioned Corps officers). As a result, 48 IHS employees are detailed to the Health Center under such agreements. The Tribe has hired a Chief Executive Officer of the Health Center and is working hard to fill the 24 vacancies inherited from IHS. The Tribe is actively engaged in recruitment activities, including a job fair held just this week.

The Tribe's goal is to have a single integrated system of care for its tribal citizens. The Spirit Lake Tribe believes that it can use the flexibility of self-governance to redesign the health care programs and funding at the Spirit Lake Health Center in order to address the specific needs of our community and to be accountable to tribal citizens in a way that IHS cannot. The Tribe has only begun its journey to assume greater control over its health programs and its future, but it is excited about the opportunities and promise afforded by self-governance to improve health care for its people.

While it has not been easy, the Tribe would like to express its gratitude to Indian Health Service, in the Area Office and Headquarters, particularly the Office of Tribal Self-Governance, for their technical assistance and cooperation as the Tribe gathered information about the Health Center and negotiated the Compact and Funding Agreement. The Tribe looks forward to a collaborative relationship with IHS in the future to provide the highest quality health care for our people.

I offer a few reflections based on the Tribe's experience to date.

The Spirit Lake Tribe found the tribal survey to be a useful tool to learn about patient experiences at the Spirit Lake Health Center. The Tribe intends to continue to use surveys in order to evaluate the health care programs and services that it provides. We recommend that IHS increase its use of surveys.

The Tribe also recommends that IHS expand its efforts to interact with tribal government of the communities which it serves, through regular meetings, consultations and a tribal liaison function at the Service Unit level.

The Tribe is still reviewing S. 2953 and reserves the right to submit additional comments later. However, in light of the Tribe's experience, I offer comment on certain provisions. For example, Section 4 would provide that before appointing, hiring, promoting or transferring a candidate to a senior position or a management position in an Area office or Service unit, IHS must, except in certain emergencies, consult with affected Indian tribes. The Tribe believes that this provision would be an improvement as it would enhance information provided to tribal government about important personnel decisions affecting the health care program serving the tribal community. Such communication between IHS and the tribal government representing the patients whom IHS serves should improve accountability, IHS responsiveness to local needs and the quality of care. The Tribe recommends that the Committee and IHS continue to search for ways to incorporate tribal input into IHS decisionmaking.

The Tribe also believes that the provisions in Section 5 for incentives for recruitment and retention, including authority for granting or rescinding bonuses to promote patient safety, employee performance or for recruitment, performance-based retention bonuses, and reimbursement to employees of relocation costs, would be beneficial. The reasons for the Tribe's decision to assume the Spirit Lake Health Center include the Tribe's greater ability—compared with IHS—to develop packages of compensation and other employment terms to attract and retain quality medical providers and other staff. Section 5 appears like to improve IHS's flexibility in this regard as well. The Tribe is studying the proposed changes regarding the pay scale for IHS providers.

I thank the Committee for inviting me to give testimony today. I am available to answer questions.

The CHAIRMAN. And thank you very much, Ms. Blueshield.

Now we turn to Ms. Stacy Bohlen, who is the Executive Director of the National Indian Health Board in Washington D.C.

**STATEMENT OF STACY A. BOHLEN, EXECUTIVE DIRECTOR,
NATIONAL INDIAN HEALTH BOARD**

Ms. BOHLEN. Thank you, Mr. Chairman, and members of the Committee, and Congresswoman Noem. My native name is [spoke in Lakota.] and that name means turtle woman, and that name carries responsibility to speak the truth for all people, and it's with that being that I'm very honored to be here today on behalf of the National Indian Health Board. Thank you for inviting us to be here.

I'm a member of the Sault Sainte Marie Tribe Chippewa Indians from Michigan, but my father was born and raised here in Milbank and Crow, South Dakota. I spent most of my childhood here in South Dakota, so I have a strong-rooted affinity in my heart for the place and the people here.

The National Indian Health Board is a nonprofit organization. It serves all 567 federally-recognized tribes to provide policy analysis and advocacy for all of the tribes of this nation. It was founded by the tribes to serve as one voice affirming and empowering American Indian and Alaskan Native peoples, to protect and improve health, reduce health disparities, and ensure the Federal Government upholds its trust responsibilities for the health care of our people.

Unfortunately, we're all here today because of long-standing systemic issues within the Indian Health Service that have led to crises situation in the Great Plains, but other crises in other areas are on the cusp of showing themselves, as well, and it is from a national perspective that I believe that the NIHB was asked to be here.

Now that we are in a crisis situation, we believe there are two separate courses of action that must be taken. First and for most, immediate corrective action must be taken to rectify the closing and cutting off of IHS services so that there are no more unnecessary deaths of our people in this region or anywhere in this country. Once this crisis is stabilized, we must address the fundamental and systemic issues that have been occurring within the agency for decades. These reforms may start in the Great Plains; however, they must be implemented nationally so that all tribes and tribal citizens receiving their health care from IHS are assured safe, reliable, and quality health services.

The legislation proposed by Chairman Barrasso and Senator Thune, the Indian Health Service Accountability Act of 2016, is attempting to address long-standing tribal concerns and the move forward in attempt to improve the overall accountability and transparency of IHS. It is admirable and appreciated and necessary for staff. The spirit and intent of this legislation is clearly aimed at responding to the call of tribal leaders, patients, and families like all of those we heard yesterday and that we've heard down through the decades.

Many folks here have already testified about a variety of concerns included in the NIHB testimony, so if you don't mind, I'm

going to skip forward to a couple of things that I believe will add to the discussion.

First of all, we believe that structure reform of the agency is needed. There are unique challenges to delivering health care in any rural setting in the United States. These include provider shortages, isolation, long travel distances, scarcity of specialty care, and under-resourced infrastructure. However, there are successfully run rural health care systems operating all over the United States. A pressing need and opportunity exists within the Indian health and it's many rural, geographically isolated hospitals and clinics to reform the structure in administration oversight of the service units and the area to more reflect what's happening in the private sector.

Medicine is business. It is the business of medicine, and it works in many, many areas of this country. The examples are all around us of what is successful and what will work, and we, at NIHB, believe that IHS has the authority to innovate. There are dramatic efforts underway right now to reach for and achieve innovation and we encourage those to continue and be, perhaps, even more aggressive and more dramatic.

While one element that is absolutely necessary to such an aspiration is a dramatic increase in the funding that is currently held by the Indian Health Service; however, that is hand in hand with adopting standard and generally accepted business practices throughout the service, and NIHB too, believes that creating partnerships with mainstream and private entities will help IHS improve operations and systems, and, in fact, provide a learning laboratory for system-wide reform.

The National Rural Hospital Association, the American Hospital Association, and the many—wow, it really goes fast—sorry. That just took another 20 seconds off my time.

The CHAIRMAN. Go ahead.

Ms. BOHLEN. Thank you, Senator. Sorry. Now I'm having a hot flash. Jeez.

[Audience laughter.]

Okay. All right. let's get back to it.

Your bill, of course, mandates the Secretary of HHS to report each quarter of the fiscal year describing expenditures, outlays, transfers, programming obligations, and other spending at each level of the service to Congress, tribes and the IHS. It does not have substantive measures in place to ensure that the mismanagement of these resources does not continue.

And, to make it quick, we believe at NIHB that these quarterly reports should have a few measurable standards that are transparent to everyone. The tribes can see them, where is the money going, where is the third-party billing coming in, where is it going out, where is the federal expenditure of dollars taking place, and what is being achieved with that outlay; quality assurance and transparency.

Many reports attribute to deplorable quality of health care at IHS, to poor agency management at all levels. We know that the hiring decisions are often lengthy, and poor performing employees at both the service unit clinic, and hospital administration and headquarters are not terminated, but moved around or moved up.

We know that this needs to be reformed, because without patients there's no hospital. That was a quote from a tribal leader during a town hall that IHS held earlier this year. Without the patients, there's no hospital. So the patients become so disenchanting with the system that they just won't go there, which is already widespread. You don't have a hospital, you don't have a system. You have a whole lot of people waiting until they are so sick that of the top five services that people come in for, septicemia is one of them. Because you're so sick by the time you go for care that it's like very, very, very, very serious.

So I'm going to skip ahead to recruitment and retention of personnel. While we understand that it can be challenging to achieve this, we think that HHS has additional tools already at its disposal to do so. The proposed legislation at hand provides for improved incentives to recruit and retain a quality health care workforce. It begins to address setting competitive pay scales for IHS employees and so forth. But wouldn't it be something to imagine and possibly achieve in the housing shortages that we have to bring our doctors in.

For example, a mainstream company like Walgreen's, which resides at the "Corner of healthy and happy," to come forward, make it healthy and happy forgive me, as an example, what if we had the corner of healthy and happy at Pine Ridge and right in the middle of it the Walgreen's house of healing for doctors so that our tribes have a chance. That would be an interesting undertaking.

Finally, many policy makers do not realize that the system of the United States that we employ to train medical residents, as well as dentists and some nurses, is an entitlement program paid for through Medicare called Graduate Medical Education. The GME program exceeds \$15 billion annually. Congress capped the number of residency training positions in the United States as part of the Omnibus Budget Reconciliation Act of 1997. There's been some amendments since then to allow for more residency training; however, the limit never existed where there were never residency trainings or where they were trying to be built in a place that was medically underserved, that's Indian Country.

Medical specialties remain highly motivated to increase the number of residency training positions within their various colleges and academies. That creates partnership opportunity. A win/win would be the potential, perhaps, for increasing the number of physicians serving in Indian Country to set aside some of the residency training positions, create new ones that can only be filled by people who will commit to working in Indian Country when they finish.

I know you want to me to stop. I'm almost done. I swear. So let me finish.

Here's the deal, and, Chairman, you're aware, as obviously an orthopedic surgeon who went to school 700 years, maybe a few less, but it probably felt like 700.

So, the thing is, say a resident goes into family practice and it's a three-year internship, a three-year residency training program. The indirect medical costs, which is the majority of the money for that resident's training goes to the hospital. That would be a great thing for our facilities to have. You have ten residents, a hundred thousand dollars each, the indirect medical education comes into

our system per placement or training, but in this scenario we're increasing the number of residency training positions working with American Academy of Orthopedic Surgeons, College of OBGYN, pediatrics, emergency physicians, they all want their residency positions to increase. So they come and they have residents who fulfill these American Indian and Alaskan Native positions with the stipulation that if they don't serve the exact number of years in Indian Country, that that residency training consumed and was paid for by the American people, they get to pay that money back to the United States and the institution gets to pay it back to the United States. That's pretty highly incentivized to be successful. Nobody wants to pay that back.

So, sorry if I went a little over time. I'm past my time. There's words to be said by better people than me, so in close, thank you. [The prepared statement of Ms. Bohlen follows:]

PREPARED STATEMENT OF STACY A. BOHLEN, EXECUTIVE DIRECTOR, NATIONAL INDIAN HEALTH BOARD

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

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

Unfortunately, we are all here today because of longstanding, systemic issues within the IHS that have lead to crises situations in the Great Plains Area. In the last year, several hospitals in this region have lost, (or received threats of revocation) their ability to bill Centers of Medicare and Medicaid Services (CMS) due to the failure of federally run sites to comply with basic safety and regulatory procedures. As early as this week, an IHS facility, the Rosebud Hospital on the Rosebud Sioux Reservation here in South Dakota, closed their surgical and obstetrics care services division. Now, patients seeking surgical and obstetrics care must go to privately owned facilities over 40–50 miles away. This is unacceptable.

Many of the issues now coming to light are not new to American Indian and Alaska Natives that rely on the Indian Health Service as their primary source of health care and health information. At least five years ago then-Senator Dorgan released a report exposing the chronic mismanagement occurring at both the IHS regional

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

(Area office) level and the Headquarters level of the Agency. A 2011 report by a separate U.S. Department of Health and Human Services (HHS) task force specifically noted that: “. . .the lack of an agency-wide, systematic approach makes it virtually impossible to hold managers and staff accountable for performance and to correct problems before they reach crisis proportions.”

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

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

Federal Trust Responsibility

The federal trust responsibility for health is a sacred promise, grounded in law, which our ancestors made with the United States. In exchange for land and peaceful co-existence, American Indians and Alaska Natives were promised access to certain paybacks, including health care. Since the earliest days of the Republic, all branches of the federal government have acknowledged the nation’s obligations to the Tribes and the special trust relationship between the United States and American Indians and Alaska Natives. The Snyder Act of 1921 (25 USC 13) further affirmed this trust responsibility, as numerous other documents, pieces of legislation, and court cases have. As part of upholding its responsibility, the federal government created the Indian Health Service (IHS) and tasked the agency with providing health services to AI/ANs. Since its creation in 1955, IHS has worked to provide health care to Native people. As recently as 2010, when Congress renewed the Indian Health Care Improvement Act, it was legislatively affirmed that, “it is the policy of this Nation, to ensure the highest possible health status for Indians. . .and to provide all resources necessary to effect that policy.”²

Disparities

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

² Indian Health Care Improvement Act, § 103(2009).

³ *Ibid*, p 5.

Tribal communities, suicide rates are nearly 50 percent higher in American Indian and Alaska Natives compared to non-Hispanic whites.

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

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

Structural Reform

There are unique challenges to delivering health care in any rural area, including provider shortages, isolation, long travel distances, scarcity of specialty care, and under-resourced infrastructure. However, there are successful rural health systems operating all around the country that are able to deliver especially innovative and locally responsive and coordinated care. A pressing need and opportunity exists within the Indian Health Service, and its many rural, geographically isolated hospitals and clinics, to reform the structure in administrative oversight of the Service Units and Service Area offices. We believe that rather than reinventing a health system out of whole cloth, or reform around the edges of a system desperately in need of dramatic and deep reforms, IHS should aspire to achieve parity with mainstream, successful medical and health systems. One element absolutely necessary to such an aspiration is dramatic increases in the current funding levels of the Indian Health Service; however, adopting standard and generally accepted business practices is also necessary. NIHB believes that creating partnerships with mainstream and private entities will help IHS improve operations and systems and perhaps provide a learning laboratory for system-wide reform. The Rural Hospital Association and the American Hospital Association are just two places to examine for potential collaboration and learning.

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

Quality Assurance

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

So, in addition to the staffing and accountability provisions included in the newly proposed legislation we are discussing here today, attention must also be directed at improving the quality of care provided at federally run IHS facilities. This can be done by strengthening agency-wide standards for hiring quality and qualified individuals who are capable of fulfilling the role as expected; for example, hiring a qualified Hospital Administrator to run a hospital or clinic and implementing quality and performance improvement measures from the top down. Quality would also be furthered through implementing and nurturing a culture and practice of Continuous Quality Improvement, management and supervisory training and setting performance benchmarks that are reviewed twice-yearly. If employees are not performing, generally accepted management practices and principals must be in place, respected and consistently upheld. Creating and sustaining a culture where quality and compassion are expected from all IHS employees is an absolute must.

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

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

Recruiting and Retention of Personnel

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

The proposed legislation at hand, provides for improved incentives to recruit and retain a quality health care workforce. It begins to address setting competitive pay scales for IHS employees that would be comparable to other physicians, dentists,

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

Many policymakers do not realize that the system the United States employs to train medical residents, as well as dentists and some nurses, is through an entitlement program, Graduate Medical Education, within Medicare. The GME program exceeds \$15 billion annually. Congress capped the number of residency training positions in the United States as part of the Omnibus Budget Reconciliation Act of 1997. Since 1997, several legislative amendments and changes have occurred to make slight increases and variances on the resident limit; however, the medical specialties remain highly motivated to increase the number of residency training positions within their various colleges and academies. One potential opportunity to increase the number of physicians serving in Indian Country is to set aside a certain number of new residency training positions for those willing to serve in Indian Country. The number of years of service in Indian Country following completion of residency training would be equal to the number of years the resident took to complete the residency. In states like Connecticut, where residency training positions are approximately \$155,000 per resident per year, that is an astonishing incentive to complete service to Indian Country. Likewise, since most of the GME funding is in Indirect Medical Education expenses—paid directly to the training institution, perhaps a similar incentive could attach to the training institute if the resident does not fulfill the commitment. Further, there are very limited numbers of residency training programs in IHS facilities—and among the exceptions to the caps on new residency positions is if the new program were to be in a rural or medically underserved community or if a residency training program has never before existed in the training center. The Secretary of Health and Human Service has the authority to approve such growth: indeed, is this not the very definition of Indian Country?

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

Likewise, one of the inherent flaws in the Indian Health system is the lack of qualified hospital administrators and lack of basic business acumen in the management, leadership and operation of health systems. We, therefore, also advocate for measures to recruit, retain and fund students to enter Masters of Business Administration, Hospital Administration and related professions necessary to any chance of achieving and sustaining meaningful reforms in the IHS system.

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

Additionally, a long-term solution to addressing American Indian and Alaska Native health disparities lies in investing in our youth. We can improve the future of the Indian health care workforce by developing a culturally and linguistically competent workforce of Native health professionals and administrators. We know that AI/AN providers are more likely to remain in their own communities long-term and to provide culturally appropriate care. Therefore, Congress and the Service should

prioritize resources and relationship building with academic institutions and national health professional organizations to engage Native youth in cultivating interest and capability in pursuing medical and health professions.

Medical Literacy for Patients, Patient Advocacy

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

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

Finally, we have heard numerous reports from patients who are afraid to report their negative patient encounters for fear of retaliation against themselves or their families. We believe it is vital to have a safe method for patients to share their comments and experiences with the IHS system. Therefore, we believe a system that values feedback to improve the patient experience is a necessary component of quality. An anonymous, third party service that engages IHS patients about their care experiences would offer very valuable insights to inform the quality improvement process.

In Conclusion

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

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

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

Finally, because this legislation seeks to amend the Indian Health Care Improvement Act, the National Indian Health Board would like to take this opportunity to remind the Committee that the Indian Health Care Improvement Reauthorization and Extension Act (S. 1790, enacted in H.R. 3590) permanently reauthorized and

made several amendments to the Indian Health Care Improvement Act (IHCIA). Numerous provisions of S. 1790 have not yet been fully implemented. Below is a summary of the progress in implementing these provisions. Without full funding and implementation the strides we have already made to achieve quality improvement remain unfulfilled.

Attachment

I. INDIAN HEALTH MANPOWER—67 PERCENT OF PROVISIONS NOT YET FULLY IMPLEMENTED

Sec. 119. Community Health Aide Program—Authorizes the Secretary to establish a national Community Health Aide Program (CHAP).—Sufficient funds not yet appropriated.

Sec. 123. Health Professional Chronic Shortage Demonstration Project—Authorizes demonstration programs for Indian health programs to address chronic health professional shortages.—Sufficient funds not yet appropriated.

II. HEALTH SERVICES—47 PERCENT OF PROVISIONS NOT YET FULLY IMPLEMENTED

Sec. 106. Continuing Education Allowances—Authorizes new education allowances and stipends for professional development.—Sufficient funds not yet appropriated.

Sec. 201. Indian Health Care Improvement Fund—Authorizes expenditure of funds to address health status and resource deficiencies, in consultation with tribes.—After consultation, IHS decided to make no change in use of funds at this time.

Sec. 204. Diabetes Prevention, Treatment, and Control—Authorizes dialysis programs.—Sufficient funds not yet appropriated.

Sec. 205. Other Authority for Provision of Services—Authorizes new programs including hospice care, long-term care, and home- and community-based care.—Sufficient funds not yet appropriated for long term care programs.

Sec. 209. Behavioral Health Training and Community Education Programs—Requires IHS and DOI to identify staff positions whose qualifications should include behavioral health training and to provide such training or funds to complete such training.—Identification of positions has occurred, but IHS and DOI have lacked funds to provide required training.

Sec. 217. American Indians into Psychology Program—Increases institutions to be awarded grants.—Sufficient funding not yet appropriated for additional grants.

Sec. 218. Prevention, Control, and Elimination of Communicable and Infectious Diseases—Authorizes new grants and demonstration projects.—Sufficient funds not yet appropriated.

Sec. 223. Offices of Indian Men's Health and Indian Women's Health—Authorizes establishment of office on Indian men's health, maintains authorization of office on Indian women's health.—New offices have not yet been created due to lack of funds.

III. HEALTH FACILITIES 43—PERCENT OF PROVISIONS NOT YET FULLY IMPLEMENTED

Sec. 307. Indian Health Care Delivery Demonstration Projects—Authorizes demonstration projects to test new models/means of health care delivery.—Sufficient funds not yet appropriated.

Sec. 312. Indian Country Modular Component Facilities Demonstration Program—Directs the Secretary to establish a demonstration program with no less than 3 grants for modular facilities.—IHS has not yet established the program due to lack of funds.

Sec. 313. Mobile Health Stations Demonstration Program—Directs the Secretary to establish a demonstration program with at least 3 mobile health station projects.—IHS has not yet established the program due to lack of funds.

IV. ACCESS TO HEALTH SERVICES—11 PERCENT OF PROVISIONS NOT YET FULLY IMPLEMENTED

Sec. 404. Grants and Contracts to Facilitate Outreach, Enrollment, and Coverage Under Social Security Act and Other Programs—Directs IHS to make grants or enter contracts with tribes and tribal organizations to assist in enrolling Indians in Social Security Act and other health benefit programs—IHS has not yet established the grants due to lack of funds.

V. URBAN INDIANS—67 PERCENT OF PROVISIONS NOT YET FULLY IMPLEMENTED

Sec. 509. Facilities Renovation—Authorizes funds for construction or expansion.—Sufficient funds not yet appropriated.

Sec. 515. Expand Program Authority for Urban Indian Organizations—Authorizes programs for urban Indian organizations regarding communicable disease and behavioral health.—Sufficient funds not yet appropriated.

Sec. 516. Community Health Representatives—Authorizes Community Health Representative program to train and employ Indians to provide services.—Sufficient funds not yet appropriated.

Sec. 517–18. Use of Federal Government Facilities and Sources of Supply; Health Information Technology—Authorizes access to federal property to meet needs of urban Indian organizations.—Protocols developed, but property transfer costs require additional funding.

—Authorizes grants to develop, adopt, and implement health information technology.—Sufficient funds not yet appropriated.

VI. ORGANIZATIONAL IMPROVEMENTS—0 PERCENT OF PROVISIONS NOT YET FULLY IMPLEMENTED

VII. BEHAVIORAL HEALTH—57 PERCENT OF PROVISIONS NOT YET FULLY IMPLEMENTED

Sec. 702. Behavioral Health prevention and Treatment Services—Authorizes programs to create a comprehensive continuum of care.—Sufficient funds not yet appropriated.

Sec. 704. Comprehensive Behavioral Health Prevention and Treatment Program—Authorizes expanded behavioral health prevention and treatment programs, including detoxification, community-based rehabilitation, and other programs.—Sufficient funds not yet appropriated.

Sec. 705. Mental Health Technician Program—Directs IHS to establish a mental health technician program.—IHS has yet not established the program due to lack of funds.

Sec. 707. Indian Women Treatment Programs—Authorizes grants to develop and implement programs specifically addressing the cultural, historical, social, and childcare needs of Indian women.—Sufficient funds not yet appropriated.

Sec. 708. Indian Youth Program—Authorizes expansion of detoxification programs.—Sufficient funds not yet appropriated.

Sec. 709. Inpatient and Community Health Facilities Design, Construction, and Staffing—Authorizes construction and staffing for one inpatient mental health care facility per IHS Area.—Sufficient funds not yet appropriated.

Sec. 710. Training and Community Education—Directs Secretary, in cooperation with Interior, to develop and implement or assist tribes and tribal organizations in developing and implementing community education program for tribal leadership.—Comprehensive community education program has not been implemented due to lack of funds, although IHS and agencies do provide some trainings.

Sec. 711. Behavioral Health Program—Authorizes new competitive grant program for innovative community-based behavioral health programs.—Sufficient funds not yet appropriated.

Sec. 712. Fetal Alcohol Spectrum Disorders—Authorizes new comprehensive training for fetal alcohol spectrum disorders.—Sufficient funds not yet appropriated.

Sec. 713. Child Sexual Abuse and Prevention Treatment Programs—Authorized new regional demonstration projects and treatment programs.—Sufficient funds not yet appropriated.

Sec. 715. Behavioral Health Research—Authorizes grants to research Indian behavioral health issues, including causes of youth suicides.—Sufficient funds not yet appropriated.

Sec. 723. Indian Youth Tele-Mental Health Demonstration Project—Authorizes new demonstration projects to develop tele-mental health approaches to youth suicide and other problems.—Sufficient funds not yet appropriated.

VIII. MISCELLANEOUS—9 PERCENT OF PROVISIONS NOT YET FULLY IMPLEMENTED

Sec. 808A. North Dakota and South Dakota as Contract Health Service Delivery Areas—Provides that North Dakota and South Dakota shall be designated as a contract health service delivery area.—IHS has not yet implemented citing lack of funds.

The CHAIRMAN. Well, thank you very much.

Dr. Wakefield, I appreciated the fact that you listened closely to each person's testimony, and I can see that you were watching closely as to what was happening. The concern that I have, and it was mentioned at the hearing back in February, we visited about

how appalled people were to learn that the acting Chief Medical Officer, Susie Carol, statements came up in the Committee about babies being born on the bathroom floor and it was an unfortunate situation.

And the other thing that came up in the Committee was the fact that we heard people who maybe shouldn't be working within the system simply just get moved, get shuffled around from one place to another place. And I recently learned that this doctor had been appointed by HHS to be the Chief Medical Officer through the Great Plains Area, so I think we're all worried about tribal consultation and accountability and, you know, the tribes weren't consulted on that decision to kind of move a person from one place to another within the region when, you know, there were real concerns about the person and their performance.

Dr. WAKEFIELD. I cannot speak to the specific question that you asked about tribal consultation with regard to that individual. I can say that we have—we certainly have been focusing intensively on improving accountability using our performance evaluation structures that we have for evaluating our personnel in IHS.

And to give you one example, we have embedded within our performance appraisals our annual evaluations of the individuals that are working in the Great Plains Area expectations that, in the hospitals where they work, they are held responsible for meeting conditions of participation, for example, that are the CMS's conditions of participation.

The accountability piece that you've identified in your bill, we certainly agree, is extremely important and we have other strategies we talked about, to hold providers accountable, as a whole. I'll stop there.

The CHAIRMAN. The concern that we've heard in D.C. and in talking with people here today and yesterday, as well, is a performance approval, if the people who are judging the performance are not actually the patients and the families who are being taken care of under that system, where there's just one provider saying, you're real good, and then the other provider saying, you're really good, that doesn't give the accountability that, I think, we're looking for.

Performance approval, in my mind, should have members of the tribe, the patients, consulted as well, and that was very much a concern.

[Audience applause.]

Dr. WAKEFIELD. Thank you for that recommendation. We'll be happy to take that into consideration and see how we can incorporate exactly patient feedback back into the processes.

The CHAIRMAN. I think it's critical. There was another provision of the bill that talked about how unobligated funds would be used, and one provision says the secretary shall only use unobligated funds from the fiscal year to support patient care specifically. And I think you raised that, Ms. Stabler, costs of central medical equipment, purchase of preferred care, purchase approved by the secretary after consultation with the appropriate tribe. I'm sure you support that you use that money in that way.

The concern that Ms. Stabler raised earlier had to do with there was a settlement where HHS allowed \$80 million in Indian Health Service funds to be used for union settlements. That the money

came from funds allocated for staffing needs and for patient care. To make matters of even greater concern to all of us is the attorneys, you know, get a percentage of settlement. The attorneys in this settlement got an estimated \$20 million that should have been used for patient care.

In the meanwhile you have hospitals in the Great Plains that are understaffed, lack of basic medical equipment, the patients are dying, and my question is are tribes consulted on those sorts of decisions to take that kind of money away from the patient care to be used for a union settlement and their lawyers?

Dr. WAKEFIELD. So it's you, Senator, you, Mr. Chairman, have raised with us the need that you've identified and expressed to me very directly for IHS to be more forthcoming in terms of additional consultation. As a matter of fact, other members of this panel, Senator Thune, Senator Rounds, Congresswoman Noem have all expressed concern about and interest in IHS engaging in more robust and more frequent consultation.

Based on the conversations that I've had with each of you, because you've made that very clear to me. I've taken your recommendations back. I've shared them with Mary Smith and they are advancing strategies to accomplish just that.

We've also heard the same from tribal leadership. Between what we've heard from you and also tribal leadership, it is clear to us that there's more to be done in terms of improved consultation. I would say Mary Smith has been in the Great Plains Area, specifically in South Dakota now. This is her third trip here. She's engaged in a number of consultations with the Great Plains Area tribal leadership.

Having said that, it's clear there's more that we need to do on all of our parts in terms of engaging consultation, and you, Mr. Chairman, have made that clear to us. I take that recommendation seriously, and we are acting on it.

The CHAIRMAN. Thank you. Ms. Bohlen, I don't know if there was some additional things that you wanted to get out that you didn't feel you had the chance to, but I just feel—I'm so impressed with your testimony. You talked about what must be done to ensure accountability.

Ms. BOHLEN. Yes, sir.

The CHAIRMAN. And you see it as somebody being born and raised here, but also what you do in Washington and across the country. But we want this bill to be as strong as possible.

So, for the record, could you expand on some specifics that you might have that we could do with this bill to be sure that the dollars are getting to the patients who need it? Do you have additional thoughts?

Ms. BOHLEN. Yes, sir, I do. May I share something else first?

The CHAIRMAN. Go ahead, yes.

Ms. BOHLEN. I wanted to, especially in this setting, I wanted to acknowledge Congresswoman Noem for alleviation of the employer mandate from the tribes. That bill never would have gotten through Weighs and Means this week without her and input from the tribes and I want to make sure to mention that acknowledgment. Thank you, Congresswoman Noem.

Congresswoman NOEM. I appreciate that. Thank you.

Ms. BOHLEN. Accountability, one of the things that we say, if you can't measure it, you can't manage it. And with the ongoing research that all of us have been doing to try to find good answers for IHS in the future, before we can even get to the point of accountability, we have to know what we're talking about.

The audit that Senator Thune has been discussing, and all of you have been discussing, is essential to that being possible. Once we can get our arms around what it is that we—you know, measuring what it is that we're talking about, we'll be able to better manage it.

I will share with you that the National Indian Health Board also believes that the tribe needs to be engaged in all of the decision-making about their health care and their dollars. The third-party billing revenue in 2015 from the Great Plains was \$134 million. The Great Plains tribes, largely through Medicaid and Medicare, and about 33 million from third-party billing came through because the tenacity of the tribes to use that opportunity as additional income and resources and, as the questions have implied, they are not always able to be part of the decisionmaking in making sure that those dollars are spent the way they'd like to see them spent.

We believe that there should be some medical literacy training that goes on in Indian Country. For three generations the IHS has been the only health system that many people in Indian Country are familiar with, and in order for tribes to be able to uniquely engage in their own decisions and their own care, we believe there has to be more light brought to bear on what the law is, how it works, what their rights are, what all the cards are that are on the table, because if you don't know what all the pieces are on each side of the table, you're not playing the same game.

So we believe that given disproportionate levels of low literacy in Indian Country, that it has direct impact on the health outcomes and their need for care, and it is absolutely clear that more resources and training are needed within the Indian Health system to improve the patients' understanding of their own health care and their own health delivery system.

One of the other stories that we consistently hear is that patients—I stumbled upon this when I was invited to Winnebago in 2014 to meet with their Tribal Council and learned what was going on, and one of the things that was the most resonating for me at that time was when council members said they are afraid to speak up, because if they speak up, they will not get health care and neither will their families.

Well, there's an easy way around that. We know that one of the greatest quality improvement measures is patient direct surveying. My tribe, the Sault Sioux St. Marie tribe, uses a company in Ann Arbor, Michigan. It's a private third-party that keeps patient confidentiality, and after every patient encounter, those patients are called and surveyed about their experience.

If we had a system like that where the patients could engage in a safe way, where they really felt that they could talk freely, we would probably find out some good things that are happening, too. So, you know, those kind of efforts to increase transparency, increase knowledge base of the tribes, empower tribes to be able to make their own decisions, and nothing empowers like knowledge.

Open up the data to the tribes so they can see what is here and be a true partner with the tribes and understand that at the end of the day it is their people and their health that is at stake. Thank you.

The CHAIRMAN. Thank you very much. Senator Thune.

Senator THUNE. Thank you, Mr. Chairman. And, again, thank you all to our panelists who were here today for sharing their insights.

And, you know, the one thing, I guess, that I've, in looking at these issues, have sort of concluded is that—and we were talking earlier this morning in an earlier meeting Evie Espinosa, who is the Tribal Health Director for the Rosebud Sioux Tribe was talking about is that the psychological toll that the negativity surrounding these stories and this narrative just perpetuates year after year, the effect that has on people. And what I concluded is we can't fix the problem here by a tweak here or a fine tune here. This requires systemic change. You can't fix this by changing the oil and replacing the tires. We need a whole new car. I mean, the problems that are here are very deep seated. They are fundamental, and they require something that really does represent systemic change.

And so the Chairman, in listening to everybody this morning and others who have shared with us over the past several months, try to get at in this bill, and, again, it's a starting point, some of those issues. You know, for one, how do we get change? We start with leadership, making it easier to replace leadership; to get medical professionals who are willing to serve and recruit and retain reservation hiring incentives, bonuses, competitive pay, temporary housing and housing costs, that sort of thing. Getting accountability both on the spending side, on the staffing side, so people know where money's going. I mean, \$80 million. \$80 million, Mr. Chairman, that went for litigation that was taken from patient care in the Great Plains Area. \$6.2 million came out of this region and a million out of Rosebud. 1.3 out of Pine Ridge. That just can't continue. And so there's got to be the fiscal accountability piece of this.

There's got to be whistleblower protection so when things go wrong and people report it, they aren't retaliated against, which is what you were getting at.

[Audience applause.]

And there's got to be the consultation, which my impression is, just doesn't and hasn't existed in the past. And so, I mean, these are big systemic things that we need to do to fix this problem.

And, unfortunately, It took a crisis to kind of get us to this point, and, unfortunately, IHS has not been transparent and they have not been forthcoming about these issues, and they've asked these questions in the recent past and not gotten straight answers.

And so December 5th of last year, IHS had conversations with my staff in which they said that everything is okay, the problems have been abated. That very day, later that day, we got notified that CMS had put the Rosebud Emergency Department on emergency status. There is a huge disconnect in communication.

So I guess I want to just, Mr. Bear Shield, ask you in the course of last six or seven months, because we had this conversation, we

had it several times, but we had this conversation in February, has consultation improved between the tribes and IHS?

Mr. BEAR SHIELD. First of all, getting back to, real quick, to the Act, before I forget, I'd really like to give thanks to the people sitting behind you, the staff. They've really done a great job coming to the tribe, getting to the tribe, everything—Ms. Noem's and your bills are exactly what we've been telling them, and a big thank you to them. Every morning I usually wake up to text or e-mails from them.

But, Senator Thune, getting back to your question, you know, I have a hard time trying to—every time I—every day I pray and think that it's getting better. Something is going to break today where things are going to get better, and then it doesn't. You know, take for instance these contracts that were let out over for consultation for our ED. There's a young lady that has been calling me, asking me, a reporter, and I was at home and she calls me one day to—she says, Mr. Bear Shield, what do you think of the contracting company that contracted your ER? And I said, What? I said, What do you know? I'm sure you probably know more than I do.

So then I call Ms. Espinosa and I say, Hey, have you heard? She said, Yeah, it's on the news, you know. And I'm not—the Chairman, Mr. Kindle and Ms. Espinosa and myself, we're usually the first ones to know, but that's the kind of stuff that still goes on today.

And you know what Ms. Stabler and Ms. Blueshield and Ms. Bohlen were saying about, you know, contracts, there's some up and coming and we really need to be a part of. You know, we need to get away from this type of consultation which definitely isn't in our favor, you know. We've got the telehealth coming, we've got the sole sources sought, you know, five positions within IHS facilities, you know, we need help with those because the tribes need to be involved in those.

And not only that, we send e-mails and calls up the line and they're not getting answered back.

And even with Sioux San's current situation, we don't know what's going on there. You know, the last we knew that they worked out a—they got off immediate jeopardy status and they are working on an SIA agreement, I guess, and corrective action plan or what have you, but we sent e-mails also asking, you know, what's the status, and how can we assist and we need to be involved there. Rosebud, Pine Ridge, and Cheyenne River being the governing body there, you know, it concerns us. It's always concerned us.

So, it isn't there. You know, on the tribe's part, ever since the last hearing, and you heard them, you know, just like today, we just heard that, you know, communities are important to us. Well, if that was the case, why didn't they let South Dakota providers in on the ED contract, you know?

That doesn't make no sense to me.

So, you know, with that being said now, I'm very confident that these bills will pass. Once they're passed and part of the law, the shoe needs to go on the other foot this time. We do not need IHS

to define what that bill means to the tribes. Tribes need to define to them. They say, This is our bill, this is what this means to us.

The CHAIRMAN. Thank you, Mr. Bear Shield.

Senator THUNE. So I'll assume the same as Ms. Blueshield, that the similar type of experiences on the consultation issue, but I guess what I would say, Secretary Wakefield and Ms. Smith, to that point there's got to be a way in which we can create a mechanism formalized so that consultation can take place. And the bill requires when it comes to major hires, if it's an area director or service unit, that there's consultation with the tribes, but I'm looking to you. We, I think, are all looking to you to work with us and with the tribes to create a way in which that happens so that we don't get these news bulletins about a contractor being hired and, frankly, a contractor that is, sounds like, from all we've been able to ascertain, pretty suspect based on the record with regard to previous work they've done for the tribes.

And so that being said, I would just say to all of you, and, again, CMS, IHS are both under and that they seem to be operating on very different tracks, and where is the coordination, the conversations and consultation that we need to have; and, please, I would just say to you, I know the time is up, but work with us on getting that coordinated.

Ms. Blueshield.

Ms. BLUESHIELD. When I was putting this together, I was thinking about everything that happened, all the years, and I thought, you know what? Why isn't there a tribal liaison or somebody that's in between the IHS and the people and the Tribal Council, and why isn't there somebody that advocates for us, that can explain things to the Tribal Council, or they can bring a message to the Tribal Council from IHS or somebody from IHS or something. But that was what was missing in our clinic and the things that we were doing, because we e-mailed all the time. I mean, we had phone calls, and once in a while we had somebody come and meet with us, but I think initially having somebody that was an advocate that could go both ways and talk to both sides, somebody in the middle that could be objective would be a possibility.

The CHAIRMAN. Senator Rounds.

Senator ROUNDS. Thank you, Mr. Chairman. And let me just share with everybody one of the rules in the Senate in terms of presenting testimony. When we ask questions, that we're normally limited by Committee to 5 minutes to do it, and so I would just thank the Chairman for the understanding and patience as each of us have kind of worked our way through. So thank you, Mr. Chairman, for that.

Dr. Wakefield, I want to just preface my questions to you with this. Currently we're still experiencing underfunding with IHS and so forth, and I spoke earlier about the fact that I want the money to go in and get results. I want it to go directly to places where it's going to help people, but let me just put into perspective just exactly what we're talking about in terms of underfunding. At the federal level right now, the Bureau of Prisons currently spends about \$5,100 per inmate on health care. Through IHS we spend \$3,099, or about \$2,000 less per individual on IHS funding than we

do for the inmates in the Bureau of Prisons, and so we recognize that there is a discrepancy here in terms of focus.

But at the same time if you put more money into this process and we don't know where it's going, and if we can't point to where it's being used successfully, then we're not going to get the results we want and we'll end up with more problems than we've got right now. In fact, I know you're aware, because we discussed this previously, Dr. Wakefield came in and spoke with all of us, we had a very good meeting, and there were several things that we committed at that time. I just want to walk through this in the public record on this.

You're aware, because we discussed previously, but, again, I would like to raise my concerns about the financial discrepancies in the Department of Health and Human Services fiscal year budget specifically over IHS. The FY 17 budget intended to spend \$40 million more on tribally operated facilities compared to federally operated facilities in the Great Plains Area. Given the Great Plains Area only has 17 tribally operated facilities versus 35 federally operated, I repeatedly asked for explanation. Although my office has never received a response, we found that your website published a correction indicating that you had misreported the appropriation amount the IHS facilities in the Great Plains Area by \$80 million. Now this is disturbing.

If your budget analyst and your IHS national directors and your agency officials did not notice these very extreme inaccuracies, how do acting directors, some of who only have three months on the job, have any understanding on how to distribute this money between the 52 facilities when there are inaccuracies in your annually published budget of at least funds of as much as \$80 million?

And just as a real quick follow-up, would you, once again, commit to that independent audit to make sure that IHS can develop a transparent, clear and accurate budget?

Dr. WAKEFIELD. Thank you very much, Senator. And I said it at the very beginning, but, again, I want to tell you how much we appreciate the administration's intense interest and focus and leadership of the Chairman and of the three representatives, the members of Congress from South Dakota. You have been focused so intensively on ensuring access to quality care for American Indian populations and we appreciate the working relationship that we have with you to achieve a shared goal. So thank you for your willingness to spend time with me as we work through what are very significant challenges.

In terms of the specific issues that you've raised, I would defer to Mary Smith about that because you raised that with me and that brought back immediately, the information was updated on that website after you flagged it. Thank you for flagging it. And, in addition to an audit, as we had discussed, you've raised that with me when we met. I said to you then, and I'll say it again for public record, you're certainly welcome to that. In the five-part strategy that we shared with you and Mary shared with the Great Plains Area leaders, the very first part of that five-part strategy is on our expectation to improve our transparency. It's critically important that we surface problems and that we work immediately to address those problems with the resources that we have.

Transparency also involves consultation, which all of you have spoke about and we're trying to drive forward in a much more meaningful way than we have historically. So I agree with you about welcoming the audit. That's part of transparency, and we will do our level best, as we have been and continue to drive strategies forward that improve surfacing problems and immediately addressing them.

Senator ROUNDS. Let me just follow up on that then, please. We're talking about improving accountability at IHS. You've already heard a number of questions about CMS issues and our region's staffing concerns. While I certainly echo the concerns, we want to remain consistent through all these, the IHS inadequacies, poor communication, and literally no consultation.

I want to illustrate this for you just in terms of what we've learned so far. The Great Plains Area IHS leadership hosted a call on December 4th regarding Pine Ridge and Rosebud CMS issues. Within three hours of the call, IHS sent out a press release outlying upcoming Rosebud Emergency Department diversion. Despite knowing that diversion was a possibility, IHS did not notify tribal leadership until they were issuing the press release.

Secondly, with the revolving door of Great Plains Area directors, IHS has not been forthcoming about changes. Ron Cornelius was reassigned without notice hours before the February 3rd Senate Committee Indian Affairs hearing. When Rear Admiral Meeks signed on to serve as acting director, his commitment was for three months, but the tribes were not told this until his final days.

We were pleased when IHS Principal Deputy Director Mary Smith, who is here with us today, visited South Dakota hoping for true discussion and consultation. Director Smith explicitly mentioned the means for better communication and promised improvement. Unfortunately, while you were here making that promise, the Emergency Department RFP had been issued; however, our tribes in South Dakotas three major health care systems, were not properly notified, did not receive timely responses to inquiries, and simply did not have enough information to consider these major contracts.

A month after Director Smith's visit, local media outlets reported that another Great Plains Area hospital, Sioux San, was facing CMS violations. This newspaper headline came after days of tribes inquiring to IHS officials about such rumors, but our tribal leaders never received a response.

So I'd like your commitment to reforming the culture in IHS to insisting that agency leaders treat their constituency with the dignity and the respect that they deserve. Do I have a commitment? And if I do have that commitment, I'd like you to share with us how you would execute it to make this change.

Ms. SMITH. Thank you, Chairman Barrasso, Senator Thune, Senator Rounds, and Congresswoman Noem. I really appreciate the opportunity and your interest and your leadership on bringing this field hearing today. I also want to thank all the tribal leaders and everyone here today to address this important issue. To me, there's nothing more important than health care in Indian Country.

We've heard a lot of issues discussed today, and I know one of the issues, Senator Rounds, that you're raising is the issue of being

transparent and open communication, and I fully agree with you on that. And, obviously, you know, there are more things we need to do, and I guess, you know, you asked how would we do that.

The first thing I want to do is reach out to you all and the tribes, I think that open and honest communication occurs not only just with our tribal partners, the people we serve, but also Congress. And so I guess we are happy to continue talking with both the tribal leaders and yourselves as to what would be meaningful communication to you, because you do have my commitment that we will do whatever it takes to ensure that you get the information and we have the dialogue with you to do this.

Senator ROUNDS. Mr. Chairman, you've been very kind with your time, and let me just finish with this very quickly. It seems like every time we have an emergency that comes up and there's an obvious layout program, we find out more things are a problem and it brings in the public attention, but what we end up doing is we provided a band-aid. In December we provided spending \$2 million to go directly into the contracting work. What I think we have to do is to focus on the long-term issues surrounding IHS and provide more transparency so the tribes can actually make a decision about whether they want IHS to provide the services directly or if they want to look at doing independent activity among the tribes, themselves. And the only way that that's going to happen, I believe, is if we simply have systemically in place a plan that does not let us get focused on the emergency only, and let the big picture get away.

And this time, unlike previous attempts, I think you're going to find that Congress is not going to let this get away again, and that we're going to continue to ask the hard questions and refocus on whether or not the job is getting done.

[Audience applause.]

The CHAIRMAN. Congresswoman Noem—I know you all have questions—but you can go ahead at this time.

Congresswoman NOEM. Thank you. I appreciate that, Mr. Chairman. And I've got a lot of questions so we're going to move kind of fast. I hope your answers are brief, but factual, if that's okay, and I will do that as well.

Willy, we talked about before the culture that's ongoing within IHS, the fear, nepotism, corruption, and we can make a lot of changes in legislation, but it's hard to change attitudes and character in office. And, Willy, could you just speak a little bit about what that—in reality that is, because we have protection in U.S. law for whistle blowers, but, frankly, I have had whistle blowers contact my office that are scared of retaliation when they tell the truth about what's going on in IHS.

So I want Willy to tell us a little bit about some of the culture that they see in IHS facilities and what it means to people, and then I want to get your commitment that whistle blowers will be protected and that there is not an environment of retaliation within IHS.

Willy, do you have anything you can share with us about what it's like?

Mr. BEAR SHIELD. The other day I know we had visited—you know, backing up even to Chairman Barrasso's initial statement

about the whole issue with the Indian Health Service, Mr. Andrews, your chief staffer came and visited a coalition of large tribes two weeks after initially hearing a representative of our tribe was there, Chairman Old Coyote from Crow Agency Montana Senate of Indian Affairs Committee for their work in coming to the Great Plains and having the hearing, but he said, Don't stop there. Come to the Billings area because the same thing is happening there. So I'm telling you how widespread it is.

Now going back to Ms. Noem, there was an individual that came from there, you know, a provider in the past that had told me that, you know, he tried to make some changes himself, as a provider within the IHS system, and he pretty much got ran out of town. Work started getting audited, he was hounded, you know, quite often concerning his work because of the issues that he brought up, and he said ever since that day he's been afraid to do that.

You know, the culture of people I do know. I think they may have—I was told the other day that, you know, they were going to make a video for recruiting or retention or a brochure, what have you. I don't know what people said, but, you know, I know tribal members, I think, that work in the facility weren't asked to be a part of it, but I do hope that they brought up our culture, our community, those type of issues because we are a very proud people, you know, rich in land and also in our own culture, and we're very proud of that fact.

Going back to the initial questions of some of the disparity and frustration that this has caused us since we've been on diversion status, I do know I had an elder, his daughter called me from Valentine, and he said, Call Willy Bear Shield. I'm having a heart attack. He told me that I'll probably have to pay for it. This is even after December 5th, after Mr. Cornelius reporting this, I specifically stood up, and he was standing behind me in Tribal Council chambers, and I said, Okay, for the record, does this mean everything will get paid for while we're on this diversion status, and I mean everything? If they can't be fixed in Rosebud, no matter where you're sent, it's going to be paid for? And he said, Yes.

So now we're running into purchase referred care dollars that aren't there. So what does that mean? And this elder gentleman just said, I don't want you kids to be riddled with a flight bill if I die anyway, so I'm not going to go. So I just said, Go, we'll take care of it. We'll take care of it. So those kind of issues.

We have people that—even Chairman Flying Hawk, the other day at a chairman's association meeting, you know, they have a hard time waiting until the community hospital or clinic opens up so they get referred just across town because it's not going to get paid for there either. So there's a lot of issues. Even these people know about it, and it's disheartening to them to get their health care or even think about it.

Congresswoman NOEM. Thank you. Well, I appreciate that Senator Thune's bill, he has some more whistle blower protections, and I just I want everyone to know, and I want you to know that we're obviously aware that there are people scared of retaliation. And I want your commitment that we won't see that while we're going through this emergency situation. People are willing to tell the truth about what's really going on in facilities.

Dr. WAKEFIELD. Congresswoman, this is critically important. We cannot surface problems——

Congresswoman NOEM. Right.

Dr. WAKEFIELD. Right, if people are uncomfortable with flagging those problems for us. We cannot solve those problems if people don't identify them so that we can begin to work to address them. Under Mary Smith's leadership we are committed wholly to a culture that is designed to improve transparency with the expectation that people are supported in bringing their concerns, problems, challenges forward. Whistle blower protection isn't an option, it's an obligation.

Congresswoman NOEM. Thank you.

Dr. WAKEFIELD. It is critically important to control—[Applause.] we're totally supportive of that, and, in fact, I would just say that HHS and IHS have recently wrote to Office of Inspector General on facets of this very issue. Through Mary Smith's leadership, she recently released a memo to all staff of IHS, not just the supervisors, but the employees, as well, basically letting them know it's not an option, it's an obligation that if you see examples of waste, fraud, abuse, we expect you to report them and to feel comfortable to report them to the IG.

Congresswoman NOEM. Thank you.

Dr. WAKEFIELD. And we provide them the information about who called and——

Congresswoman NOEM. Could you quickly tell me why AB Staffing, which was considered for the contract, when their employees were previously a part of the problems that were ongoing in these facilities, why were they——

[Applause.]

Dr. WAKEFIELD. So what I can tell you, first of all, is that obviously Emergency Department Services are critically important and——

Congresswoman NOEM. But some of the same employees are even in the positions, and that's what I really don't really understand is that if you continue working with a company that has failed us in the past and you put them on an even playing field with other contracting firms and allowed them to have a position to come in and bid for these contracts—my legislation deals in changing the contracting process, which I think needs to happen. I think we've discussed long-term contracts with local providers that understand the challenges of servicing health care and serving people in rural America, and especially in rural South Dakota. I'd much rather see Avera, Sanford, Rapid City Regional Health in these hospitals than AB Staffing solutions.

[Applause.]

So I just want to question why there is not a red flag at any point with you when somebody fails and has a problem that we don't kick them out of the pool of people who can bid for contracts?

Dr. WAKEFIELD. First of all, with regard to ED, you did flag for us, you and I had that conversation and you directed——

Congresswoman NOEM. But I didn't really get an answer on what happens, I mean, when people fail —

Dr. WAKEFIELD. You flagged for me the importance of engaging and ensuring that local, regional facilities have an opportunity to

bid on contracts, and certainly that was the case with the ED contract. Part of the challenge was the lack of familiarity that that opportunity was even available, I think, was part of the issue here, and so what you saw certainly with the telemedicine contract was additional efforts to share the information about the availability of that bidding process.

Having said that, the federal procurement process that we are required to follow was followed in the awarding of that contract, so I can tell you that, because I went back to ensure that that process was followed.

With regard to the specifics of that contract, I would ask Mary to speak to that. But I can tell you on the front end that the expectations around the awarding of contracts, those policies and procedures were followed. That, I can assure you of.

Congresswoman NOEM. I'll just close with this, that I also understand that IHS relies on a Norwegian accrediting body, DNV GL, to maintain your accreditation at some of these hospitals throughout the region and it includes Pine Ridge, Rosebud, and Sioux San, and I know many of the witnesses here today reference CMS for finding problems and I think they deserve to know why their accrediting body has clearly failed in the past.

Has IHS, CMS, HHS, and you can respond—I know I'm out of time—you can respond to me later about this, but I want to know if you had conversations with DNV GL regarding the accreditation issues at these Great Plains hospitals, because I want to know whether they visited these facilities or did they come ever to these facilities and do a proper accreditation program, and will IHS's contract with DNV GL, will it expire, and will you renew it, because they've obviously failed, and I need to know if you'll consider changing to something like a joint commission on these accreditation processes. But I'll leave it at that. Thank you.

The CHAIRMAN. Thank you. In addition to our follow-up questions, the tribes have asked for a copy of the contract. And can we get it from you, a copy of the contracts?

Ms. STABLER. We were told we had to follow them. We think we should have a copy though.

The CHAIRMAN. We all think we should have a copy.

Dr. WAKEFIELD. Mr. Chairman, yes. Yes is the answer to that. There is a process with which we can make the contract available, yes. Yes, there is a way to get.

The CHAIRMAN. But will we be able to use that process to actually successfully get a copy of it or not?

Dr. WAKEFIELD. Yes.

The CHAIRMAN. Thank you.

Senator THUNE. Chairman Barrasso, one quick follow-up on that point. And I fully appreciate the fact, Secretary Wakefield, that you followed the protocols and whatever the bidding requirements to award that contract, but, my gosh, there has got to be some recognition of past performance. I mean, if what we hear from the tribes is true about the contractor, how could you contemplate re-issuing a contract? Even if it meets the, you know, that just, to me, it's almost incomprehensible.

[Applause.]

The CHAIRMAN. Senator Rounds.

Senator ROUNDS. Just to clarify the Chairman's request. The contracts that are there that the tribes have not been able to get, how long will it take for this Committee to receive those copies of the contracts?

Ms. SMITH. It's my understanding that the Committee has already received a copy of the contract, and we are happy to provide them to the tribes after the request is made as expeditiously as possible within a few days.

Dr. WAKEFIELD. So, bottom line, Mr. Chairman, we'll make those contract copies available to you. But because they are contracts, there is an additional step that outside groups need to go through. It's a requirement, but they absolutely can be made available, and we'll work with the individuals for requesting them to ensure that they know what that process is, and I will commit that we will expedite that process.

The CHAIRMAN. Thank you. I appreciate that commitment. Members of the Committee—yes, I'm sorry, Mr. Bear Shield.

Mr. BEAR SHIELD. One more thing, I guess, we'd like to know if we're going to be a part of upcoming contracting, the telehealth, the positions of the sources sought, five positions, you know, I guess, we need to enter that for the record if we're going to be able to have a say-so in those, and those need to be immediate. I mean, because if you can have a mediocre provider sitting somewhere, all he has to do is push a button and he could be hooked up to Sioux Falls or Rapid City somewhere and at least get a second opinion and save lives.

The CHAIRMAN. And that's exactly why we're here today. That's why we've written this piece of legislation on improving accountability. We want all of these things, is why we asked the specifics of what do we need to put in here so you get everything you need. That's why we've come here today. That's why we've had the listening sessions. We want to get all of that and we want to get it into the law.

Mr. BEAR SHIELD. And, lastly, we just heard them say they're committed to waste, fraud, and abuse. I guess if that's the case, you helped the Great Plains Tribal Chairman's Association and Health Board, they just passed a resolution, you know, for years we've been saying we don't get any leadership or technical assistance out of the area office. We want to do away with that. That money needs to come down to the local units and go to health care for the people, and we'll just deal with the headquarters. Thank you.

The CHAIRMAN. Yes, Ms. Bohlen.

Ms. BOHLEN. Mr. Chairman, I know you're not supposed to speak impromptu at these kind of things, but I can't fight my nature. So the National Indian Health Board has believed that the \$80 million that was used on third-party revenues to pay off the legal settlement that should have maybe come from the Department of Justice instead of the third-party billing, is there any way to try to get the money back?

[Applause.]

Could you maybe look at a process for which maybe that cost could be shifted to DOJ and the tribes could recapture that \$80 million?

The CHAIRMAN. We'll certainly have to look into that.

Ms. BOHLEN. Thank you, sir.

The CHAIRMAN. I appreciate everyone who has come out to be with us today. Thank you. Thank you so very much for coming, and yesterday, and sharing your stories. The hearing record is going to be open for another two weeks—we may ask you to come up with your input to some additional questions, we're going ask that you provide and get to those and so I want to thank all the witnesses for coming, for traveling here from so many different places, but I want to thank the audience as well, the Senators; the dedicated members of the South Dakota; congressional delegation, Senator Thune, Senator Rounds, Congresswoman Noem. Thank you so much with all of your help, and thank you.

With that, this hearing is adjourned.

[Whereupon, at 12:25 m., the hearing concluded.]

A P P E N D I X

PREPARED STATEMENT OF HON. CAROLYN N. LERNER, SPECIAL COUNSEL, U.S.
OFFICE OF SPECIAL COUNSEL

Chairman Barrasso, Ranking Member Tester, and Members of the Committee:

Thank you for the opportunity to submit written testimony on behalf of the Office of Special Counsel (OSC). OSC protects the merit system for over 2 million civilian employees in the federal government, with a particular focus on investigating and prosecuting allegations of whistleblower retaliation. We appreciate the Committee's efforts to support whistleblowers and promote accountability within the Indian Health Service (IHS), and we offer the following views on S. 2953, the Indian Health Service Accountability Act ("the Act").

Section 6 of the Act establishes a new "mandatory reporting" procedure for IHS employees who witness retaliation or other misconduct. This new mandatory reporting procedure will restrict, rather than expand, existing channels for whistleblower disclosures. Under current law, IHS employees may choose to disclose information directly to their chain of command, to an Inspector General, to OSC, or through other avenues. Employees should have the flexibility, as they do under current law, to determine the best avenue for making a disclosure. However, Section 6 would require IHS employees to disclose the information to an official designated by the Secretary of Health and Human Services (HHS). Section 6's procedure does not include rules on confidentiality for the designated HHS official, and does not clearly define the terms that trigger the automatic reporting requirement to HHS. As stated, since IHS employees can already disclose information directly to the OIG, the benefit of establishing a new designated official to forward employee reports to the OIG is unclear. Reinforcing the existing channels for reporting concerns will result in better protections and outcomes for IHS whistleblowers. It would be appropriate to require HHS or IHS to provide additional information to IHS employees on available options for reporting wrongdoing.

Additionally, Section 3 of the Act establishes a new process for the removal of IHS employees based on performance or misconduct. We understand that the intent of this provision is to promote accountability within IHS by providing the Secretary of HHS with an additional, expedited process for disciplining IHS employees. We note, however, that the new process is modeled, without modification, on a similar provision adopted by Congress to discipline senior executives within the Department of Veterans Affairs (VA). The VA provision has been subject to constitutional attack in federal court. The constitutional challenge has significantly delayed final resolution of disciplinary actions taken against senior VA officials. If the goal of this legislation is to expedite disciplinary actions against IHS employees, the Committee may wish to consider modifying the provision to ensure the constitutionality of the process.

PREPARED STATEMENT OF FAITH SPOTTED EAGLE, TREATY CHAIRWOMAN, YANKTON
SIOUX/ITANKTONWAN TRIBE

Introduction

The elected Treaty Committee, the formal elected officials of the Business and Claims Committee; the Tribal Chairman, Robert Flying Hawk; and Michael Horned Eagle, Wagner Service Unit Director have all established a positive partnership consistent with the mission of the Indian Health Service to raise the physical, mental, social and spiritual health, of American Indians and Alaska Natives to the highest level possible, and in this case the Yankton Sioux Reservation in the Aberdeen Area Healthy Service Unit. This partnership must remind us of the Indian Health Service priorities which are supported by the foundation of treaty rights delineating delivery of health, education and welfare to Native nations. These agency priorities are:

- Renew and strengthen partnerships with tribes and Urban Indian Healthy Programs
- Improve the Indian Health Service
- Improve the quality and access to care
- Ensure that work is transparent, accountable, fair and inclusive

Treaty rights and trust responsibility

As clearly outlined in the Position statement of the National Congress of American Indians regarding health care; the treaties signed by the Native Nations created the clear trust responsibility of the government to the individual Nations in health care on what we call Turtle Island, or in this case the United States, located on Indigenous lands.

When the Treaty of 1858 was signed under duress by the Yankton, it created the current reservation; the boundaries of which have been even further diminished by state and county action in an attempt to disestablish the reservation. The descendants of these immigrant families have short memories, as the Yankton shared our land with them to an extreme. The Supreme Court declined to hear the disestablishment case; thus the Yankton have retained their boundaries in a close call. However, despite the sad history of treaties, it was clear that treaty signatories had future generations in mind, by essentially creating a form of pre-paid health care. For this promise of health, education and welfare the Yankton signatories essentially granted almost the entire half of eastern South Dakota to the US and immigrants through the Dawes Act, the Treaty of 1858 and the 1894 Act. In later years, the Pipestone Quarry was also lost; although guaranteed in the 1858 Treaty.

In the case of the Yankton/Ihanktonwan, there were three large land actions which almost decimated the Yankton.

- The first was the coerced Treaty of 1858, which was signed under duress and military captivity with the coming of Ft. Randall. Prior to the signing of this Treaty, the tribes domain was greater than 11 million. Per the 1858 Treaty, the tribe ceded more than 11 million acres. The Yankton retained a reduced amount of 430,400 acres which was further reduced by subsequent US government actions.
- Following the cessions of the 1894 Act, the reservations was reduced to 262,300 acres. The 1894 Act was designed to obtain more Indian land even after treaties were done away with by the US government.
- The Pick Sloan Act took even more land from the Yanktons and destroyed highly productive farmlands on the Missouri River and created further homelessness. Only recently has legislation occurred to try to correct this.
- The tribe now has a mere 37,600 acres held in trust.

In light of the tremendous land losses and subsequent impact of historical trauma faced by our people through impacts of attempted assimilation; it is even more important that these historical sacrifices receive justice through quality health care for not only future generations but a population made vulnerable through cultural loss and infrastructure destruction. It is obvious that the massive historical trauma inflicted on the Yankton and Native Nations has resulted in stress related diseases such as cancer, diabetes and lupus. Now we have the opportunity to right these human rights infringements and wrongs and create just health care, funded at an effective level.

Challenges faced by the Wagner Service Unit

- Inadequate staff composition and staff to cover an extremely large population area: The Unit website states that the Wagner location provides care from 7 am—11 pm; with 6 Primary Care Providers and 2 PA-C's. Although it is located on the Yankton Sioux Reservation, it provides services to patients from surrounding reservations and communities throughout South Dakota, Iowa, Minnesota and Nebraska. Unit director Mike Horned Eagle, has stated to us that the largest population area that Wagner provides service to is Sioux Falls, SD which is two hours ago. He also stated that each month, the unit has 39,000 contacts which is totally overwhelming when compared to funding, staff and capability. This creates added stress to a small system and can set up scenarios of vulnerability for an overloaded system.
- Need for full emergency room: In past years, Wagner had a full fledged emergency room, however due to Indian Health actions and lack of congressional funding and support, this ended. Currently what exists is an urgent care unit. Recently the writer of this testimony had a first-hand experience at the urgent

care unit this June 2016, when a young relative was taken in for an impending miscarriage. It took 45 minutes for the doctor to arrive; it took another 50 minutes for staff to arrive to do bloodwork and start the analysis machines and another 45 minutes for the ambulance to arrive and another hour to transport the young mother to Sacred Heart hospital in Yankton, SD; not counting how much it took for intake at the receiving facility. The mother subsequently suffered a miscarriage. This is a systemic problem, not necessarily always a staff problem although they could be related due to low levels of funding.

- The Wagner Unit Diabetes Program has identified 634 diabetics receiving care at this clinic. This is roughly 20 percent of an on-reservation population of approximately 3000 rounded up to the nearest thousand out of a total Yankton/Ihanktonwan Sioux Tribal population of 9,000 again rounded off at the nearest thousand according to the tribal enrollment office. The current staffing could be potentially detailed to care only for the high number of diabetics who usually have systemic health problems way beyond high blood sugar.
- The National Center for Health Workforce Analysis has identified that among rural residents, there are proportionately more providers in occupations that require fewer years of education and training than providers in occupations which require more years of expertise. For example there are EMT's and paramedics per capita residing in rural as opposed to urban areas, and more physicians and surgeons per capita residing in urban as opposed to rural areas. This is already a problem for rural areas such as the Yankton Reservation.
- The same data center has identified that prison populations receive better care than Indian Health service populations, further compromising the future of our children, elders and families.
- Increased Indian Health Service funding has to be a priority to meet the treaty rights of Native nations. In the current situation, priority is given to those suffering from potential loss of life and limb, thus compromising preventive health care which in the long run will save money.
- Increased use of meth amphetamines and prescriptions are contributing to early organ, teeth and systemic failure. This is a national epidemic that has special consequences for an already rural compromised locale that has high poverty rates.

Strengths of the Wagner Unit

- This past spring, the Yankton Sioux Tribe is very proud of its partnership with Indian Health and other providers with the opening of a ground breaking local dialysis unit adjacent to the Indian Health Service Clinic. This has taken years to develop and funding must continue.
- The Wagner Unit has developed a competent systemic track record of cooperative billing via medicare/Medicaid and other sources. They are to be commended for maintaining but further funding must continue for updated software and input staff who are always at a shortage, thus creating staff stress.
- The Director, Mike Horned Eagle has developed a positive working relationship with the Ihanktonwan/Yankton leadership and is willing to jointly partake in the following recommendations and plan.

Proposed Basic Plan for Solution Improvement at the Wagner Unit

The answer is those who have an emic perspective on what is needed, or those who are intimate users of the system being examined that will be impacted by the Indian Health Care Improvement bill.

1. Tribal users of the Wagner IHS Clinic are ideally situated to provide problem areas they experience and solutions they propose and these should be documented. Importantly, their perspective on local IHS Wagner staff members is needed because they can identify who is helpful and who embodies the mission of the IHS.

Therefore, a focus group of 10 diverse IHS Wagner users should be convened to list problems/concerns. Also, to identify a list of 10 IHS Wagner staff they perceive as most helpful and dedicated to the mission.

2. A focus group of 10 IHS Wagner staff will be convened as identified by the Tribal user group. They too will identify the top problem areas they see from the inside perspective on service delivery. In addition, they will identify what they perceive as priority solutions.

3. A report will be completed by the IHS Wagner Facility Director to delineate his inside or emic perspective on solutions.

4. An appropriate tribal member from Yankton should lead the IHS consumer group with staff support to document notes and generate a qualitative report, which would be determined by the leadership team of Mr. Horned Eagle, Treaty Committee and Business and Claims Committee.
5. An appropriate outside healthcare professional should lead the IHS staff group along with a Yankton Tribal Member.
6. The appropriate healthcare professional can generate the final report to Senator Thune and the tribe, determined by the tribal leadership team who will then present the findings in hearings to the Ihanktonwan/Yankton Sioux Tribe.
7. All parties, with the strong support of Thune to seek restoration of funding for a FULL FLEDGED EMERGENCY ROOM AT THE WAGNER UNIT, TO PREVENT FURTHER UNTIMELY DEATHS.
8. We will provide joint leadership from the tribe, Senator Thune, the Chairman, the Treaty Committee and the Business and Claims Committee to revisit and clearly define and explore the best benefits for both parties in regard to the Veteran's Administration and Indian Health Service and seek technical assistance from the Veteran's Administration for a more balanced relationship. At the current time, the Wagner Unit is giving more than receiving from the VA.
9. Senator Thune will take actions to obtain appropriate funding to implement the findings. The IHS Wagner Facility Director will measure the outcomes and providing follow reporting per protocol. This is encouraged by Mr. Thune's statement below.
10. Lastly, we strongly urge Senator Thune to seek INCREASED NEW FUNDING TO ACCOMPLISH THE PROPOSED FOLLOWING THREE ITEMS IN THE NEW LEGISLATION AND THAT THEY NOT BE FUNDED BY EXISTING LEVELS, WHICH ARE INADEQUATE FOR ALL OTHER AREAS.
 - Improving protections for employees who report violations of patient safety requirements.
 - Mandating that the secretary of HHS provide timely Indian Health Service spending reports to Congress; and
 - Ensuring the Inspector General of HHS investigates patient deaths in which the Indian Health Service is alleged to be involved.

" . . . We need a willing partner at IHS who takes these issues as seriously as I do. As far as I'm concerned, this conversation is far from over."

A part of this conversation can be an emic viewpoint from those who receive healthcare services and those who deliver them. This is organizational wisdom from a Dakota culturally based foundation.

PREPARED STATEMENT OF SUSAN T. GRUNDMANN, CHAIRMAN, U.S. MERIT SYSTEMS PROTECTION BOARD (MSPB)

Chairman Barrasso, Vice Chairman Tester, and distinguished Members of the United States Senate Committee on Indian Affairs. Thank you for the invitation to present a written statement on behalf of the United States Merit Systems Protection Board (MSPB) in connection with the Committee's June 17, 2016 hearing entitled: "Improving Accountability and Quality of Care at the Indian Health Service through S. 2953."

As an initial matter, I would like to note that under statute, MSPB is prohibited from providing advisory opinions on any hypothetical or future personnel action within the executive branch of the federal government. 5 U.S.C. § 1204(h) ("The Board shall not issue advisory opinions."). Accordingly, this statement should not be construed as an indication of how I, any other presidentially appointed, Senate-confirmed Member of the Merit Systems Protection Board ("Board"), or an MSPB administrative judge would rule in any pending or future matter before the agency. Moreover, during my time as Chairman, MSPB has not taken policy positions on legislation pending before Congress. Generally, I view MSPB's role in the federal civil service as an independent adjudicator of appeals in accordance with legislation passed by Congress and signed into law by the president. Accordingly, I would respectfully request that the Committee consider the substance of my statement to be technical in nature.

MSPB's Adjudication Function

MSPB's views on S. 2953—the Indian Health Service Accountability Act of 2016, or the "IHS Accountability Act of 2016"—derive from its statutory responsibility to adjudicate appeals filed by federal employees in connection with certain adverse em-

ployment actions. Generally, after a federal agency imposes an adverse personnel action upon a federal employee, such as removal or demotion, and the federal employee chooses to exercise his or her statutory right to file an appeal with MSPB, MSPB will begin the adjudication process. In the case of a federal employee who is removed from his or her position, that individual is no longer employed by the federal government, and is not receiving pay at the time he or she files an appeal with MSPB or at any point during the subsequent MSPB adjudication process.

Once an appeal is filed, an MSPB administrative judge¹ in one of MSPB's regional or field offices will first determine whether MSPB has jurisdiction to adjudicate the appeal. If MSPB has jurisdiction, the administrative judge may conduct a hearing on the merits and then issue an initial decision addressing the federal agency's case and the appellant's defenses and claims. Thereafter, either the appellant or the named federal agency may file a petition for review of the MSPB administrative judge's initial decision to the three-Member Board. The Board Members constitute an administrative appellate body that reviews the administrative judge's decision and issues a final decision of the MSPB. Both the Board Members and MSPB administrative judges adjudicate appeals in accordance with statutory law, federal regulations, precedent from United States federal courts, including the Supreme Court of the United States and the United States Court of Appeals for the Federal Circuit, and MSPB precedent.

Requirements of S. 2953

S. 2953 contains language that is virtually identical to Section 707 of the Veterans Access, Choice, and Accountability Act of 2014 ("the 2014 Act"), which was enacted into law and became effective in August 2014. (Public Law No. 113-146). In pertinent part, S. 2953 would allow the Secretary of Health and Human Services ("Secretary"), acting through the Director of Service, to remove, demote, or transfer employees, including Senior Executive Service ("SES") employees, of the Indian Health Service ("Service") if the Secretary determines the performance or misconduct of the employee warrants such a personnel action. Specifically, S. 2953 would allow the Secretary to take the following personnel actions:

- Remove the employee from the civil service altogether;
- Regarding SES employees, transfer the employee from the SES to a position in the General Schedule at any grade of the General Schedule for which the employee is qualified and that the Secretary determines is appropriate; and
- Regarding managers and supervisors, reduce the grade of these employees to any other grade for which the employee is qualified and the Secretary determines is appropriate.

With respect to the above-referenced personnel actions, S. 2953 provides that "the procedures under chapters 43 and 75 of title 5, United States Code, shall not apply."² Instead, S. 2953 provides that "before an employee may be subject to a personnel action, he or she must be provided with: (1) written notice of the proposed personnel action not less than 10 days before the personnel action is taken; and (2) an "opportunity and reasonable time" to answer orally or in writing. Finally, with respect to SES employees who are transferred to a General Schedule position and managers/supervisors whose grades have been reduced, S. 2953 provides that they

¹ MSPB administrative judges are federal employees under the General Schedule System employed by MSPB. They are not "administrative law judges" appointed under 5 U.S.C. § 3105 nor federal judges.

² Under 5 U.S.C. § 7513(b)(1)-(4) and (d), a federal employee against whom certain adverse actions are proposed is generally entitled to: 1) at least 30 days advance written notice stating the specific reasons for the federal agency's proposed action; 2) not less than 7 days to respond to the proposed adverse action; 3) be represented by an attorney or other representative before the federal agency; 4) a written decision and the specific reasons therefor by the federal agency; and 5) file an appeal to MSPB under 5 U.S.C. § 7701. Under 5 U.S.C. § 4303(b)(1), a federal employee who is subject to removal or a reduction in grade for unacceptable performance is generally entitled to: 1) at least 30 days advance written notice of the federal agency's proposed action identifying certain information; 2) be represented by an attorney or other representative before the federal agency; 3) a reasonable time to answer orally and in writing to the proposed adverse action; 4) a written decision by the federal agency specifying the instances of unacceptable performance which has been concurred in by an employee who is in a higher position that proposes the removal or reduction in grade; and 5) appeal to MSPB under 5 U.S.C. § 7701. Moreover, under 5 U.S.C. § 4302(b)(5), before a federal agency can take a personnel action based on performance, the employee whose performance is in question shall be provided an opportunity to improve his or her unacceptable performance.

may not be placed on administrative leave or “any other category of paid leave”³ during the period during which an MSPB appeal is ongoing.

Expedited MSPB Appeal Rights Under S. 2953

Employees who are either removed or demoted by the Secretary may appeal that personnel action to MSPB “under section 7701 of title 5.” Any appeal must be filed with MSPB “not later than seven days after the date of the personnel action”⁴ and the MSPB will be required to refer the appeal to an “administrative law judge”⁵ for adjudication. An administrative law judge would be required to issue a decision “not later than 21 days after the date of the appeal,” and that decision “shall be final” and not subject to further review, either by the Board or a United States federal court. In the event that an administrative law judge does not issue a final decision within 21 days, the decision of the Secretary to remove or demote the employee becomes final and the employee has no further right to appeal.

Possible Constitutional Defects of S. 2953

In May 2015, MSPB released a study⁶ entitled: *What is Due Process in Federal Civil Service Employment?* The report provides an overview of current civil service laws for adverse actions and, perhaps more importantly, the history and considerations behind the formation of those laws. It also explains why, according to the Supreme Court of the United States, the Constitution requires that any system which provides that a public employee may only be removed for specified causes must also include an opportunity for the employee—prior to his or her termination—to be made aware of the charges the employer will make, present a defense to those charges, and appeal the removal decision to an impartial adjudicator. We encourage Members of the Committee and their staff who have interest in these issues to read this report.⁷

In the landmark decision of *Cleveland Board of Education v. Loudermill*, 470 U.S. 532 (1985) the Supreme Court held that while Congress (through statutes) or the president (through executive orders) may decide whether to grant protections to employees, they lack the authority to decide whether they will grant due process rights once those protections are granted. Stated differently, when Congress establishes the circumstances under which employees may be removed from positions (such as for misconduct or malfeasance), employees have a property interest in those positions. *Loudermill*, 470 U.S. at 538–39.⁸ Specifically, the *Loudermill* Court stated:

Property cannot be defined by the procedures provided for its deprivation any more than can life or liberty. The right to due process is conferred, not by legislative grace, but by constitutional guarantee. While the legislature may elect not to confer a property interest in public employment, it may not constitutionally authorize the deprivation of such an interest, once conferred, without the appropriate procedural safeguards.

³This provision appears to prohibit a federal employee from using any accrued annual or sick leave if he or she chooses exercise his or her right to appeal the adverse action of a transfer or demotion. Unlike employees who are removed from the civil service, employees who are transferred and/or demoted remain federal employees during the pendency of an MSPB appeal. Thus, this provision would appear to prohibit a federal employee from using leave which he or she has earned and—in most circumstances—is entitled to use, while employed. It is also possible that this provision could have a chilling effect on employees who seek to file MSPB appeals, per their statutory rights.

⁴Generally, under current law, an appeal must be filed at MSPB no later than 30 days after the effective date, if any, of the action being appealed, or 30 days after the date of the appellant’s receipt of the agency’s decision, whichever is later. 5 C.F.R. § 1201.22(b).

⁵MSPB does not directly employ any administrative law judges, but can retain the services of administrative law judges via service contracts with other federal agencies. Thus, if S. 2953 were to become law, and MSPB were required to retain the services of administrative law judges to adjudicate appeals covered by this legislation—instead of using MSPB administrative judges—MSPB would likely incur significant operating costs. Moreover, MSPB has no supervisory authority over administrative law judges and could not ensure that they issue final decisions within 21 days. MSPB recommends amending S. 2953 to address this matter.

⁶In addition to adjudicating appeals filed by federal employees, MSPB is required under statute to: Conduct, from time to time, special studies relating to the civil service and to the other merit systems in the executive branch, and report to the President and to Congress as to whether the public interest in a civil service free of prohibited personnel practices is being adequately protected. 5 U.S.C. § 1204(a)(3).

⁷This report can be found at: <http://www.mspb.gov/netsearch/viewdocs.aspx?docnumber=1166935&version=1171499&application=ACROBAT>

⁸The *Loudermill* case involved a state employee, not a federal employee. Nevertheless, while the Federal Government is covered by the Fifth Amendment and the states by the Fourteenth Amendment, the effect is the same. See *Lachance v. Erickson*, 522 U.S. 262, 266 (1998); *Stone v. Federal Deposit Insurance Corp.*, 179 F.3d 1368, 1375–76 (Fed. Cir. 1999).

Id. at 541.

The Court explained that the “root requirement” of the Due Process Clause is that “an individual be given an opportunity for a hearing before he is deprived of any significant property interest,” and that “this principle requires some kind of a hearing prior to the discharge of an employee who has a constitutionally protected property interest in his employment.” *Id.* at 542.

According to the Court, one reason for this due process right is the possibility that “[e]ven where the facts are clear, the appropriateness or necessity of the discharge may not be; in such cases, the only meaningful opportunity to invoke the discretion of the decisionmaker is likely to be before the termination takes effect.” *Id.* at 542. The Court further held that “the right to a hearing does not depend on a demonstration of certain success.” *Id.* at 544.

I further note that the requirements of the Constitution have shaped the rules under which federal agencies may take adverse actions against federal employees, as explained by the Supreme Court, U.S. Courts of Appeal, and U.S. District Courts. Accordingly, should Congress consider modifications to these rules, many of which have been in place for more than one hundred years, MSPB respectfully submits that the discussion be an informed one, and that all Constitutional requirements be considered.

As stated above, S. 2953 provides ten days’ notice to an employee prior to a personnel action, a “reasonable time” to respond, and the right to an expedited appeal at MSPB. Whether these rights—taken as a whole—satisfy constitutional due process requirements would depend on the various factors and the circumstances of a given appeal, and it would be inappropriate for me to address that issue here. I note, however, that the constitutionality of Section 707 of the 2014 Veterans Access, Choice, and Accountability Act is currently the subject of litigation at the United States Court of Appeals for the Federal Circuit. *Helman v. Dep’t. of Veterans Affairs*, Case No. 15–3086 (Fed. Cir. 2015). The plaintiff in that litigation is alleging that Section 707 is unconstitutional primarily on two grounds:

- By permitting the Department to remove a tenured federal employee without any pre-removal notice or an opportunity to respond, and by severely limiting post-removal appeal rights, Section 707 violates an employee’s right to constitutional due process as articulated by the Supreme Court; and
- By removing the Board from the MSPB appellate review process and permitting MSPB administrative judges to make a final decision binding an executive branch agency which is not reviewable by a presidential appointee, Section 707 violates the Appointments Clause contained in Article II, Section 2 of the United States Constitution.

Significantly, on June 1, 2016, the United States Department of Justice filed a brief with the Federal Circuit in *Helman* stating that it was declining to defend the constitutionality of the provision of Section 707 that removed the Board members from the MSPB adjudication process and permitted MSPB administrative judges to have final decisionmaking authority in appeals on behalf of the MSPB. According to the Department of Justice, the “final authority to interpret and apply the civil service laws of the United States” must remain in the hands of officials properly appointed under the Appointments Clause of Article II of the Constitution. It noted that MSPB administrative judges are “regular government employees” who—under the 2014 Act—are provided “the significant authority” that is properly exercised by the presidentially-appointed, Senate-confirmed “members of the Merit Systems Protection Board.” Consequently, the Department of Justice moved the Federal Circuit to declare that provision of law invalid and remand Ms. Helman’s appeal back to MSPB for further proceedings. On June 17, 2016, the Department of Veterans Affairs announced that it would no longer use the personnel authority provided by the 2014 Act as a result of the Department of Justice’s determination that the above-referenced provision of the Act was unconstitutional.

Finally, I note that the provision of S. 2953 that states that the Secretary’s decision with respect to the personnel action in question becomes “final” in the event that an administrative law judge does not issue a decision within 21 days may very well be on weak constitutional footing. This provision could be interpreted to suggest that a federal employee—who unquestionably possesses a federal property interest in his or her federal employment—loses his or her right to due process if the MSPB (a government actor) fails to hold a hearing and issue a final decision within 21 days.

In *Logan v. Zimmerman Brush Co.*, 455 U.S. 422 (1982), the Supreme Court noted that “the Due Process Clause grants the aggrieved party the opportunity to present his case and have its merits fairly judged. Thus it has become a truism that ‘some

form of hearing' is required before the owner is finally deprived of a protected property interest." *Id.* at 433, citing *Board of Regents v. Roth*, 408 U.S. 564, 570–571, n.8. The *Logan* Court considered whether Mr. Logan lost his due process right to a hearing and final decision on his claims because the State of Illinois failed—through its own fault—to comply with a 120 day procedural requirement required under Illinois statute. It held that he did not.

The Court emphasized that the Fourteenth Amendment requires “an opportunity. . . . granted at meaningful time and in a meaningful manner. . . . for a hearing appropriate to the nature of the case.” *Id.* at 437 (internal citations omitted) (emphasis added). Thus, under *Logan*, an individual who possesses a federal property interest in his or her federal employment must be provided a meaningful hearing prior to that deprivation of that property, and the failure of a government actor to comply with certain procedural requirements—such as a time requirement in connection with a hearing—likely does not eliminate that individual’s constitutional rights. In light of *Logan*, I urge the Committee to consider whether any time limit with respect to the issuance of a final MSPB decision is proper.

Permitting Appeals to MSPB “Under 5 U.S.C. § 7701”

Similar to the 2014 Act, S. 2953 would permit covered employees to appeal to MSPB “under 5 U.S.C. § 7701.” Section 7701 of title 5, United States Code, provides in pertinent part that “the decision of an agency shall be sustained. . . . only if the agency’s decision. . . . is supported by a preponderance of the evidence.” 5 U.S.C. § 7701(c)(1)(B). The term “preponderance of the evidence” is defined as “the degree of relevant evidence that a reasonable person, considering the record as a whole, would accept as sufficient to find that a contested fact is more likely to be true than untrue.” 5 C.F.R. § 1201.4(q).

Additionally, 5 U.S.C. § 7701(c)(2)(B) provides that “an agency’s decision may not be sustained. . . . if the employee or applicant for employment shows that the decision was based on any prohibited personnel practice described in section 2302(b) [of title 5, United States Code].” Among the “prohibited personnel practices” described in section 2302(b) are illegal discrimination, 5 U.S.C. § 2302(b)(1)(A)–(E), coercion of political activity or reprisal for refusal to engage in political activity, 5 U.S.C. § 2302(b)(3), and reprisal for lawful “whistleblowing,” 5 U.S.C. § 2302(b)(8). Thus, if such issues are raised by appellants as defenses in appeals filed pursuant to the language contained in S. 2953, MSPB administrative judges will be required under law to consider those defenses—which often are fact intensive and complicated—prior to issuing a final decision within 21 days.

This concludes my written statement. I am happy to address any questions for the record that Members of the Committee may have.

PREPARED STATEMENT OF MAX STIER, PRESIDENT/CEO, PARTNERSHIP FOR PUBLIC SERVICE

Chairman Barrasso, Vice Chairman Tester, Members of the Senate Committee on Indian Affairs, thank you for the opportunity to provide a statement for the record on S. 2953, the *Indian Health Service Accountability Act of 2016*.

I am Max Stier, President and CEO of the Partnership for Public Service. The Partnership is a nonpartisan, nonprofit organization dedicated to revitalizing our federal government by inspiring a new generation to enter public service and transforming the way government works. We believe that making our government more efficient, effective, and accountable begins with smart hiring practices, engaged employees and strong, competent leaders. Congress has entrusted the Indian Health Service (IHS) with making good our country’s obligations to native peoples. If the agency is to do so, it must be able to recruit, hire and retain talented employees, hold those employees accountable for their performance, and provide them with the resources and tools to necessary to achieve their unique and rewarding mission of delivering quality health care to American Indians and Alaska Natives. In this statement, I will focus on the proposed legislation’s accountability, performance and hiring provisions.

The good news is that, as a whole, employees of the Indian Health Service are highly connected to the mission of the agency, as measured by the Partnership’s, *Best Places to Work in the Federal Government* rankings¹. The rankings, based on data from the Federal Employee Viewpoint Survey (FEVS) administered by the Office of Personnel Management (OPM), are the most comprehensive and authoritative

¹The *Best Places to Work in the Federal Government* rankings are produced in partnership with Deloitte Consulting.

rating of employee satisfaction and commitment in the federal government. They consist of an “index score”, which measures employees’ satisfaction and commitment, and 10 “workplace categories” which measure employees’ views on particular aspects of the workplace. In 2015, IHS scored 79.9 out of 100 in the workplace category of “Employee Skill-Mission Match”, which measures the extent to which employees feel that the agency uses their skills and talents effectively.² The category also assesses the level of which employees get satisfaction from their work and understand how their jobs are relevant to the organizational mission. This score was relatively high with a ranking of 57 out of 319 ranked agency subcomponents, putting the IHS in the group’s top quartile. According to the 2015 FEVS, IHS employees also score above government as a whole on specific questions including “I like the kind of work I do,”³ and “My talents are well used in the workplace.”

The Indian Health Service faces challenges as well. The agency scored near the bottom of all agencies in the workplace categories of “Effective Leadership”, “Teamwork”, and “Support for Diversity.”³ The IHS ranked 301 out of 318 agency subcomponents in employee views of leadership, 317 out of 319 in employee views of teamwork in their agency and 313 out of 319 in employee views of how their agency promotes and respects diversity. These data are consistent with the findings of the Committee’s 2010 report, “In Critical Condition: The Urgent Need to Reform the Indian Health Service’s Aberdeen Area” as well as more recent investigations.⁴ Particularly troubling is how poorly the IHS fares in the category of “Effective Leadership” and especially the subcategory measuring employee opinions of their immediate supervisor, including how well supervisors give employees the opportunity to demonstrate leadership, support employee development, and provide worthwhile feedback about job performance. The Partnership’s research has consistently found that employee views of leadership are the single biggest driver of satisfaction with their organization. The IHS ranked 315 out of 318 subcomponents with a score of 53.2 out of 100 in the “Effective Leadership: Supervisors” subcategory. To put this in context, the highest scoring subcomponent in this subcategory in 2015 was the Federal Energy Regulatory Commission’s Office of the General Counsel with a score of 86.1.⁵ The state of leadership at the Indian Health Service should, therefore, continue to be a priority for this Committee. The IHS significantly underperforms government as a whole in positive responses to FEVS questions including “Supervisors work well with employees of different backgrounds”, “I have trust and confidence in my supervisor”, “My supervisor treats me with respect”, and “Employees in my work unit share job knowledge with each other.” In the overall measure of employee satisfaction and commitment, the Indian Health Service ranked 248 out of 320 total agency subcomponents with an index score of 54.5.⁶

This committee is right to be troubled by the reports coming out of particular Indian Health Service facilities, and the Partnership shares your concern. It is unfortunate that the actions of a few can do so much to tarnish the work of the many thousands of employees who have dedicated their careers to serving Native communities. However, firing a few bad actors is not a long-term solution to systemic management problems; the IHS will never be able to fire its way to excellence. The Partnership believes that the most effective way to address the performance and talent challenges of the IHS and other agencies is a comprehensive overhaul of the civil service system, and we outlined a framework to achieve this goal in 2014.⁷ We understand that this kind of reform is outside the committee’s purview. In its absence, there is still much you can do to hold poor performers accountable, as well as attract new talent, reward and recognize the best employees, and set them up for success

²“Department of Health and Human Services.” Best Places to Work in the Federal Government. Accessed June 24, 2016. <http://bestplacetowork.org/BPTW/rankings/detail/HE37>.

³The workplace category of “Effective Leadership” measures the extent to which employees believe leadership at all levels of the organization generates motivation and commitment, encourages integrity and manages people fairly, while also promoting the professional development, creativity and empowerment of employees. “Teamwork” measures the extent to which employees believe they communicate effectively both inside and outside their team organizations, creating a friendly work atmosphere and producing high-quality work products. The “Support for Diversity” category measures the extent to which employees believe that actions and policies of leadership and management promote and respect diversity.

⁴United States of America. United States Senate Committee on Indian Affairs. *In Critical Condition: The Urgent Need to Reform the Indian Health Service’s Aberdeen Area*. Washington, DC: United States Senate Committee on Indian Affairs, 2010.

⁵“Department of Health and Human Services.” Best Places to Work in the Federal Government. Accessed June 24, 2016. <http://bestplacetowork.org/BPTW/rankings/detail/HE37>.

⁶*Ibid.*

⁷United States of America. Congressional Research Service. *The Indian Health Service (IHS): An Overview*. By Elayne J. Heisler. Washington, DC: Congressional Research Service, 2016.

without jeopardizing due process or moving towards an “at-will” system of employment that would undermine our non-political civil service.

Faster Firing Is Not the Answer

The goal of an accountable and well-equipped Indian Health Service workforce is an important one. As the Committee considers the *Indian Health Service Accountability Act of 2016*, we urge you to think carefully about whether these proposed changes to due process and employment rights are the best way to achieve this goal. In the Partnership’s view, they are not the answer; in fact, the changes considered here may have unintended consequences that reduce protection for whistleblowers and diminish incentives for experienced and dedicated employees to join an agency already struggling to recruit the talent it needs. Though well intentioned, S. 2953 severely undermines due process protections for employees and could lead to removals for partisan or discriminatory reasons.

We believe strongly that the Indian Health Service has the authorities needed to take corrective action, up to and including removing an employee from the civil service when warranted. If it is to tackle these problems in a sustainable and lasting way, the IHS needs empowered managers who are willing to take action to deal with poor performers and senior leadership and human resources staff willing to support them. The agency also needs employees who are engaged in the work and mission of their agency, communicate effectively, and work together toward common goals.

While accomplishing these things will take time, there is much that the Committee can do to move the Indian Health Service in the right direction. For example, requiring more training on the disciplinary process and how to deal with poor performers would better equip frontline managers and supervisors to manage the performance of their employees and engage in difficult conversations that many now choose to avoid. This training should include how to motivate, engage and reward employees. Managers should then be held accountable for the performance of their employees and their efforts to keep their teams satisfied and engaged. The Committee should also strengthen the probationary period at the IHS for both frontline employees and new supervisors and managers. In the federal government, newly-hired employees and new supervisors undergo a probationary period, typically of one year, to evaluate the employee’s conduct and performance to determine if the employee’s appointment to the civil service should become final.⁸ In the IHS, as in most other federal agencies, the probationary period is considered a formality rather than an extension of the assessment process as it was originally intended to be.⁹ By requiring supervisors to make an affirmative decision to keep an employee past the employee’s probationary period, you can ensure agencies are using this time to evaluate new employees and determine whether they have earned a permanent place in the workforce.

Finally, the Committee should require the Indian Health Service to collect and report data on disciplinary process outcomes. Significant changes to the law should be based on measurable data rather than on anecdotes and individual cases. It is critically important that in considering further legislative changes, the Committee takes care to make reforms after fully deliberating their potential impact. The Committee can better understand the disciplinary process at the IHS by requiring the agency to report on the number of disciplinary actions proposed, the result of those actions, the average length of the disciplinary process, the extent to which administrative leave is used in disciplinary cases, and the number of decisions overturned or settled. These data would allow the IHS and the Committee to understand better the state of the disciplinary process, process outcomes, and where breakdowns occur, and could inform future oversight. We would be pleased to provide legislative language to the Committee to this effect.

Recommendations

Beyond the ideas offered above, I include here several additional recommendations for improving S. 2953 as currently drafted:

- *Handle Appeals at the Level of the Full Merit Systems Protection Board*—Employees and executives slated for demotion or removal under the *Indian Health Service Accountability Act of 2016* would have their appeal heard by an MSPB administrative law judge (ALJ). Such an appeals structure is problematic. As a recent decision by the U.S. Department of Justice (DOJ) relating to nearly identical language in Section 707 of the *Veterans Access, Choice, and Account-*

⁸United States of America. Merit Systems Protection Board. *The Probationary Period: A Critical Assessment Opportunity*. Washington, DC: Merit Systems Protection Board, 2005. i.

⁹*Ibid* ii.

ability Act of 2014 found that vesting final decisionmaking authority in an ALJ violates the Constitution's Appointments Clause and is, therefore, invalid.¹⁰ Given this recent decision, we recommend amending the language in S. 2953 to send appeals to the full Merit Systems Protection Board. This change will sidestep the current legal challenges as well as bring to bear greater resources in the adjudication of IHS appeals.

- *Align Accountability Provisions with Current Law*—We believe the bill can better address concerns over fairness through greater alignment with existing law. First, an employee facing a major adverse action such as demotion and removal from the civil service should have 30 rather than ten days of written notice. This change would align the bill with current law and provide employees more time to prepare a meaningful response to the agency's action.¹¹ Second, the language granting the Secretary authority to remove an employee from the civil service, if the Secretary determines that the performance or misconduct of the employee warrants removal, should be amended to state that the personnel action will promote the efficiency of the service. This addition will align the bill with current statute.¹²
- *Provide More Flexibility in the Use of Administrative Leave*—The Act states that the agency cannot place an employee appealing a personnel action on administrative leave. We recommend changing this language to allow the agency to place an employee on administrative leave with the approval of the Director of the Indian Health Service. There may be rare instances when it makes sense to use administrative leave, such as if an employee poses a threat to themselves or other employees, if their presence would result in loss or damage to government property, or if the employee otherwise jeopardizes legitimate government interests. It also may be appropriate to remove an employee from the worksite in situations where an investigation is taking place and the agency does not have all the facts. In any case, the use of leave should be limited and transparent.
- *Sharing of Senior Executive Personnel Files Raises Privacy Concerns*—We are concerned that language in Section 4 of the proposed legislation making available a senior executive's employment record to tribal organizations may present privacy concerns. Further, the knowledge that individuals from outside the agency will review an executive's records may lead to a reduced willingness on the part of managers to put clear and candid information in files. We do recognize, however, the importance of transparency with the customers of the IHS, and urge the Committee to consider alternate ways to transmit and share information about the senior executives responsible for leading Area offices or Service units with tribes in a manner that does not compromise privacy.
- *Require a Performance Plan for the Director of the Indian Health Service and Other Political Appointees*—Career employees and executives undergo a performance planning and appraisal process every year. Political appointees should be required to participate in a similar process. For example, as the highest level of leadership in the Indian Health Service, the Director plays a crucial role in providing leadership and setting priorities. In 2015, the Indian Health Service ranked just 271 out of 318 agency subcomponents in employee satisfaction with senior leaders. Appraising political leadership on and holding senior leaders accountable for setting expectations and developing an empowered and engaged workforce can improve satisfaction and help accountability cascade throughout the organization. Leaders should be rated on efforts to promote best practices and efforts to recruit, select and retain talent, engage and motivate employees, train and develop future leaders, and hold managers accountable for managing performance and dealing with poor performers.

Hiring Reforms are a Good Start, and the Committee Should Go Further

We are pleased to see the Committee demonstrate a strong commitment to addressing the Indian Health Service's long-standing workforce challenges. Inspiring and hiring a new generation into public service is a core part of the Partnership's mission; we believe agencies must have a more flexible and responsive hiring process that more effectively locates and assesses talent. For this reason, we believe the ideal solution is comprehensive hiring reform that places agencies on a level playing

¹⁰ *Helman v. Department of Veterans Affairs*, No. 15-3086 (Fed. Cir.). Loretta E. Lynch to Patricia Bryan, Senate Legal Counsel. May 31, 2016. Office of the Attorney General, Washington, DC.

¹¹ 5 U.S. Code § 7513

¹² *Ibid.*

field with each other and, to the extent possible, with the private sector. Hiring improvements should be combined with marketbased compensation that grants agencies the flexibility to set salaries the way any private sector organization would. While the Indian Health Service is not alone in its struggles to recruit, hire and retain specialized talent—organizations such as the Department of Veterans Affairs face similar difficulties—its challenges are nonetheless significant and require action.

The Indian Health Service faces two major hurdles in bringing in the talent it needs: recruiting medical professionals to remote locations and compensation below comparable private sector levels. The numbers paint an alarming picture of the Indian Health Service's success in addressing these challenges. GAO's March 2016 report, *Indian Health Service: Actions Needed to Improve Oversight of Patient Wait Times*, reported that according to the IHS 2016 budget justification, the agency had over 1,550 healthcare professional vacancies in the system.¹³ In testimony before this Committee in February, Robert McSwain, Principal Deputy Director of the Indian Health Service, reported that the Great Plains Area is facing a physician vacancy rate of 37 percent.¹⁴ In 2014, the system-wide vacancy rate for physicians and nurses was 20 percent, and 650 separate IHS facilities reported provider shortages.¹⁵ On the compensation side, the IHS starting salary is roughly a third of what providers can earn elsewhere.¹⁶ And while IHS offers some loan repayment and scholarship programs for medical professionals, they are underfunded and underutilized; in fiscal year 2014, over 500 applications for loan repayments were denied due to¹⁷ limited funds.¹⁸

The Indian Health Service faces recruitment and hiring difficulties by nature of the location of its facilities and compensation structure, but the agency's hiring process exacerbates these challenges. A 2011 report by Merritt Hawkins found that "paperwork/red tape" was the factor having the most negative effect on clinician turnover at IHS facilities.¹⁹ The Department of Health and Human Services FY 2016 Annual Performance Plan and Report stated that the IHS average time to hire was 114 days as of 2014. GAO found that at one Navajo area facility, the length of the hiring process averaged 190 days, with some hires taking as long as 738 days.²⁰ These figures are well above the target of 80 days laid out by the administration as part of its 2010 hiring reform effort.²¹ The most recent FEVS data shows that only just over a third of IHS employees believe their work unit can recruit people with the right skills—below the government-wide score. IHS is reportedly working to re-engineer its human resources, deploy new strategies and tools to recruit medical professionals, and better utilize external partners to build its workforce.²² These are, taken together, an important step in the right direction, and we encourage the Committee to maintain its focus on the organization's human capital needs.

The *Indian Health Service Accountability Act of 2016* includes some important and meaningful reforms that we believe will have a positive impact on the agency's outstanding recruitment and hiring challenges. In particular, we applaud the Com-

¹³United States of America. Government Accountability Office. *Indian Health Service: Actions Needed to Improve Oversight of Patient Wait Times*. Washington, DC: Government Accountability Office, 2016. 21.

¹⁴"*Reexamining the Substandard Quality of Indian Health Care in the Great Plains*", 114th Cong., 9 (2016) (testimony of Robert McSwain, Principal Deputy Director, Indian Health Service).

¹⁵United States of America. Congressional Research Service. *The Indian Health Service (IHS): An Overview*. By Elayne J. Heisler. Washington, DC: Congressional Research Service, 2016.

¹⁶United States of America. Government Accountability Office. *Indian Health Service: Actions Needed to Improve Oversight of Patient Wait Times*. Washington, DC: Government Accountability Office, 2016. 23.

¹⁷United States of America. Government Accountability Office. *Health Care Workforce: Federally Funded Training Programs in Fiscal Year 2012*. Washington, DC: Government Accountability Office, 2016. 21.

¹⁸United States of America. Government Accountability Office. *Indian Health Service: Actions Needed to Improve Oversight of Patient Wait Times*. Washington, DC: Government Accountability Office, 2016. 23.

¹⁹2011 Clinical Staffing and Recruiting Survey. Report. Merritt Hawkins. Rockville, MD: Indian Health Service, 2011.

²⁰United States of America. Government Accountability Office. *Indian Health Service: Actions Needed to Improve Oversight of Patient Wait Times*. Washington, DC: Government Accountability Office, 2016. 23.

²¹"Human Capital Management Hiring Reform." U.S. Office of Personnel Management. Accessed June 27, 2016. <https://www.opm.gov/policy-data-oversight/human-capital-management/hiring-reform/#url=Hiring>.

²²"*Improving Accountability and Quality of Care at the Indian Health Service Through S.2953*", 114th Cong., 11 (2016) (testimony of Mary Smith, Principal Deputy Director, Indian Health Service).

mittee for authorizing direct hiring at the Indian Health Service and expanding market pay under Title 38 to IHS medical professionals. The Partnership advocated for both reforms in our 2014 civil service reform report. Allowing the IHS to request waivers for Indian Preference if the agency cannot otherwise access the talent it needs is also a good idea, and the Committee should consider offering this flexibility to other agencies, such as the Bureau of Indian Education, with similar recruitment and hiring difficulties. The additional recruitment and relocation incentives should be helpful tools as well.

To further improve the bill's hiring provisions, we urge you to think about what more can be done. We recommend the Committee consider language allowing the IHS to rehire former employees noncompetitively at any grade for which they qualify. Currently, agencies can only reinstate former employees at the last grade they held or below. This limited reinstatement authority means that qualified medical professionals who have left the agency and gained valuable experience outside of government may not be considered for noncompetitive reinstatement to a higher grade. It is in the government's interest to allow the IHS to have this option as an additional weapon in its arsenal to recruit former employees who may otherwise not return to federal service. Finally, the IHS should work with OPM to figure out how the agency can utilize the *Competitive Service Act of 2015*, enacted into law earlier this year, to reach talented individuals who were interviewed and rated by other agencies but not hired. This law gives the IHS the ability to access a broad pool of vetted talent from across government.

Recommendations

In addition to the ideas offered above, we would like to make the following recommendations to strengthen the recruitment, hiring and retention provisions of S.2953:

- *Expand upon GAO Report on IHS Staffing Needs*—The Partnership supports the bill's provision requiring a GAO report on Indian Health Service staffing needs. Making wellinformed decisions about how to address IHS workforce challenges requires accurate and up-to-date information. Towards this end, we believe GAO's report could be made even more useful. The Committee should request that the report also look at current legislative and regulatory barriers to more effective hiring at the IHS, current demographics of the organization's workforce, use of existing recruitment and retention tools and the state of workforce and succession planning at the agency. Specifically, does the IHS know who in the workforce is most likely to leave, what actions the agency is taking to address skills gaps and retain key talent, and what the agency is doing to transfer institutional knowledge?
- *Use the IHS Staffing Plan as an Accountability Mechanism*—Requiring the agency to develop a plan to address its staffing needs is a useful initial step. We believe the Committee can increase the value of this plan further. First, the IHS should be required to deliver the report within three to six months of the completion of GAO's study, rather than a full year. Given the need for drastic and immediate change at the IHS, a year is simply too long to wait. Second, the report should be recurring either for a set number of years or until the agency reaches a milestone determined by the Committee. Regular reporting on the recruiting, hiring and retention strategies of the IHS, combined with data on the agency's success in meeting the goals it has set for itself, will act as a meaningful measure of accountability both for the organization and for this Committee. The IHS staffing plan should also include, in addition to the responses to GAO's recommendations, how the IHS plans to work with other federal agencies and external organizations to improve recruitment and hiring, an evaluation of the agency's success in meeting hiring goals, and how the organization will utilize local talent sources. The IHS is reportedly looking at how to do these things already, and should integrate this information into the staffing plan.²³
- *Implement an Exit Survey at the IHS*—One of the best ways an agency can inform its recruitment and retention strategies is to understand why employees are leaving in the first place. We believe a voluntary exit survey would provide the IHS with useful data to help it retain key talent. These data should then be made available to all IHS human resources staff and hiring managers. IHS could also be required to report survey data to the Committee and held accountable for taking actions to improve.

²³ *Ibid.*

- *Collect Data on Hiring Process Outcomes*—If the Indian Health Service is to improve its hiring process, it must be able to measure outcomes and hold itself accountable for improvement. There are several sets of data which the Partnership believes are key to the IHS wrapping its arms around the state of its hiring process: information on the use of special hiring authorities and flexibilities, time-to-hire data disaggregated by internal and external hires, manager satisfaction with the quality of applicants and new hires, and satisfaction of applicants and new hires with the hiring process. The IHS should ensure that this data is being collected and shared consistently, and is being used to make meaningful process improvements. The IHS is reportedly taking proactive steps to ensure broad and diverse applicant pools, and we believe this data will greatly enhance that effort.²⁴
- *Provide Training to Managers and Supervisors on Hiring Authorities and Flexibilities*—The Committee should consider language requiring training for both human resources staff and hiring managers on how to use these new tools, as well as how to maximize current authorities and navigate Indian Preference, to enhance the effectiveness of its hiring process. As part of this, the agency should identify ways that it will educate its staff on how to improve recruitment and hiring practices. OPM’s “Hiring Excellence” campaign is already traveling the country offering in-person and virtual sessions to help federal agencies “foster collaboration and the strategic use of recruitment and hiring tools.”²⁵ However, given the unique nature of the Service’s work and its many agency-specific hiring authorities, additional training and education for employees would be warranted. Managers should then be held accountable for their efforts to bring talent into the organization; other agencies, such as the National Protection and Programs Directorate within the Department of Homeland Security, already do this.
- *Better Utilize Student Interns as a Pipeline for Entry-Level Talent*—According to data from the OPM FedScope database, just under seven percent of IHS employees are under the age of 30.²⁶ Compare this to the US workforce as a whole, in which workers under 30 make up 23 percent of the total.²⁷ The Pathways internship programs, created in 2010, allow agencies like the Indian Health Service to noncompetitively convert program participants to full-time federal employment from any federal agency as long as the individual meets the eligibility requirements for conversion. Given this authority, we recommend that the IHS work with the Department of Health and Human Resources and other agencies to create lists or platforms that allow it to access this talent pool. The Committee should also codify Pathways conversion authority for third-party and unpaid interns in undergraduate and graduate programs at the IHS. As of now, interns hired to work in government agencies through third-parties like the Washington Internships for Native Students Summer program hosted by American University can only credit half their hours towards conversion to a full-time position, despite the fact that they are performing substantially the same work; unpaid interns receive no credit at all towards conversion. The Committee should also look at expanding AmeriCorps noncompetitive hiring eligibility to encourage former AmeriCorps members to join IHS. Each of these reforms would expand the pipeline of proven entry-level talent entering the IHS and are especially critical given the overall lack of young talent at the agency. Chairman Barrasso, Vice Chairman Tester, Members of the Committee, thank you for providing me the opportunity to share the views of the Partnership for Public Service on this important piece of legislation. I look forward to further engagement with this Committee on how to strengthen the workforce of the Indian Health Service.

²⁴ Ibid.

²⁵ “Hiring Excellence.” U.S. Office of Personnel Management. Accessed June 24, 2016. <http://www.opm.gov/policy-data-oversight/hiring-information/hiring-excellence/>.

²⁶ “U.S. Office of Personnel Management—Ensuring the Federal Government Has an Effective Civilian Workforce.” FedScope Home Page. Accessed June 24, 2016. <https://www.fedscope.opm.gov/>.

²⁷ Rein, Lisa. “Millennials Exit the Federal Workforce as Government Jobs Lose Their Allure.” The Washington Post. 16 Dec. 2014. Web. 2016.

PREPARED STATEMENT OF HON. JOHN YELLOW BIRD STEELE, PRESIDENT, OGLALA
SIOUX TRIBE

My name is John Yellow Bird Steele and I serve as the President of the Oglala Sioux Tribal Council. The Oglala Sioux Tribe has been a consistent voice and has testified before this Committee on numerous occasions concerning the need to improve accountability and quality of care within the Indian Health Service (IHS). I appreciate the opportunity to submit this testimony on behalf of the Oglala Sioux Tribe to provide the Committee with the Tribe's views on S. 2953 and the need for legislation to address the current Indian health care crisis in the Great Plains region.

The United States is falling short of its treaty obligations to provide health care services to our tribal members.

In February, my colleague Sonia Little Hawk-Weston, Chairwoman of our Tribal Council's Health and Human Services Committee, testified before this Committee on the current state of crisis within the Indian health care system in the IHS Great Plains Area. As she stated in that testimony, the United States owes a trust duty to all Tribes and a specific treaty obligation to the Oglala Sioux Tribe to ensure the health and wellbeing of our Indian people. In the Sioux Treaty of 1868 (known as the Fort Laramie Treaty), the Great Sioux Nation and the United States agreed on a *quid pro quo*; by the terms of the Treaty, the United States promised to provide certain benefits and annuities to the Sioux Bands each year, including health care services, in exchange for the right to occupy vast areas of Sioux territory. The IHS is tasked with carrying out this duty by providing quality health care services in our communities, though the

responsibility belongs to the United States federal government as a whole. The evidence is clear that the IHS—and as a result, the United States—is failing at that task.

We thank the Committee for holding this field hearing, and we applaud Chairman Barrasso and Senator Thune for the introduction of S. 2953, the Indian Health Service Accountability Act of 2016. These steps and your leadership are sorely needed to address this very serious emergency, and the Oglala Sioux Tribe appreciates your efforts to hold the IHS—and indeed the federal government as a whole—accountable to deliver on the promise of quality health care for our people. As it stands, the Pine Ridge Hospital is not a functioning facility that is capable of meeting even the basic health care needs of our community. On top of the mismanagement problems that have been well highlighted by reports and witness testimonies before this Committee, our hospital facility is only utilizing a portion of our inpatient beds, and our intensive care unit is not even operational, due to funding, staffing, and equipment shortages and despite the high level of unmet health care needs on our Reservation. This situation is unacceptable; falls far short of the federal government's treaty obligations to our Tribe; and must be addressed.

S. 2953 would take important steps to implement needed reforms.

We are pleased to see that S. 2953 seeks to address several of the specific problems that the Oglala Sioux Tribe has raised in past testimony before this Committee.

Employee Accountability. The Oglala Sioux Tribe testified in February, for example, that poor management practices and the “recycling” or shuffling of problem employees persists within the Great Plains Area, as does the use of administrative leave in lieu of more appropriate action like demotion and firing. Simply put, the IHS is not accountable if its employees are not held accountable. S. 2953 seeks to address this mismanagement problem by enhancing the Secretary's authority to hire, fire, demote, and reward employees based on performance; by prohibiting any form of paid administrative leave during an appeal of any demotion, or payment of any rate increase, award, bonus, or other benefit during an appeal of any removal; and by assessing and beefing up whistleblower protections within the IHS. The Oglala Sioux Tribe supports these reforms, and emphasizes the importance of qualified and accountable leadership within the IHS and the Department of Health and Human Services, as well as strong ongoing Congressional oversight, to ensure that these authorities are appropriately utilized to fulfill the United States' trust responsibility to provide our tribal members with quality health care.

Staffing and Housing. The Oglala Sioux Tribe has also testified that insufficient staffing is a serious problem impacting both access to and the quality of health care services in the Great Plains Area. There are many factors that contribute to this staffing problem, including mismanagement, uncompetitive salaries, unattractive and underequipped facilities, the rural and isolated location of our facilities, lack of housing and other infrastructure, and many others. S. 2953 would take steps to address some of these specific factors—including staff housing, through a GAO study and housing plan as well as a housing voucher program in shortage areas—and by commissioning a GAO study on IHS staffing needs. We believe such a report could be an important tool in improving patient care, provided the report considers all of the interrelated factors contributing to the staffing problem within the IHS, is completed promptly,

and is followed by concrete steps to address those contributing factors. We would also refer this Committee to our February testimony, which notes the lack of housing on the Pine Ridge Reservation for health care and other professionals. While a housing voucher program could be useful, it will only be successful in combination with the development of housing infrastructure in the vicinity of our hospital and clinic facilities, as well as our schools, which are also in need of nurses and mental and behavioral health professionals.

Streamlined Hiring Authority. We are also happy to see that S. 2953 recognizes the need to streamline the hiring process within the IHS. We are somewhat concerned that, while S. 2953 removes time-consuming civil service hiring requirements for IHS employees, it does not provide an alternate system to ensure that the IHS follows a fair and impartial process to hire qualified candidates, and may be overbroad by including all categories of employees (e.g., groundskeepers, maintenance, accounting staff). We note that H.R. 5406, the Helping Ensure Accountability, Leadership, and Trust in Tribal Healthcare (HEALTTH) Act, would allow the Secretary to utilize, in place of the civil service requirements, VA hiring authorities set out in existing law in the hiring of employees for positions involving direct patient services or services incident to direct patient-care services (in other words, health care professionals). We are not certain that these authorities have succeeded in resolving recruitment and retention problems for the VA, but we do believe that careful attention should be paid to the question of what alternative hiring processes and procedures should be followed by the Secretary, and it may be helpful to draw from existing models.

Consultation in Hiring. S. 2953 would also require the Secretary to consult with Indian tribes located in the service area before hiring or transferring senior executives or top managers. This is a very important step to ensure transparency and accountability in IHS hiring decisions. The Oglala Sioux Tribe has testified previously to the need for the Tribe to be notified of and involved in the candidate selection process when the Area Office is listing and filling job vacancies.

Transparency in Financial Management. The Oglala Sioux Tribe has similarly testified that the IHS must improve transparency with respect to financial management. From the Tribe's perspective, we know only that very little funding seems to reach the facility level for direct patient care. What we currently lack is information necessary to determine the extent to which those funding inadequacies are the result of poor management decisions at the Area Office level and whether the Area Office is appropriately managing its funding to maximize patient care. S. 2953 responds to these concerns by requiring the Secretary to provide a report to Congress and Tribes each quarter of a fiscal year describing spending and outlays at each level of the IHS, and by limiting how the Secretary can spend unobligated funds at the end of the fiscal year.

In addition to these measures, the Oglala Sioux Tribe would like to see tribal consultation on the allocation of funding for the Pine Ridge Service Unit, not just unobligated funds. Furthermore, the report provided to Congress in Section 9 (609) (c) of the bill must also include a requirement that IHS report on the amount of third party resources collected by facility and service unit, and how those funds are being used to improve patient care in that service unit. Section 401(e) of the Indian Health Care Improvement Act, 25 U.S.C. 1641(e) requires the IHS to ensure that each service unit receive 100 percent of any third party resources it collects.

Per 25 U.S.C. § 1641(e)(1)(B), third party collections are primarily to be used “to achieve or maintain compliance with applicable conditions and requirements” of the Medicaid and Medicare programs. If there are amounts collected in excess of what is needed for this purpose, such collections shall be used “subject to consultation with the Indian tribes being served by the service unit . . . , for reducing the health resource deficiencies (as determined in section 1621(c) of this title) of such Indian tribes.” In addition, Section 207 of the IHCA, 25 U.S.C. 1621f requires third party resources collected at the service unit level to be credited to the service unit and used for the provision of health services.

The Tribe has reason to doubt that third party collections at the Pine Ridge Service Unit have been left at the Service Unit and used to provide health services at the service unit level and to meet Medicare and Medicaid conditions of participation. First, as has been well documented, the Pine Ridge Hospital is not currently meeting Medicare conditions of participation despite the fact that we understand that it does collect third party resources from the Medicaid and Medicare programs. Second, the IHS recently used \$50 million in third party collections to pay an administrative settlement of a union grievance in arbitration.¹ The Tribe challenged the IHS in court over the use of the \$50 million in third party collections to pay for the settlement as unlawful under the IHCA. Unfortunately, we did not prevail on the temporary restraining order and the IHS moved forward and expended the funds to settle its union grievance. We remain gravely concerned by the fact that there was such a large amount of third party collections readily available to the IHS that was not being used for maintaining compliance or for reducing health resource deficiencies at the service unit level as already mandated by Congress in Sections 207 and 401 of the IHCA. Thus, we ask that S.2953 require the IHS to include an accounting of third party resource collections and expenditures at the service unit level in the reports required by Section 9 of the bill.

Monitoring Quality of Care. Much of the Oglala Sioux Tribe’s prior testimony, of course, has focused on the shockingly substandard quality of care provided in the Great Plains Area. Part of the quality of care problem at the Pine Ridge Hospital has been the lack of any transparent or functioning system to handle patient grievances. S. 2953 would require the Secretary, in consultation with the Inspector General, to establish a program within the IHS to monitor the quality of patient care, and would require the Office of the Inspector General to conduct an audit of IHS reporting systems and to provide recommendations and technical assistance to improve those systems. The bill also addresses transparency by requiring the Secretary to provide quarterly reports to Congress and Tribes on the safety, billing, certification, credential, and compliance statuses of each IHS facility and to publicly post materials relating to patient safety and compliance. The Oglala Sioux Tribe supports these measures, and hopes that quality improvement efforts will incorporate responsive patient grievance processes and procedures at the facility level.

¹ The settlement had two categories: \$60 million for back pay and back pay-related costs (such as payroll taxes), and \$20 million for administrative costs and attorneys’ fees. \$50 million of the \$60 million amount was paid from third party collections and \$10 million from expired appropriations. The \$20 million was paid from then current FY2015 appropriations.

Funding is a necessary and integral component of successful IHS reform.

Of course, we are anxious to share with you several additional measures we would like to see taken to improve accountability and quality within the IHS system, some of which are absolutely critical to the health and safety of our tribal members. We understand that your goal is to take a comprehensive approach to address this crisis, and we hope that this testimony will help you to achieve that goal.

One of the most significant impediments to successful reform of the IHS and achieving quality health care for Indian people is the severe funding shortage faced by the system. The National Tribal Budget Formulation Workgroup recently estimated that the full funding need of the IHS is approximately \$30.8 billion, but the agency's FY 2016 enacted funding level was only \$4.8 billion. Though reforms to IHS management practices, hiring, transparency and accountability measures are critical, we cannot expect the system to function well with only a fraction of the resources it truly needs. The impacts of insufficient funding are felt throughout the system—from recruitment and retention, to facilities and equipment, to the scope and quality of care. Quite simply, the system is starving. While the Oglala Sioux Tribe recognizes that S. 2953 is not an appropriations bill, it must recognize the significance of IHS funding needs by authorizing sufficient funding to carry out the reforms it seeks to implement in a successful manner and by taking other measures to ease the IHS funding burden where possible. Moreover, we ask for leadership and support from this Committee and individual Members throughout the appropriations process. The funding problem is part and parcel of these reform efforts and cannot be ignored.

Purchased/Referred Care must be fully funded. For example, the Purchased/Referred Care or “PRC” program is a crucial aspect of the IHS system, but it is failing our patients, at least in the Great Plains Area. Again, a large part of this problem is funding. The PRC program is intended to ensure access to primary and specialty health care services that the IHS is unable to provide in its own facilities and must purchase from outside providers. Funding for the PRC program is so limited, however, that care is frequently rationed and limited to emergency “life or limb” situations. On Pine Ridge, even these emergency “priority 1” cases are sometimes rejected by the IHS due to funding constraints. The Oglala Sioux Tribe has previously testified that tribal members routinely forego necessary medical care because the IHS refuses to pay through PRC. In the alternative, if these patients do seek the care, they often find themselves in financial crisis because the IHS will not cover the costs.

This is no way to run a health care system. It incumbent on the United States as our trustee to ensure that preventive and primary and specialty care is available to our patients *before* their conditions become chronic or life-threatening. Not only is that the only humane and responsible approach, but rationing and delaying care until a health condition becomes an emergency means that condition will be significantly more costly and difficult to treat.

Improving and fully funding the PRC system is a top priority for the Tribe and must be a part of comprehensive reform efforts. “Prioritizing” limited funding is not enough. Though fully funding the PRC system would require an up-front investment, the return would be substantial in terms of health outcomes and system efficiency.

Medicare-Like Rates. Increased PRC appropriations are absolutely necessary, but there are other legislative measures that could help. Extending Medicare-Like Rates to non-hospital PRC services, for example, would greatly increase the efficiency of the PRC program. In 2013, the GAO released a report finding that extending Medicare-like rates to non-hospital PRC services would save the IHS approximately \$32 million per year, which could be used to pay for needed services that the IHS must now deny. The IHS has recently adopted and is now implementing regulations to this effect, but they have no teeth because the IHS cannot condition provider participation in Medicare on the acceptance of these rates from the IHS. In the absence of that enforcement mechanism, which only Congress can provide, access to care concerns arise in areas where providers may simply decline to see PRC patients at the lower rates. A bill to extend Medicare-Like Rates was introduced in the last Congress, H.R. 4843, that was strongly supported by Tribes and would be appropriate for inclusion in a comprehensive IHS reform bill.

Funding is needed for transportation and expanding the scope of local services. Another significant problem for health care in our area is transportation. The Oglala Sioux Tribe has previously testified before this Committee on the high costs associated with transporting patients to locations where primary and specialty care that cannot be provided at our hospitals and clinics is available. Again, due to funding constraints, the IHS does not always pay for these costs and our patients do not have the resources. The Tribe frequently ends up covering transportation costs associated with medical care, which diverts tribal funding that is badly needed for other purposes. Dedicated, full funding for transportation for health care referrals is necessary to assure access to care. In addition, enhancing the capacity of local IHS facilities like the Pine Ridge Hospital to provide the full range of primary care services to their full patient population and expanding the scope of specialty care available at those local facilities would cut down significantly on expensive patient travel. This, of course, would require funding for increased staffing, improved facilities, and necessary medical equipment.

Funding is needed for medical equipment and facilities. In February Councilwoman Little Hawk-Weston testified to the fact that the Pine Ridge Hospital lacks not only staff, but also facility space and equipment necessary to meet health care demands. The Pine Ridge Service Unit has documented a need for, among other things: fetal monitoring systems, telemetry systems, surgery lights, a nurse call system, dental chairs and equipment, and IV pumps. Some of this equipment is critical and could mean the difference between life or death in a patient emergency. Additionally, the space is inadequate to handle the hospital's user population. The IHS Service Unit profile shows that the Service Unit currently services a user population of 51,227 in a space designed for a user population of 22,000. And, as noted previously, not all of the existing space is even being utilized, because we lack the staff and equipment necessary for operations.

Funding to ensure that our IHS facilities are adequate and have the necessary equipment to provide needed services is an integral part of ensuring that the IHS is meeting its duty to provide competent, quality care. The Tribe has also pointed out in prior testimony that these facility and equipment shortcomings are yet another contributing factor to the shortage of qualified staff, which is something that S. 2953 specifically seeks to address. Competent, qualified staff do not want to work in a facility where they lack the tools necessary to do their job

or where their job is made harder (or even impossible) by a lack of resources. Again, these issues are interrelated, and must all be considered together if comprehensive reform of the IHS is to become a reality.

Authorizations and appropriations are needed to fully fund the PRC program; to cover transportation costs when patients must be referred out to far-away facilities; to bring our facilities and equipment up to date and in line with the level of need; to fund recruitment and retention measures including housing, salaries and bonuses so the IHS is able to attract and maintain qualified professionals; and to increase the scope of services the IHS is able to provide at a local level. All of these are costs, but they are part of the Federal Government's trust and treaty responsibilities to Indian people and they are necessary to achieve anything more than a quick-fix, Band-Aid response to this dire crisis. Moreover, they will reduce suffering and result in significant long-run savings by creating healthier tribal communities and reducing the high-cost chronic and emergency health conditions that are so prevalent among our people today. Our current approach is not sustainable and must be remedied.

Leveraging other federal funding would help. Various other measures could also help to ease the funding burden on the IHS system. Directing resources to maximize Affordable Care Act enrollment, for example, would provide a return by boosting third party revenues to the IHS. So would Medicaid expansion under the Affordable Care Act or State waiver or demonstration programs that leverage the newly-expanded CMS policy on 100% federal matching for services to American Indians and Alaska Natives. In fact, this Committee could hold an oversight hearing to investigate whether CMS is doing everything it can to allocate its resources to improve health care for American Indian and Alaska Native beneficiaries and to assist the IHS in doing so. We have seen CMS criticize and penalize the IHS for compliance violations—actions that are warranted—but is CMS, another federal agency that also owes a trust duty to Tribes, doing all it can to help remedy the situation? Are there additional Medicare and Medicaid resources that CMS or Congress could direct to the Indian health system, like the recent expansion of 100% federal matching to cover certain transportation costs?

Advance Appropriations would assist in financial planning and stability. Further, although advance appropriations alone would not increase IHS resources, it would promote stability and permit better, smarter budgetary planning. It would also help with hiring and retention as the IHS would know what funding is available for those purposes ahead of time, and employees would not be impacted by agency funding interruptions to the same degree. For all of these reasons, Tribes have been advocating for advance appropriations for IHS for several years.

Maximizing third party revenue must be a priority. Finally, the Oglala Sioux Tribe is not convinced that IHS staff are sufficiently trained in collection of third party revenues, and is concerned that service unit income and budgets suffer because of that. We would propose a study and report to determine whether the IHS is maximizing the recovery of third party resources at all of its facilities, and if not, why not, and what steps can and should be taken to ensure that reimbursement dollars are not left on the table.

Additional measures must be taken to improve accountability and quality of care.

Though a lack of funding permeates every aspect of our health care crisis, there are other specific measures that are not currently addressed in S. 2953 that the Tribe feels should be part of comprehensive reform.

Expand local access to high-demand services. Again, we need to expand local access to services, including specialty care for which there is a high level of need in our community. Psychiatric care is a prime example: in February, Councilwoman Little Hawk-Weston testified before this Committee that the Pine Ridge Hospital lacks adequate psychiatric facilities to serve the patients with severe and immediate psychiatric needs that come into the hospital on a daily basis. In light of the suicide crisis, trauma, and substance abuse challenges affecting our Reservation population, it is hard to see how the IHS can expect to deliver comprehensive health care to our people without a psychiatric component. The same is true for other specialties, such as respiratory care, which is in high demand but not available in our local facilities.

Support for telemedicine. One way of dealing with the lack of access to specialty care and other challenges posed by our remote location is telemedicine. Developing our telemedicine and telehealth capacity has been a priority for the Tribe and could be an important feature of a reformed, more responsive, and higher quality health care delivery system in the IHS. The IHS is already exploring telemedicine possibilities, but legislative support including authorizations for appropriations, pilot projects or programs, and dedicated funding would help to ensure that these efforts bear fruit.

Accounting of the Great Plains Area Office. The Tribe also believes that a fundamental reorganization of the Great Plains Area, including quite possibly the elimination of the IHS Area Office altogether, may be needed. Though legislation is not necessary to undergo such reorganization, the Tribe has in the past had difficulty obtaining information it needs from the Area Office to assess this question. For example, the Area Office has refused to provide specific and accurate information on how funding is allocated by the Office and why funding is withheld from the Service units. We need a full accounting of the funding received by the Area Office, how it is allocated, its employees, programs, and what functions the Area Office serves. We suspect that most of the Area Office functions could be delegated to the service unit level and that the Area Office could operate with only a skeleton crew. We do note that the IHS has recently initiated consultation on this question and appears open to discussing the possibility of reorganization. We appreciate that step, but a Congressionally-mandated comprehensive accounting of the Area Office could be a great help.

I would also like to briefly address some ideas that have been raised by others for inclusion in IHS reform legislation that the Oglala Sioux Tribe would support:

Mandatory employee drug testing. Last week, Representative Noem introduced H.R. 5437 to implement a mandatory random drug testing program for IHS employees. While we have not had an opportunity to review the text of H.R. 5437, the Oglala Sioux Tribe strongly supports mandatory drug testing not just for IHS management, but for all IHS employees. We understand that the VA utilizes pre-employment drug testing as well as random employee drug

testing in its facilities, and the same should be true of the IHS. Health professionals should not be reporting for duty while under the influence of illegal substances.

Addressing patient wait times. Representative Noem has also introduced an IHS reform bill, H.R. 5406, which includes provisions in response to long wait times for services at IHS hospitals. This has been a major problem at Pine Ridge and is not directly addressed in S. 2953 as currently drafted. H.R. 5406 would require the IHS to promulgate regulations establishing standards to measure timeliness of the provision of health care services at IHS facilities and to develop a process for IHS facilities to submit data under those standards to the Secretary. The Oglala Sioux Tribe supports this requirement and would suggest that the Secretary be required to promulgate such regulations through negotiated rulemaking, to ensure that Tribes have meaningful input into those regulations.

Exploring contracting options while maintaining federal responsibility. H.R. 5406 would also create a pilot program to explore long-term contracting of IHS facilities, and S. 2953 directs the GAO to consider the use of independent contractors to replace full-time equivalent employees at the IHS in its report on staffing needs. The Oglala Sioux Tribe is not opposed to the consideration of new and innovative ideas to address deep-rooted and systemic problems, and perhaps other federal health care contracting models exist and could offer solutions. However, we emphasize that the trust and treaty responsibility to provide health care to our tribal people belongs to the *United States Federal Government* and cannot be contracted out or privatized. Accordingly, while the Oglala Sioux Tribe wants a health care system that *works* and would be happy to see changes to the system that produce meaningful results, the federal government must always remain accountable to our Tribe and is ultimately responsible for carrying out its solemn trust duties and treaty commitments.

Finally, we must recognize the extent to which our health care crisis is impacted by the other challenges we face in providing economic opportunity and other social services to our community members. We know that systemic poverty leads to poor health outcomes, and that our physical health is impacted by our psychological health and wellbeing. Moreover, it is difficult to run a high-quality medical facility with top-notch staff in an isolated and economically depressed area. Though this bill focuses specifically on reforms within the IHS system, we must not lose sight of the importance of the federal government's other trust and treaty obligations to Tribes and to the interrelationship among those obligations.

Implementation of 25 U.S.C. 1678a. The designation of South Dakota and North Dakota as a single contract health service delivery area (CHSDA) is already in statute. However, the IHS is not implementing this provision. IHS's regulations do not include the States of South Dakota and North Dakota in its list of CHSDAs. See Title 42 C.F.R. Section 136.22. 25 U.S.C. 1678a, which was enacted over six years ago as part of the permanent authorization of the Indian Health Care Improvement Act states:

(a) In general

The States of North Dakota and South Dakota shall be designated as a contract health service delivery area by the Service for the purpose of providing contract health care services to members of Indian tribes in the States of North Dakota and South Dakota.

(b) Maintenance of services

The Service shall not curtail any health care services provided to Indians residing on any reservation, or in any county that has a common boundary with any reservation, in the State of North Dakota or South Dakota if the curtailment is due to the provision of contract services in those States pursuant to the designation of the States as a contract health service delivery area by subsection (a).

Implementation of this provision is not discretionary. Congress mandated that North Dakota and South Dakota be designated a single CHSDA, and as a result any action by IHS to deny services to any individual based on its pre-existing CHSDAs in those states is unlawful. Yet, IHS continues to deny services to individuals throughout both States based on the geographic limitations in the CHSDAs it established in those States prior to the enactment of 25 U.S.C. §1678a.

The IHS has taken the position that it cannot implement 25 U.S.C. 1678a without further appropriations. But 25 U.S.C. 1678a is not dependent on additional funding. Rather, it imposes a mandatory statutory duty on the IHS to designate both North Dakota and South Dakota a single CHSDA, 25 U.S.C. 1678a(a), and ensure that there is no curtailment of services to individuals living on or near a reservation in North Dakota or South Dakota as result of carrying out Congress' directive that those states should encompass a single CHSDA, 25 U.S.C. 1678a(b).

The IHS's failure to implement 25 U.S.C. 1678a has had multiple negative effects throughout both States. Because the IHS continues to deny PRC authorizations for American Indians living outside the pre-existing CHSDAs, those individuals are forced to either forgo needed care, or seek care even if they lack the resources to pay for it. When there is no valid PRC authorization, those individuals may be liable for the cost of that care. If they cannot afford the care, both they and their non-IHS provider suffer. The American Indian's credit may be affected by bill collectors, and the non-IHS provider cannot receive payment for the services they have provided. The issue is compounded for emergency services because hospitals are required under EMTALA to provide such services even when the individual seeking them cannot pay.

S. 2953 should include a provision that directs the IHS to implement 25 U.S.C. 1678a. Additionally, as the Pine Ridge Reservation includes a portion of Nebraska we note that the CHSDA for Nebraska remains the same.

Improving Consultation. Executive Order 13175 mandates that each federal agency shall have an accountable process to ensure meaningful and timely input by tribal officials in the development of regulatory policies that have tribal implications. Every President has reinstated Executive Order 13175 since President Clinton initially issued it in 2000. This Executive Order is regularly cited by Tribal governments to keep agencies accountable and engaging with tribes as agencies develop policies that will affect tribes. However, the consultation process is not always effective or followed to the letter. For instance, Section 3(c) of the Executive Order states:

“[w]hen undertaking to formulate and implement policies that have tribal implications, agencies shall: (1) encourage Indian tribes to develop their own policies to achieve program objectives; (2) where possible, defer to Indian tribes to establish standards;....”

This Section calls for deferring to tribes, where possible, to establish standards. This provision, however, has been routinely overlooked by the IHS, particularly at the Great Plains Area Office. A recent example was the Tribe’s effort to incorporate language into the Systems Improvement Agreement (SIA) between IHS and CMS to address IHS’s deficiencies in operating the Pine Ridge Hospital Emergency Department. We, as the beneficiary of the SIA, submitted several edits for the SIA, but the IHS did not accept them and they did not appear in the final executed SIA. Furthermore, Section 5(d) of the Executive Order states:

“[o]n issues relating to tribal self-government, tribal trust resources, or Indian tribal treaty and other rights, each agency should explore and, where appropriate, use consensual mechanisms for developing regulations, including negotiated rulemaking.”

We highlight the use of consensual mechanisms for developing regulations. As health care is a treaty right, IHS should be implementing the use of consensual mechanisms as we move forward to fix the IHS’s provision of health care in the Great Plains.

H.R. 5379, the RESPECT Act, is currently pending in the House. It essentially would codify Executive Order 13175 which would ensure that its provisions have teeth. Provisions of the RESPECT Act could be incorporated in S. 2953 to ensure that the IHS carries out effective and meaningful consultation. We highlight Section 401 of the RESPECT Act which provides a remedy for egregious failures of consultation requirements. Per this section a tribe would have the same judicial enforcement remedies as provided in the Administrative Procedures Act. We believe this would work well for holding IHS accountable to its consultation requirements.

PREPARED STATEMENT OF THE UNITED SOUTH AND EASTERN TRIBES SOVEREIGNTY PROTECTION FUND

The United South and Eastern Tribes Sovereignty Protection Fund (USET SPF) is pleased to provide the Senate Committee on Indian Affairs (SCIA) with the following testimony for the record of its June 16, 2016, field hearing on, “Improving Accountability and Quality of Care at the Indian Health Service through S. 2953.” USET SPF acknowledges the long standing and systemic challenges faced in the Great Plains Area and throughout the Indian Health System. We appreciate the Committee’s commitment to addressing issues in the Great Plains Area and throughout the IHS with the introduction of S. 2953, and offer section by section recommendations to further strengthen the provisions of the bill. USET SPF maintains, however, that until Congress fully funds the Indian Health Service (IHS), the Indian Health System will never be able to fully overcome its challenges. While USET SPF supports the intent of S. 2953, *The Indian Health Service Accountability Act of 2016*, we reiterate the obligation of Congress to meet its trust responsibility by providing full funding to IHS and support additional innovative legislative solutions to improve the Indian Health System.

USET SPF is a non-profit, inter-tribal organization representing 26 federally recognized Tribal Nations from Texas across to Florida and up to Maine.¹ Both individually, as well as collectively through USET SPF, our member Tribal Nations work to improve health care services for American Indians. Our member Tribal Nations

¹ USET SPF member Tribal Nations include: Alabama-Coushatta Tribe of Texas (TX), Aroostook Band of Micmac Indians (ME), Catawba Indian Nation (SC), Cayuga Nation (NY), Chitimacha Tribe of Louisiana (LA), Coushatta Tribe of Louisiana (LA), Eastern Band of Cherokee Indians (NC), Houlton Band of Maliseet Indians (ME), Jena Band of Choctaw Indians (LA), Mashantucket Pequot Indian Tribe (CT), Mashpee Wampanoag Tribe (MA), Miccosukee Tribe of Indians of Florida (FL), Mississippi Band of Choctaw Indians (MS), Mohegan Tribe of Indians of Connecticut (CT), Narragansett Indian Tribe (RI), Oneida Indian Nation (NY), Passamaquoddy Tribe at Indian Township (ME), Passamaquoddy Tribe at Pleasant Point (ME), Penobscot Indian Nation (ME), Poarch Band of Creek Indians (AL), Saint Regis Mohawk Tribe (NY), Seminole Tribe of Florida (FL), Seneca Nation of Indians (NY), Shinnecock Indian Nation (NY), Tunica-Biloxi Tribe of Louisiana (LA), and the Wampanoag Tribe of Gay Head (Aquinnah) (MA).

operate in the Nashville Area of the Indian Health Service, which contains 36 IHS and Tribal health care facilities. Our citizens receive health care services both directly at IHS facilities, as well as in Tribally-operated facilities operated under contracts with IHS pursuant to the Indian Self-Determination and Education Assistance Act (ISDEAA), P.L. 93–638.

Uphold the Federal Trust Responsibility to Tribal Nations

We again remind SCIA that through the permanent reauthorization of the Indian Health Care Improvement Act, “Congress declare[d] that it is the policy of this Nation, 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.” As long as IHS is so dramatically underfunded, the root causes of the failures in the Great Plains will not be addressed, and Congress will not live up to its own stated policy and responsibilities. USET SPF urges this Committee to consider carefully the level of funding it will support for IHS and its impact on the Agency’s ability to provide quality care as it considers S. 2953. Further, we recommend the inclusion of language directing the IHS to request a budget that is reflective of its full demonstrated financial need, as this is the only way to determine the amount of resources required to deliver comprehensive and quality care. USET SPF remains hopeful that Congress will take necessary actions to fulfill its federal trust responsibility and obligation to provide quality health care to Tribal Nations, including providing adequate funding to the IHS.

Need for Tribal Consultation

We agree with members of the Committee and with Tribal witnesses calling for increased transparency and accountability within the IHS. We are very concerned that conditions in the Great Plains area have resulted in severe gaps in access to care for American Indian/Alaska Native (AI/AN) patients. These gaps in access will only continue to widen the disparity in health status between AI/AN and the general U.S. population if not addressed. While we seek comprehensive solutions to the complex and multifaceted issues within the Indian Health System, we seek the empowerment of Tribal Nations in decisions regarding health care. We request that additional language be inserted into S.2953 requiring Tribal consultation on all provisions of the law, as it is implemented. On-going, meaningful Tribal consultation is essential to mitigating current challenges, preventing future crises, and increasing the health status of AI/AN.

Implement Advance Appropriations for the IHS

In order to address the challenges facing health care delivery in Indian Country, SCIA should work to ensure funding is received on time by authorizing advance appropriations for IHS.

On top of chronic underfunding, IHS and Tribal Nations face the problem of discretionary funding that is almost always delayed. In fact, since FY 1998, there has only been one year (FY 2006) in which appropriated funds for the IHS were released prior to the beginning of the new fiscal year. The FY 2016 Omnibus bill was not enacted until 79 days into the Fiscal Year, on December 18, 2015. Budgeting, recruitment, retention, the provision of services, facility maintenance, and construction efforts all depend on annual appropriated funds. Many of our USET SPF member Tribal Nations reside in areas with high Health Professional Shortage Areas and delays in funding only amplify challenges in providing adequate salaries and hiring of qualified professionals.

As this Committee seeks to improve IHS’ ability to attract and retain quality employees, USET SPF urges the inclusions of language that would extend advance appropriations to the IHS.

Addressing Health Professional Shortages in the Indian Health System

One of the major ways that the IHS and Tribal Nations seek to combat persistent provider shortages is through the IHS Scholarship Program and Loan Repayment Program (LRP). Although these programs have helped to increase the amount of provider placements in the Indian Health System, they are significantly limited by the level of funding available to make awards and by the treatment of these awards under the Internal Revenue Service Tax Code. In FY 2015, a total of 1,211 health professionals including physicians and behavioral health providers received IHS loan repayment. During the same fiscal year, the LRP was unable to provide loan repayment funding to 613 health professionals who applied for funding, of which only 200 still accepted employment at an IHS or Tribally Operated Health facility. IHS estimates that it would need an additional \$30.39 million to fund all the health professional applicants from that year.

Additionally, payments to Indian health care providers through the LRP and IHS Scholarship are currently considered taxable income under the Internal Revenue Service (IRS) Tax Code for awardees. However, an exemption exists for benefits paid to providers under similar programs like the Armed Forces Health Professions Scholarships and loan repayment under the National Health Service Corps. S.2953, as written, does not address this discrepancy. We request that language be included in the S.2953 to create parity for IHS with other federal health professions incentive programs and provide IHS with the greatest amount of tools to recruit quality providers.

Finally, we request that additional funding be made available to assist in the recruitment of AI/AN health professionals from within local Tribal communities. We believe that the best way to care for our citizens is to ensure that health professionals are deeply connected to the communities they serve. In order to promote pathways to increase AI/ANs entering health professions, we request additional funding, beyond the IHS' Budget Request, be made available for the American Indians into Nursing Program, Indians into Medicine (INMED) program and American Indians into Psychology Program.

Section-by-Section Comments

In addition to urging the inclusion of the above proposals, USET SPF provides several recommendations to strengthen the existing provisions of S.2953. If implemented together, we believe that the IHS and Tribal Nations can begin to make gains in the quality of care delivered through the Indian Health System and improve AI/AN patient outcomes.

Sec. 3. Removal of Indian Health Service Employees Based on Performance or Misconduct

We support strengthening the Secretary's authority to remove or demote IHS employees based on performance or misconduct. We also support the "Employment Record Transparency" language which will ensure that prior employee personnel actions are adequately notated and considered in future hiring processes. However, in addition to Congressional leadership, Tribal Leadership must also be notified when employees within their Service Area become subject to a personnel action. In Section 3 under Sec. 603(d), we recommend inserting "Tribal Governments located in the affected service area". Increasing transparency and access to information for Tribal Nations will be essential to rebuilding the confidence and trust in the IHS.

Sec. 4. Improvements in Hiring Practices

We recommend adding additional language to the "Notice of Removal Based on Performance or Misconduct" in Section 4 which would broaden access to records, available to Tribal Governments upon request, to include all clinical IHS employees. As the draft is currently written, access to personnel records is limited to Senior Executive, manager and supervisor level positions. Increasing transparency and access to records including clinical positions will allow Tribal Nations to have greater knowledge about and confidence in the clinicians delivering care to their citizens.

Sec. 5 Incentives for Recruitment and Retention

While USET SPF agrees that addressing the provider shortages across Indian Country requires innovative solutions and incentives, the IHS is not equipped to implement these initiatives without additional appropriations. With IHS funded at 59 percent of demonstrated need, any mandate to provide housing vouchers, relocation costs, or increase pay scales must be funded using patient care dollars. While the attraction of qualified staff is critically important, it must not be done by diverting precious resources from health care services. For this reason, we request that S. 2953 include additional funding to support these incentives without impacting patient care.

Sec. 10. Transparency and Accountability for Patient Safety

USET SPF has concerns regarding the lack of specificity in Section 10, as well as its feasibility. Although we support transparency and accountability in patient care, we believe that requiring an investigation of all patient deaths, "in which the Service is alleged to be involved by act or omission," is unnecessary and will merely result in an investigations backlog. Due to the risks inherent to the delivery of medical care, patient death is a sad reality for all medical systems, with many patient deaths occurring through no fault of the provider or facility. We urge SCIA to consider narrowing the language of Section 10 to require an investigation only into deaths where there is an allegation of negligence or malpractice on the part of the IHS. In addition, we seek additional Tribal consultation on this section, in particular, to assist in providing further clarity on the criteria for investigation.

Conclusion

USET SPF appreciates SCIA's efforts to seek solutions to the long-standing challenges within the Indian Health System. However, we note the initiatives proposed in S. 2953 do not address the root cause of these issues: the chronic underfunding of the IHS. Only when Congress acts to uphold the federal trust responsibility by providing full funding and parity for the Agency will the Indian Health System be equipped to provide an adequate level of care to AI/AN people. Nonetheless, with some targeted changes, we believe that S. 2953 could be an important step in this direction. We appreciate the opportunity to provide comments on this bill and look forward to an ongoing dialogue to address the complex challenges of health care delivery in Indian Country.

PREPARED STATEMENT OF THE YANKTON SIOUX TRIBE

Dear Chairman Barrasso, Members of the Committee, and Senator Thune:

Thank you for the opportunity to submit written testimony on the IHS Accountability Act of 2016, S. 2953. My name is Robert Flying Hawk, and I am the Chairman of the Business and Claims Committee of the Yankton Sioux Tribe. I also serve as the Treasurer of the Great Plains Tribal Chairmen's Health Board as well as the Great Plains representative on the Centers for Disease Control Tribal Advisory Committee.

The Yankton Sioux Tribe is encouraged that the Committee and Senator Thune have identified the IHS as an agency in need of their attention. We have long felt this way and thank the Committee and Senator Thune for their efforts. The Yankton Sioux Tribe is a treaty tribe that, like many of our relatives in the Great Plains Region, depend on IHS for the provision of health care to our members. Any changes to the operation or budget of the IHS will directly affect our members which is what compels today's testimony.

In Senator Thune's media call on the Bill on May 25, 2016, he stated that the Bill aims to increase accountability, improve hiring practices, enhance recruitment and retention, protect whistleblowers, increase fiscal accountability, and create greater transparency. These are noble goals that we agree are important to achieve, and it appears that the Bill will push IHS in the right direction. But what is glaringly missing from this list is improving patient care for tribal members and increasing funding for the agency. We do not want for these changes – though they are good and needed – to send other tribal priorities to the bottom of the barrel.

The following are a list of questions that come to mind as we review the Bill and we hope they will serve to further the discussion and evolution of this Bill. Where will the funds come from to support the new Incentives Program described in Section 5 of the Bill, ensuring health care professionals employed by IHS are reasonably paid, and rewarded for quality performance? We ask that the Committee and Senator Thune ensure us and expressly provide that this new program will not come out of the flow of funds that trickle down to the service units. Along the same lines, where will the funds come from to support the program to provide tenant-based rental assistance to IHS employees? What does it

mean to "monitor" the quality of patient care in IHS, as called for in Section 10? Funds need to be directed to these important proposed programs to ensure they actually pan out but we hesitate to support such initiatives until we can be assured the funds that will support these programs will actually be provided and will not be taken from the already underfunded Headquarters and Aberdeen Area budgets that serve our members. And without any identified funding, the provisions of the Bill could continue to be ignored along with the rest of our programs so we question whether this Bill, in the long run, would only be an empty gesture, or whether it will actually improve health care for our members.

The only discussion of prioritization of patient care comes near the end of the Bill in Section 9, which calls for the Secretary to use *whatever is left over* after the fiscal year to support patient care. Tribal health needs to be higher on the Committee's list of priorities, not merely an afterthought.

We all know that the IHS is a severely underfunded agency and the Aberdeen Service Area has historically received a disproportionately low percentage of the IHS budget. In fact, the Great Plains Region is underfunded by a staggering \$248 million following sequestration a few years ago. That is why I would like to emphasize that there are still funding problems with IHS that the Committee needs to take into account with this Bill. The Committee needs to explain, as the Bill does not answer, where the money will come from. The Headquarters in DC, the Area Office, the Service Unit? Will it be enough and will existing programs, then, have to compete with the new programs included in the Bill or will the new programs receive separate funding?

Yankton has other program-related and budget-related concerns with IHS that we encourage the Committee and Senator Thune to address in the Bill. Because we only have a small clinic on our reservation, every day our people receive "referrals" from IHS physicians to specialists, labs, and hospitals. Tribal members used to go to those referrals assuming that any costs incurred would be borne by the IHS. Unfortunately, that is not the case. At Yankton, we have an ever increasing number of tribal members who have received thousands of dollars in medical bills in the mail that they did not expect, and that they cannot pay. This has become so prevalent that we now have tribal members who are refusing to seek the referral care that is necessary to protect their health, and in some cases, even their life, because they fear the possibility of being bankrupted by unpaid medical expenses.

We feel strongly that the referrals or purchase referred care program requires attention on a program and budget level. The referred care budget has to be examined against the actual need in the Aberdeen Area, taking into account distance, our lack of quality hospitals, and the number of Indian people who require this service. Also, the IHS should be mandated to notify a patient in advance when it is not prepared to pay for a referral care visit and related costs. The IHS needs to acknowledge that unpaid medical bills can literally bankrupt a family, and our people have a right to make an informed decision about the care that they choose to seek. This is especially true in the case of our veterans. A veteran may not initially want to drive 100 miles or wait three months to see a specialist, especially when the IHS is offering him a specialist which is only 30 miles away and an appointment in 48 hours. He might feel differently, however, if he knew that he was going to receive a \$20,000 bill for taking IHS up on its offer. Please, just direct the IHS to upfront and truthful when making the referrals and set out, in writing, what amount of the purchased referred

care IHS will or will not pay in advance of the treatment and preferably at the time the referral is made.

In addition to calling your attention to the issue of funding and program operation, we would also point out that years ago, the IHS hospital and emergency room that served the Yankton Sioux Tribe and its members was closed. We now only have a clinic. We would like to work with Congress and the agency to re-open the IHS hospital and emergency room at the Wagner Service Unit. Without an IHS hospital and ER available, tribal members are forced to decide whether it will seek care at the local non-IHS hospital and ER and potentially face thousands of dollars of medical bills or not seek the necessary health care. We have had tribal members pass away or suffer major medical emergencies in the parking lot of the IHS clinic while waiting for it to open after being faced with this dilemma.

We praise the tribal consultation requirement included in the bill for the hiring of key leadership positions provided for in Section 4. We appreciate the transparency and accountability expressly provided for in Section 10, and we like the requirement of spending reports and status reports of each level of IHS – including each facility – being sent to the Indian tribes as well as the relevant Senate and House committees, keeping us all on the same page. Additionally, we support the provision in Section 9 for the Inspector General of HHS investigating each patient death associated with IHS's act or omission, and hope that will be enough to prevent the neglect that has led to too many patient mishaps and innocent deaths at the hands of poor quality IHS facilities or lack of facilities.

We very much appreciate the direction in which Senator Thune and Barrasso are trying to lead IHS with this Bill – more towards tribal interests. However, the Bill does not go far enough. Though we agree that "prioritizing patients and restoring faith in the health care system of the Indian Health Service requires greater transparency, accountability, and strong leadership," there is no doubt that to achieve this, all of the programs and improvements envisioned in the Bill must be supported by the proper funding. Thank you and we look forward to working with you on improving health care for our members.

Dear Senator Thune:

I am seeking your assistance in a personal matter involving the federal government. I hereby authorize your office to request on my behalf, that the appropriate federal agency or agencies investigate the following. (Use reverse side or additional paper as needed to detail and describe the situation and how you would like Senator Thune to help, include any additional documentation pertaining to your case.)

Re: Louis L. Black Bear injured on job site January 14th, 2016.
I fell 14 ft. from unfinished balcony. Ever since been getting
the run around in receiving medical treatment in a
timely manner. Also, needing legal help covering medical
bills, ongoing care and loss of wages being out of work.
lost house phone. no means to pay for vehicle. I have been trying
to do all this by myself. Soon asked a friend. Been to several
different lawyers. Got alot of advice along the way. No one willing to
commit. Feeling discouraged, over whelmed, trying not to stress. Continually
turning to God. I have all my records/notes/ recordings. Will forward
upon request. Justice.

I further authorize, under the provisions of the Privacy Act of 1974 the agency or agencies involved have my permission to disclose information from their records about my case or claim to the office of Senator John Thune.

SIGNATURE Louis L. Black Bear DATE June 17th, 2016

6/10/2016

To Whom it May Concern;

On May 18, 2016 at approximately 2:00-2:30 a.m. I started to have a, what I thought was a migraine headache, followed by a sharp pain in my neck, blurred vision, and nausea/vomiting. Unable to sleep because of the pain I walked to the Fort Thompson Ambulance Department. I knocked several times before anyone answered. The two individuals working at the time took my vitals in which they said were fine. Seeming very unconcerned about how much pain I was in the individuals told me that there was nothing they could give me or do for me. They then asked me if my pain was really that bad or if I would be able to drive myself to the Emergency Room in Chamberlain SD, which is 20 miles away. When I told them that I did not have a vehicle they told me that the IHS clinic would be opening in 5 hours. After explaining to them how unbearable the pain was they finally decided that they could transport me to the hospital. After having a CAT SCAN/MRI performed the results showed a brain aneurism/stroke.

If not for me being persistent about how much pain I was in and how in need of medical attention that I needed the Ambulance Service may have not transported me.

Previous to this incident I had been to the Fort Thompson IHS clinic on two other occasions for severe headache pain. I was treated with a shot to help with the pain and was instructed to wait in the dark room for an hour. No X-rays or lab tests were done. I was not even prescribed Tylenol or Ibuprofen for the pain. If the Health Providers at Fort Thompson IHS Clinic would have been more observant and looked further in-depth to my symptoms the brain aneurism/stroke may have been detected earlier for treatment or may have even been prevented. Now I am a 39 year old single parent that is at risk of having a brain aneurism/stroke at any point and time for the rest of my life. I live with the frightening thought of going to sleep at night and may not ever wake up. All in which could have been prevented if the IHS Health Providers would have taken my pain a little bit more seriously.

Thank you for your time and Attention

For Beth & all

Dear Committee Members and Senator[s]:

Welcome to South Dakota and hope everyone is well. When I took on a medical coder position at the IHS here approximately 3 years and 8 months ago I wished I knew then what I know now because I would have told them no. Anyways during the open testimony back in February I sent the US Indian Senate a copy of a grievance that the union filed on my behalf since losing my brother on December 7, 2015. He was only 45. I just want them to know that every day is an emotional battle that I am currently taking depression and anxiety medication. *Something that I had to live with.*
a the fear of becoming dependent on them is overwhelming - but I can't work w/o it.
 When I got offered this job and found out who my supervisor was it had me wondering why? When I told my brother George he laughed and said oh shit! But the pay was ~~good~~ and we both knew I had to take it. The reason being my brother George had a daughter with this supervisor's sister about 17 years ago and he was only with her a few months when fight broke out in a bar between them and George had injured their brother and left a permanent mark on his face. Since then and they despised him and even lied under oath sending the wrong person to prison so that their niece would not lose her soon to be father. Unfortunately, he and that family never made up and he was not allowed visitation after that. Well my brother and I talked about the situation to be and he said just do your job and I don't think you should have any problems. The probation period for two years was the worst and she picked at me every chance she could and so I walked on a million eggs shells during that time. Shockingly, I knew from day one she had problems as far as incompetency goes. It was common knowledge to everyone that she was weaved in because of family and cronyism but we learned to work around her and come to her aide when others picked on her. I wasn't surprised when I learned I was part of a phenomenal concept written in a book back in 1969. I had no idea the theory even existed till I read parts of book titled "Peter Principle" and I laughed so hard until I finally caught myself and asked under my breath what about the victims of cronyism? Did the author calculate those into his equation? Who picks up the pieces? That's what I am hoping your committee will do with the new bill introduced and let this be a lesson that this has gone too long and people are dying or could die or be hurt terribly.

But read the grievance and remember I was all that George had and was officially his caretaker and *Recognized with*
 pay for social security he was receiving from past head trauma that forced him to retire from roofing. Our family was so proud of him for throwing his bottle in garbage and getting off the streets and remaining sober for years without treatment. He was coach and manager of my son's softball team for years and recently we learned that they are going to place him on their Hall of Fame wall this year. If only I had not taken the job I truly believe he would still be here. I cannot express the pain and suffering me and family go thru each day still wondering is this for real?

Attached: Grievance

We are bonded with the past and the future is our choice.
P.S. Remember, even though many of us have medicine & private insurance we still choose to use Sioux Sun. for our health care.
It's part of the Sioux Sun. health care community.

Grievant: Charlene Janis, Medical Records Tech.

NATURE OF GRIEVANCE:

On or about December 6th, BUE, Charlene Janis, requested leave to address an emergent issue with her brother's health. BUE, Charlene Janis is the custodian of said brother and is responsible for his care. Ms. Janis shared with her supervisor the critical health issues concerning her brother. Ms. Janis requested leave and supervisor denied and stated that she would be AWOL. Following that event BUE, Charlene Janis went to meet with supervisor to take in documentation of brother's discharge from hospital papers to verify the seriousness of his illness, brother was to go back the following morning. Supervisor was no where to be found to get approval and employee ultimately had to seek approval from second line supervisor, Lynn Poufer who approved leave without pay. BUE, Charlene Janis, was emotional, distraught and severely stressed and wanted to ensure that she received approval prior to being out of the office. Supervisor, Alberta Bad Wound, showed no compassion, concern nor did she offer her availability to assist BUE during this critical, emotional time. Brother of BUE, Charlene Janis passed away on December 7th, the following day in which employee was attempting to secure leave approval. BUE, Charlene Janis at this time is grieving the loss of her brother and the added emotional stress she was put through by her supervisor.

Supervisor Alberta Bad Wound has violated Article 1, Section 7 and Section 16.

SETTLEMENT DESIRED:

1. BUE, Charlene Janis be assisted with processing appropriate paperwork and approved for the Leave Share Program. Notification of approval of Leave Share be sent to all employees within IHS to seek leave donors to address the period of time in which BUE, Charlene Janis needs to be away from duty during this period of grief and time of healing.
2. BUE, Charlene Janis, be referred to Employee Assistance Counseling to allow her time and the opportunity to meet with a grief counselor. Time allowed to attend counseling will be in accordance with policy for EAP Counseling. Use of Official Time.
3. BUE, Charlene Janis be assigned under the direct supervision of Lynn Poufer, the second level supervisor who showed real compassion and concern for the BUE during this difficult time.

Respectfully Submitted,

Pauline Bruce, Field Rep/Organizer
UUNA/IHSNC

Dear Sir / Ma'am,

12 Feb 16

We are Lakota women who are enrolled members of the Oglala Sioux Tribe and descendants of Chief Old Man Afraid of His Horses who also signed the Treaty with Sioux of 1868.

We are compelled to share our thoughts and answers about our Indian Health Service. We have been vigilant on this issue and the impact it has on our lives, the lives of our children, grandchildren and for the generations yet to come.

We know that we need qualified certified doctors who will provide continuity in the services we need. Our suggestion is to redirect the monies used for the flight for life and invest it back to Indian Health Services needs. We have read about the many internal problems that are partially to blame on the local IHS levels. The news is dispiriting but it is also correctable.

Our health care cannot continue to be underfunded, our membership grows everyday. For any tribal official to entertain the idea of contracting our health care service need is obviously not educated about the treaties that the United States have made with many tribes across the nation.

We believe our tribal leaders have the role of protecting our treaty rights. In closing, our hope is that more tribal members are pro-active in expressing their concerns and offering solutions to ensure our treaty promises are kept. Individuals will be held accountable to prevent this from happening again.

Thank you for reading our letter.
Heceti SKto (this is how it is)

Sincerely,

Lillian Tobacco

Lillian Tobacco - grandmother / tribal elder

From: Janis, Charlene (IHS/ABR/RCH)
 Sent: Wednesday, March 09, 2016 11:41 AM
 To: Carlow, Lisa (IHS/ABR/RCH)
 Subject: Leave situation.

Lisa,
 My husband of 24 years is currently in Regional with internal bleeding due asparta but because he has congestive heart failure along w/ a pacemaker they are keeping a close watch on him. On Monday 3.9.16 morning Sioux Sah transferred him and so I texted my supervisor ABW with a leave request and also asking for Lynn's number because I was using my husband's phone and it wasn't on there. That morning from his phone and she responded with "I can't approve any more twop pay for you and you are gonna need a doc slip and have the CEO Sorenson approve it. I asked her how she knew that without a computer because I knew I had six hours of leave and it wasn't over three days? My husband read the text cause it was his phone and started freaking out thinking I was gonna be fired. I had to remind her this is not my phone and please don't send anymore texts and I would be talking with Lynn from there on out. She said OK, Lynn approved the leave request and said ABW was not coming in that day due sickness. She did not tell me that or send an order of succession text.

I promise I won't pursue anything on this incident but someone needs to talk to her and find out if she is competent enough to stand her ground as a supervisor. I was angry at first but now I am feeling a little sorry.

Charlene M. Janis

To: Janis, Charlene (IHS/ABR/RCH) <Charlene.Janis@ihs.gov>
 Subject: RE: AWOL
 Importance: High
 Charlene,

EEO 3 AWOL

Sorry this email was an error, when you met with the EEO on the 03/31 it will be approved this time. The next time you meet with the EEO or the Union you need to let me know, so that I don't mark you down as AWOL.

From: Bad Wound, Alberta (IHS/ABR/RCH)
 Sent: Monday, April 04, 2016 8:43 AM
 To: Janis, Charlene (IHS/ABR/RCH) <Charlene.Janis@ihs.gov>
 Cc: Pourier, Lynn (IHS/ABR/RCH) <Lynn.Pourier@ihs.gov>
 Subject: AWOL

Charlene,

Please add 10:30-12:00 on 03/31 AWOL for Charlene Janis, for not getting prior approval to meet with the EEO

THANKS,

Alberta Bad Wound
 Coding/Data Entry Supervisor

TO: Oversight Hearing Committee
 FROM: Rozella Lockwood
 Enrolled member of the Crow Creek Sioux Tribe
 RE: Complaint/Indian Health Service

January 22, 2016

In the spring of 2015 I had my eyes examined by an Optometrist in Chamberlain, South Dakota who always does my eye exams. I was diagnosed with Dry Eye Syndrome and the doctor gave me a prescription for Restasis eye drops.

The next day I took my prescription to the Indian Health Service clinic here in Fort Thompson, SD to have it filled. When I called to see if my prescription was ready, the Pharmacist told that they would not fill my prescription because my eye exam was not done at the Indian Health Service clinic, so I talked to the Indian Health Service Optometrist and she said if I made an appointment with her for an eye exam that she could prescribe me Restasis and I could get my eye drops that way.

I made an appointment with the IHS Optometrist and had my eyes examined and picked out some eyeglass frames. The optometrist told me it would cost \$146.00 and I needed to bring in a money order before she could order my eye glasses, so I did that.

Two weeks later I received a call from IHS stating that my glasses were in, so I went to the clinic and she adjusted the frames, at which time I told her that I couldn't see out of them, everything was blurry. The Doctor said that I needed to wear them for a while so my eyes could adjust to the new settings. I tried wearing them that weekend, but I just couldn't see out of them.

Needless to say, over the next month, I went to several places including the Indian Health Service Clinic and had my glasses adjusted to see if they just needed an adjustment, but no, no matter how much they were adjusted, I could not see out of them.

I called the Optometrist's office in Chamberlain, SD and asked for a copy of my eye exam results, which were faxed to me, so I took my eye exams results to the Indian Health Service Optometrist and asked her to match the one from Chamberlain to her exam and see if they matched. Well, she never called me back so I tried calling her, but she never answered her telephone so I left her messages for her to call me back. I even went to the clinic two times and sat outside her office area, waiting for her or anyone to ask me what I needed, but nothing, so after waiting 20 minutes or more I would leave and try calling her, but she never answers her telephone or returns her messages!

The third time I went to the Indian Health Service clinic the receptionist said a girl was moved into the Optometrist's area, so she could take her calls and appointments, so I went to the back of the clinic and sat until another staff member came out and I went in. The girl they hired to assist the optometrist asked me what I wanted, so I told her I wanted to talk to the Optometrist, so she went into the optometrist's office and told her. The Optometrist came out and asked what I wanted so I told her I wanted to know if they prescription from the Chamberlain Optometrist's eye exam results matched hers. She said no, they were different, so I asked if she could order me new lens with the Chamberlain Optometrist's results and she said no, because it was past the six month period for exchanges, she said I would have to pay another \$146.00 if I wanted new lens put in the frames that I originally picked out. I told her no, because I couldn't afford to pay for another set of glasses and I told her to just keep my glasses and give my money back, but she said she couldn't do that either, so I told her just to keep those glasses,

I talked to several people about this incident, I even went to see the Service Unit Director, but he was in a meeting, so I left him a note asking him to call me, but he never did. I did report it to the Health Board Chairman also, but nothing has been done.

To Whom It May Concern;

June 15, 2016

I am writing to report wrongdoings done to me by the Indian Health Service. First of all, let me explain my situation. I am a federal felon on probation for Theft of Government Property (excessive overtime). I applied for a job, Motor Vehicle Operator, at the Pine Ridge Indian Health Service. This position basically a housekeeping position with about 20% of the time dedicated to MVO duties, as was explained to me during the interview.

I was informed at the beginning of April that I did get the job and that the hiring packet and background check information would be emailed to me. I filled this out as soon as I received the email and sent it back. There were a few things I had to correct at the beginning of the process. As the weeks went on, I was asked to provide various pieces of information, which I believe I did in a timely manner.

While all of this was going on my mother was admitted to Rapid City Regional Hospital and was not expected to live much longer. Because of this I did inform Lois Cross, who at that time was my only contact between myself and Donna Belgarde, who was requesting additional information periodically by this time, that I would only be able to be contacted by my cell phone. She was more or less the middle-man. Because it was uncertain when my mother would be making her journey, I did let her know that all of my spare time would be spend at her bedside so any contact would need to be made through my cell phone. She had agreed, however, each attempt to reach me following this was made to my home phone. I would get home late at night and check my caller ID and see calls from Pine Ridge IHS. The next morning I would call Lois back and she would let me know what was needed next. Again, I would remind her that I am only able to be contacted on my cell.

During this time, Donna Belgarde, through Lois, requested a letter from my probation officer stating that I have complied with all aspects of my probation and that I was in good standing with the US Probation Office. At that time, I contacted my probation officer who stated that he had never had a request like this and that he wasn't sure that he could legally provide them with anything in writing and that he would meet with his supervisor to get clarification and direction on this issue. After a few days, I attempted to contact my probation officer again but was told he would be out of the office for another week. I was able to talk to his supervisor. By this point, I was given deadlines; that if I didn't get this information to them by a certain time that they would withdraw the job offer. So that same day, I was able to make contact with my probation officer's supervisor. He informed me that he had discussed this matter with my probation officer and that he also had never had such a request and that he had made contact with his superiors to get clarification and directions on this request also. He did inform me that this would probably be a couple more days and that he would call me back as soon as he got the information he was looking for.

At that time, I did let Lois know what was going on. She got in contact with, I believe Donna Belgarde, and Lois let me know that she got an extension to the deadline they had just given me. A couple days later, I received a call from my probation officer's supervisor and he informed me that according to his superiors, he would not be able to give a letter to anyone in regards to my satisfactory probation behavior unless he ordered to by a court order and even at that time, he would only turn such a letter over to the courts. He did however state that my probation officer could give a verbal on the status of my probation.

I immediately let Lois know of this and she informed me that she would let Donna know. I did give Lois the name and number of my probation officer's work phone and his cell phone. It wasn't until the Friday, the day of the last extension I was given, that I received a call from Lois stating that no contact had been made yet. At this point, I did get in contact with Donna myself and she informed me that she could take the verbal from my probation officer. She informed me a couple hours later that she was not able to get ahold of him at either number and that if I was able to get ahold of him, he could call her directly. I was able to get ahold of him and he assured me that he would call her. I did make several attempts to call Donna back to follow up with her and make sure the call was made but for the rest of the day, I was only able to reach her voicemail. Note: this was the last day I was able to spend with my mother before she passed.

Because I had not heard from Donna or Lois the following week, I had assumed everything was still good and that processes were still being taken in my hiring. I had checked my email and the caller ID to my home phone and my cell phone to see if any contact was attempting to be made throughout the week. Because I was busy preparing my mother's wake and funeral, I did not take the time to make a call but I assumed since they didn't call me, everything must be good. On Monday morning, I did call Lois and she informed me that the job offer was rescinded. I asked why and she told me I could call Donna and she would tell me. I called Donna and she referred me to who she stated made the decision, Connie Bordeaux. I talked to Connie and she stated that she pulled the job offer because I didn't get her the information that she had requested. When I asked which information wasn't received, she stated she never received the letter she requested from my probation officer. After I explained to her what I was told from the probation office, she stated that she had received letters in the past and that I should have been able to provide the letter. I did let her know that my probation officer did give Donna a verbal. Connie said that she couldn't take a verbal through someone else. In which case, I feel that she should have stated that from the beginning and my probation officer could have contacted her directly.

I am now at a loss of which direction to take. I do not feel that I did anything wrong in regards to this whole process. I feel that I did the best of my ability to comply with the whole background check process from beginning to end.

I do have four kids who are in college and I really need employment as we all know how expensive college is. If there is anything that can be done, please let me know.

Michael J. Twiss Sr.

COMMENTS TO S. 2953 "THIS ACT MAY BE CITED AS THE "INDIAN HEALTH SERVICE ACCOUNTABILITY ACT OF 2016", AND OTHER COMMENTS ON INDIAN HEALTH CARE SERVICES.

BY Irving Provost, OGLALA SIOUX TRIBAL MEMBER

After reviewing S. 2953 the proposed changes are generally based on the "Dorgan Report". In stating this, the proposed changes within S. 2953 are policy changes within the Indian Health Service. A majority of the changes are to develop oversight and compliance of Indian health service personnel, and performance. The Indian Tribes must be actively involved in the oversight and compliance of Indian health services. Respective Indian Tribes must be included in all the proposed policy changes within S.2953.

CONCERNS

The first concern is the policy for funding, work plan activities, and reporting requirements by the Indian health service. The Indian Health Service states it offers "BASIC HEALTH SERVICES". When did the Tribes of the Great Plains ever accept "BASIC HEALTH CARE" as a treaty obligation? This Bill S. 2953 must be a start to set the foundation for the Great Plains Tribes to start to receive Complete Health Care Services based on our Treaties with the United States of America.

- On page 15 of S. 2953 (b) GAO Report on IHS Staffing Needs----. Respective Tribes must have input on the report assessing staffing needs in the Indian Health Service. Tribes and local Indian Health Service units must have input, and implementation of recommended changes based on the fact that more comprehensive health care services are needed.
- Within S. 2953 starting on page 15 SEC.5, SEC. 607, SEC. 7, local Indian service units and respective Tribes must be involved with the revision process, and implementation process.
- Within S. 2953 starting on page 36 "SEC.610 local service units and respective tribes must be involved with having input, and implementation of recommended Changes.

CLOSING STATEMENT

As stated above S. 2953 is a start to the set the foundation for Complete Health Care within the Great Plains Area. I have written previous correspondence to Senator Thune regarding Health care on the Pine Ridge Indian Reservation. (attached is a copy). In closing I will share some comments and statements, FEAR and DESPIRATION has always been associated with health care on the Pine Ridge Indian Reservation. Working together with respect, trust and wisdom, we can bring complete Health Care to the Tribes of the Great Plains without the influence of hypocrisy. In ending I would I will share these words: "A great civilization is not conquered from without until it has destroyed itself from within"

INDIVIDUAL REPORT ON INDIAN HEALTH SERVICES PROVIDED AT PINE RIDGE SERVICE UNIT

INTRODUCTION

My name is Irving Provost I am a lifelong resident of Pine Ridge Village, I have had concerns about health care on the Pine Ridge Indian Reservation for over 40 plus years. I would like to thank former Senator Dorgan for doing an investigation on overall health care within the Great Plains region. After reading the report I became interested in the overall health care that the Indian Health Service is providing to the Oglala Sioux Tribal members. I have worked for over 20 years for the Oglala Sioux Tribe and the U.S. Environmental Protection Agency as a Federal/Tribal Inspector. I do have experience within the following areas: Investigations, Development of Strategic Planning, Budgeting (development of national budgets, local budgets, budget narratives), Work plan development, implementation of work plans, and reporting, and I developed Tribal environmental organizations.

After finishing my 2 term as a Tribal council representative of the Oglala Sioux Tribe, I decided to take care of my personal health care concerns. This Individual Report is about how the Indian Health Service provided services to address my personal health care concerns, and other concerns regarding health care being provided to the members of the Oglala Sioux Tribe.

INVESTIGATION

The first priority within my personal health care was migraine headaches, I seen a doctor who did a CAT scan, after the results were reviewed the doctor informed me that I should get a MRI done but the hospital did not have a MRI machine and he prescribed medication for the migraines. I asked the doctor when I could get a MRI scan? The doctor informed me that the IHS could not provide me with a MRI scan. After several months I was informed that there was going to be a mobile MRI machine at the IHS hospital at Pine Ridge. I did get a MRI scan and was informed that the results needed to be referred to a neurologist for review. To this day I still have not been referred to see a neurologist and I still have migraine headaches. My next personal health care concern was a chip in my right elbow. After seeing a doctor I was referred to an orthopedic doctor who informed me I had arthritis in my right elbow and scheduled me to have surgery to remove the chip in my elbow. After the surgery to remove the chip in my right elbow was completed, I talked to the surgeon about my surgery he asked me why the chip was not removed earlier, I informed him that I was told the IHS considered this

surgery was not life threatening. This came as a shock to the surgeon, after my visit with the orthopedic surgeon. The orthopedic surgeon started me on injections for mobility and physical therapy to address the arthritis. The services of an orthopedic specialist is limited based on the fact this service is available on a limited monthly basis. Currently when I went to get an appointment for an eye exam I was informed to come back in about 4 weeks because the optometrist schedule was full. The dental services I received was for fillings and cleaning, I asked to be referred to get partials or dentures, and was informed that they could not be referred based on they did not have enough financial resources to complete my dental services. During the time of addressing my medical concerns I did visit with other tribal members and ask them how are your health care concerns being addressed? I received various comments but a majority of their concerns are we need more medical services not just basic health care.

ASSESSMENT

In researching, and interviewing other tribal members, regarding medical services currently being provided by the Indian Health Service at Pine Ridge. The first question concerns a statement by the Indian Health Service which is based on just providing basic health care. When did the Oglala Sioux Tribe officially accept just basic health care? Since the Indian Health Service is just providing basic health care currently I researched the budgets for Health care within Indian Country, it is generally stated that the IHS PRIORITIZED basic health care. For example after reviewing the dental services within the FY-17 budget. Dental services states they provide just basic care, without addressing and providing rehabilitate services. Looking at the goals and outputs for dental services these basic goals and outputs have been the same for years! This demonstrates the lack of improving to provide quality dental care. These goals and outputs shows they are not living up to their trust responsibility in providing quality dental care. After reviewing the Budget for fy-17 a majority of the health care services have the same goals and outputs for years. This shows that Tribal health care is not improving within Indian country, while Tribal populations increase yearly it is common sense that health care must improve to provide quality health care. No more BASIC HEALTH CARE SERVICES.

RECOMMENDATIONS

Within this section the starting point must be with the development of a data base, within the data base consideration must be on the development of individual health care plans for all Oglala Sioux Tribal members. With the completion of this step prioritization can be done by grouping health care needs. From this assessment we could start the development of a strategic/management plan (this must be a 4 year plan after 1st year review amendment's would be addressed and implemented) which would include goals, financial budget, budget narrative, and reporting. The first priority must be a complete functioning emergency room with a comprehensive functioning emergency room with trauma surgeons, life support systems. All CMS certifications must be met and a comprehensive plan implemented to maintain CMS certification with full comprehensive funding. This must be done immediately! All the Indian

Health Care service units within the Great Plains Region must develop their own individual Medical Management Plans with full comprehensive funding (Note: currently the funding for health care at the individual health care service units is within the discretionary budget of HHS this must be changed to the fixed cost budget to meet the trust responsibility. Must have direct funding to the individual health care service units i.e. direct implementation of funding) for complete health care services for our Tribal members. It is time we start having respect for each other, and stop the hypocrisy to make comprehensive complete health care a reality to fulfill the government's trust responsibility. Time has come for The Tribes to be a vital part in the implementation of comprehensive health care within their local health care services, in other words must have direct implementation of services, funding and reporting. No more middle management. In ending it is time to start to develop comprehensive quality health care NO MORE (COMPREHENSIVE) BASIC HEALTH CARE.

June 13, 2016

Dear Mr. Walters:

As the elected Chairman of the Sault Ste. Marie Tribe of Chippewa Indians, I am writing on behalf of over 43,000 members of my Tribe.

As you are the Minority Chief of Staff for the Senate Committee on Indian Affairs, I want you to be aware my Tribe has requested an amendment to HR 5406, "The Indian Health Care Improvement Act." *The amendment would exempt Tribes from the definition of "applicable large employer" as that term is defined in Section 4980H(c)(2).*

Such an amendment would have direct bearing on S 1771 and S 2953.

The proposed legislation, introduced by Representative Kristi Noem (SD) on June 8, 2016, is currently before the House Committee on Natural Resources, and the Committees on Energy and Commerce, and Ways and Means.

Attached, please find a copy of our letter to Representative Benishak, dated June 10, 2016. Similar letters were sent to all members of the Michigan Congressional Delegation.

I request that you include the letter in the record for the events listed below:

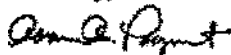
Senate Committee on Indian Affairs upcoming events:

June 16th: Town Hall Meeting "Discussing S. 2953: Improving the Indian Health Service."

June 17th: Oversight/Legislative FIELD Hearing on "Improving Accountability and Quality of Care at the Indian Health Service through S. 2953."

If you have any questions, please contact me at (906) 635-6050.

Sincerely,



Aaron Payment
Tribal Chairperson

June 10, 2016

The Honorable Dan Benishek,
US House of Representatives
514 Cannon House Office Building
Washington, DC 20515

Dear Representative Benishek:

As the elected Chairman of the Sault Ste. Marie Tribe of Chippewa Indians I am writing on behalf of my Tribe. My Tribe seeks an amendment to HR 5405, "The Indian Health Care Improvement Act."

Specifically, the Sault Ste. Marie Tribe of Chippewa Indians seeks your support of the following language to amend the Act:

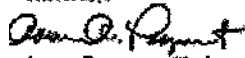
"Notwithstanding any other provision of law, an Indian tribe, tribal organization, Urban Indian organization or any agency, instrumentality or business entity the majority of which is owned by an Indian tribe or tribal organization shall not be considered an "applicable large employer" as that term is defined in Section 4980H(c)(2) of the Internal Revenue Code of 1986."

Currently, those Tribes that fall under the category of an "applicable large employer" are held subject to the employer mandate provisions of the Affordable Care Act. The mandate discourages Tribes from facilitating AI/AN Marketplace enrollment, requires Tribes to pay an individual mandate penalty by proxy on behalf of its AI/AN employees, and precludes AI/AN eligibility for tax credits. The mandate also acts as a federal directive that many AI/ANs pay for their health care in circumvention of the trust responsibility. Finally, the mandate is unaffordable for many Tribes, as Tribes will pay for both the penalties and the insurance payments with already-scarce resources that would be far better allocated towards funding direct Tribal services and programs. The proposed amendment to the bill will provide Tribes with relief from the provisions of the Employer Mandate of the Affordable Care Act.

The proposed legislation, introduced by Representative Kristi Noem (SD) on June 8, 2016, is currently before the House Committee on Natural Resources, and the Committees on Energy and Commerce, and Ways and Means. Presently, the bill has 5 cosponsors (Representatives Ashford (NE 2), Cramer (ND), Fortenberry (NE 1), McCollum (MN 4), and Smith (NE 3)).

Thank you for your support.

Sincerely,



Aaron Payment, Chairperson
Sault Tribe of Chippewa Indians

June 5, 2016

To whom it may concern/Health Committee:

I had a stroke in fall of 2011 while at work at the IHS hospital, and immediately walked over to the emergency room department. I was immediately assessed by a CNA named Jody and in a room when, one of the nurses by the name of Tess Conroy told the nurse to move me. CNA Jody told nurse Conroy that I was having stroke like symptoms and nurse Conroy got mad at her. All this happened in front of patients. I was walked over to the nurses' station and sat in the doctor's office. There wasn't any equipment in there to help me if I needed any kind of medical care. This was at the demand of nurse Conroy, I WILL NEVER FORGET HER SAYING; "she's not having a stroke, move her." I knew I had to act quickly and my aunt

who was there at the time drove me to Rapid City Regional Hospital. I am glad that I left the emergency room department because my situation was caught in time. I did have a stroke and can prove it with my medical records. At the time I also worked there in medical records and I had to put my two weeks' notice in due to horrible treatment, nepotism, moral and ethical treatment on behalf of my supervisor and other IHS staff. I can truly say that filing a complaint against Tess Conroy because of the malpractice during that time ended in back lash as an employee working there. My then Manager Lynn Pouirer and acting Supervisor Alberta Bad Wound found every way to punish me through out that year. For example I was asked more than once what my education was. . . I knew very well, if you are my supervisor you have access to my employee records and you know I have a Bachelors degree. I was literally picked on; I tried every avenue to protect myself. I know now that the protocol put in place is void and useless if you are filing complaints and sending them into Aberdeen where your supervisor has more friends and extended family. The system does not work when you have people in place that sabotage the proper protocol of filing a complaint. I literally had to make a choice of being stress free and healthy to prevent another stroke from stress. They are all close friends or relatives, I just had to make the choice to win when it came to my health and loose when it came to financial stability. I was extremely hesitant to even write a statement only because nothing has been rectified or done. Statements, complaints are filed for action to be taken and then the employee or patient has hope that they will be justified in some way. Sadly in most cases it is not. I could have died due to negligence on the choice of the nurse; I walked away from a good paying job, because that nurse is very close friends with my manager and supervisor. After this statement that I am writing I greatly hope it will help to change how employees are trained, and how employees are treated by upper management, this will definitely change how patients are treated and the type of care they receive. This is my experience as an employee and patient of IHS hospital in Rapid City, SD.

Thank you

TRIVIA AFRAID OF LIGHTNING

Good afternoon, my name is Linda Green,

A few years ago, (2012–2014) I worked at Soix San Hospital in the Patient Registration Dept., I worked with a woman by the name of, Patty Bissonette, we got along very well at first, but as the months went on I noticed she didn't like very many people and it was either because of their race and the past she had with them, some were because they were dated her ex-boyfriend. So one day I asked if she could please keep her opinions to herself, I explained to her that we were there because of the patients and not ourselves. This is one of the trainings that we had to take, to be professional, kind and put the patient before ourselves and that not to be racist or discriminate against anyone, because of their color, origin or sex. Well from time on I was on her bad side. There was another employee that had started and she was very good at doing her job and right away she noticed how, Patty's, work ethics were and wrote her up every time, Patty, made a mistake or discriminated against a patient, and when several attempts of going to the supervisor, we had a supervisor by then, his name was, Monte Gonzalez, and he was also getting tired of, Patty, for awhile then when the employee who had issues with, Patty, finally filed an EEO and somehow I got involved in it and when the Mediators came I was also told by our supervisor to attend the EEO as well since I had issues with her, but I did talk to the supervisor about, Patty, being racist and rude to certain patients so I guess this was the reason I was told to attend to resolve all the issues at once. But after that all hell broke loose, Patty, got worse with her attitude, the supervisor took her side and although I didn't really have a lot of issues with her, the supervisor and the business office manager, Colleen Steele, who was also the supervisors relative and Patty's best friend, all clicked together and started trying to make me do things that I knew if I did I would either get reprimanded and probably terminated, which they attempted to do anyway. So this woman, Patty, does not like me at all, was telling people after I left Sioux San that I was fired because I was stupid, dumb, didn't know how to do my job and how she hated me so much that she could choke the hell outta me. These are the reasons that I do not go to Sioux San for my appts or to get my medicines. I had a stroke in Spet of 2015 and had a second one in Jan of 2016, which the neurologists said was not a new stroke but was not going to rule out that it was not as troke because I had all the same symptoms.

so anyway I had an appt at Sioux San Indian Hospital on 05/08/2016, it was a friday, I was running a little late so I called to ask if my sister could check me in

and the woman that answered the phone did not identify herself, she said, "appointment desk", not a "good afternoon" or "how can I help you?", so I just continued and Identified myself so she would know who I was and told her that I had an appt and was running so I wanted to know what my appt was? the phone was dead for a few seconds, longer than usual, so I said "hello?" and she responded, "I'm right here!" with attitude, so I said "oh I just thought I got disconnected", again no response in any way, then she said, "your appt is at Sioux San Indian Hospital, Rapid City South Dakota @ 4pm (and I think it was a little later than that), so I said "ok thank you" and was going to ask if my sister would be able check me in and she hung up very hard because I heard a very loud click, so I told my sister that she just hung up, without any "have a good day or is there anything else that I can help you with?" I was shocked at her attitude and how unprofessional and rude she was, but I had to call again to make sure that it was ok for my sister to check me in, at the time I had an injured foot and was getting around very slow so I needed all the help I could get, so I called her back knowing what was going to happen. So I tried again and she answered the phone again so I asked her if she was the lady that I spoke to a few minutes ago, I Identified myself again and she said "yeah!", again with attitude, so I asked what her name was and she said "Patty!" so I said "thank you" and before I could say anything, she hung up again! same as before, no "have a good day, good bye or is there anything else I could help you with?" no apologies what so ever. So I asked my sister if she would come in with me to check in, in case she got an attitude with me, I was kind of nervous but I had to see a Dr or PA so we both went in and she was gone, her chair was turned like she ran out or something, her chair wasn't pushed in, it was turned facing the door, so I checked in with the man that was there, Humphrey Long, I knew the man so when I walked in he was laughing but I didn't know why? he was then only one in the office area, we made small talk, being cordial, and when I was finished checking in, I asked for a complaint form, he showed me where they were, so I took one, went about my way, a few days later the following week, I asked an ex co-worker if she could take the form in for me, I didn't want to face, Patty, in case she was in the area, then I was told by same ex co-worker that I should go in and speak to supervisor in person to make sure that something was being done about it so I went in later that week and I visited the supervisor, she said at the time that, that, Patty, came in on monday, first thing in the morning and she had complained about how I harassed her and intimidated her when i worked with her and she was in fear of her safety so she went to the security office and they sat and watched me as I went in to check in for my appt and that they watched me as I went up to the third floor. But the supervisor said that it was my word against hers and that she couldn't really do anything about it but that she had a talk with her and then she asked what I wanted done about her? . . . isn't it her job to take care of that kind of issues and make the place a peaceful, relaxing, comfortable place for the patient to come and get their medical issues taken care of? This woman had so many complaints wrote up on her that she shouldn't even be allowed to come near the place, shes very hateful, unprofessional and rude. I need to see a Dr or PA again to refill some of my meds but I'm very hesitant because I don't want the security sitting there watching my every move, I'm not a violent person, I was very kind to the patients when I worked there, as a matter of fact they were some of the people that told me back that Patty would talk about me when they asked where I was. There are some patients that she talked about when they would leave after they checked in for their appts. This woman needs to be made accountable for her work and watched very closely. There are other issues and I'm hoping that these people will take the time to send their complaints.

Sincerely,

LINDA GREEN
Hill City, SD.

I live on crow creek IF YOUR NOT RELATED TO AN EMPLOYEE YOU GET PICKED ON IBILLED FOR REFERRALS. CONSTANTLY HARASSED GOD FOR BID IF YOU NEED PAIN CARE. THEY ARE DRUG TESTED SOME OF THEM AREALLY MAJOR PILL HEADS. CONTRACT HEALTH I'D JOKE RUN BY DECISIONS MADE BY A HIGH SCHOOL GRADUATE NO OTHER COLLEGE EDUCATION MAKING MAJOR HEALTH ISSUES SHE HAS NO CLUE WE SUFFER GET RID OF BERNIE LONG, ROBERT DOUVILLE, PHARMACY DIRECTOR GREY. WHERE IS HIPPA ENFORCED ALL GOSSIP. IT'S SAD WE HAVE SO MANY MISDIAGNOSED.

07/02/2016

Dear Sirs,

My name is Randy St.Pierre and I have been an IHS employee at the Winnebago IHS hospital and most recently at the Rapid City IHS hospital. I just wanted to add my impressions and some of the experiences I have had while working in IHS and also being a patient at these hospitals. First of all I want to share a little of my background, I am 55 years old and am from Yankton SD originally currently living in Rapid City SD. At the present time I am not an employee at the Rapid City facility. I left in February of 2016. I am a Native American although I am not considered Native by some because my mother was Caucasian. While working in the IHS system I worked as a Medical Laboratory Technician (laboratory) and this involved working with many in the facility, particularly the medical staff. I finished my Bachelor's degree in 2015 in Hospital Administration and Management and am half-way through a Master's degree in Human Resources and Management. I wanted to work in IHS in the administrative area when I started my degree several years back but after dealing with administration in both the Aberdeen area and the Rapid City Hospital I have changed my mind because of the problems that plague these offices. In my opinion there are many but not all that are there only to get a paycheck and do not care about anything else. While working at both the Winnebago and Rapid City facilities I would have to make calls to the Aberdeen area offices several times a year and I can probably count on one hand how many times I was actually able to talk to a person there. And leaving voice mails would also be problematic since rarely would they respond to your voice mails including emails. When there was something urgent that needed to be done I would have to have my supervisor call or email and even he had trouble getting through to someone. The same goes for the local administrative offices at the hospital, the staff would rarely take your calls.

The point that has been made about trying to get rid of people is well known in IHS, an employee can almost get away with almost anything and never get fired, in the 9 years I was employed at IHS I never once saw anyone get fired except for myself. I will give a short synopsis of the event that led up to my termination at Winnebago. The laboratory had a lab aid that was Native American from the Winnebago tribe and I was warned when I started there that his brother was on the tribal council so you shouldn't upset him. Anyway, I was also told that he did not like any Natives that were not from the Winnebago tribe which I found out quickly as he would berate me in front of the lab staff, even during our lab meetings. I took a complaint to the EEOC in Aberdeen and it took them about a year to finally send someone down to investigate and in a meeting with myself and the EEOC person and the Hospital CEO which the CEO stated that this was the first he had heard of this "untrue" he had been aware of the complaints for over a year and everyone in the lab said there was no problem. So this goes on for another year when one day the lab aid pushes me off a chair and I go to the lab supervisor and he just tells me to forget about it, I was so upset I walked out and went home, the following day when I returned I was told I was being fired for going AWOL. I was actually not that upset because I was finally not having to endure the constant abuse from a fellow worker. I filed for workmen's comp and was denied because I was fired so I took it to court in Omaha NE and provided my testimony and won the case because no one from Winnebago came to the hearing. I was never bitter about this because I was never so glad to get out of a job that was so stressful every day.

I do not agree with those that say that IHS needs more funding, I believe they are funded well enough they just don't use the funds that they do receive in a way that is in the best interests of the people. And as for the employees, there are a lot of good people working in IHS but unfortunately, there are also a lot of those that should not be there. I have seen it numerous times that when a person becomes such a problem that they have to do something about them they don't fire them they just transfer them to another facility. What a great way to solve a problem, this wouldn't fly in the private sector.

And finally, about the care that the people receive at IHS, I do believe for the most part they do get very good care but it does depend on the provider and the staff. The problem I have seen with the providers, Drs and PA's is that they seem to not be very good at their jobs. I firmly believe that some if not many of these providers are those that have trouble in the private sector so they go into IHS where if they become a problem the hospital just transfers them to another facility or in most cases does not renew their short term contracts and they just go to an-

other IHS facility. There are a great many providers that I have worked with over the years that are very good but unfortunately they are in the minority.

There is so much more I could say about IHS although I don't want you to get the impression that I hate it because it is a very good service to the Native population. I just believe that if there was more accountability and not the attitude that you can never get fired from IHS then more of those people would be put in a position to be more accountable not only to their fellow workers but also the IHS system as a whole. In about a year when I finish my Master's degree program I will then reevaluate whether or not I want to pursue a career in the IHS system, I hope that I can.

RANDY ST. PIERRE
Rapid City, SD.

Dear respected members of our South Dakota community,

In 2008, I finished my master's in healthcare administration and management. Eager to work back home I applied for a position with the nascent diabetes prevention program through the IHS. I applied repeatedly and left many messages to the program managers via email and telephone. I never heard anything back. The following year I read in the Rapid City Journal that those in charge of starting the program were embezzling funds. I am only writing this to add a single voice to the problem, and share some of my frustration that many younger people feel about the state of the state.

Respectfully,

ANDREW SLAMA

We have the same problem on the white earth res in Minnesota they say we might have to pay for any of res medical treatment as they might not have the funds to pay.


**ROSEBUD SIOUX TRIBE
RESOLUTION NO. 2016-168**


- WHEREAS,** the Rosebud Sioux Tribe is a federally recognized Indian Tribe organized pursuant to the Indian Reorganization Act of 1934 and all pertinent amendments thereof; and
- WHEREAS,** in accordance with Article IV, Section 1 (a), the Rosebud Sioux Tribe is governed by a Tribal Council made up of elected representatives who act in accordance with the powers granted to it by its Constitution and by-laws; and
- WHEREAS,** Article IV, Sec. 1(v) of the Rosebud Sioux Tribe Constitution states: "The Tribal Council shall develop plans and consider implications of the decisions they make on the next seven generations."; and
- WHEREAS,** the Tribe believes that utilizing best health care management practices is essential for the proper management of the Rosebud health care facility; and
- WHEREAS,** the Tribe believes that a private sector management approach to the administration of the Rosebud health care facility is in the best interest of the Tribe and will be most effective; and
- WHEREAS,** the Tribe is actively engaging in a business partnership with a well-known, experienced, and capable health care management entity;
- WHEREAS,** the Tribe's economic arm, the Rosebud Economic Development Corporation's government contracting arm is a highly effective government contractor able to deliver goods and services on time and on budget with the highest standards; and
- WHEREAS,** the Indian Health Service has issued a sources sought for the management and administration of the Rosebud health care facility; and
- WHEREAS,** the Rosebud Sioux Tribe believes that its business arm teamed with a capable health care management entity will be able to best manage the Rosebud health care facility and provide the best standard of care; and
- WHEREAS,** the South Dakota Congressional Delegation consisting of United States Senator John Thune, United States Senator Mike Rounds and House Representative Kristi Noem has supported the Tribes attempts to provide better health care to our Tribal members and as such we respectfully request their assistance in working with IHS to accomplish to above criteria of this resolution; and
- NOW THEREFORE IT BE RESOLVED,** the Tribe Rosebud officially requests that the South Dakota Congressional Delegation work with the Tribe on having the Indian Health Service separate the Rosebud Sioux Tribe and Oglala in the sources sought and cancel the Indian Health Service sources sought for management services for the Rosebud health care facility and work directly with the Rosebud Sioux Tribe's health care logistics government contracting arm to negotiate a sole source contract for the management of the Rosebud health care facility.

CERTIFICATION

This is to certify that the above Resolution No. 2016-168 was duly passed by the Rosebud Sioux Tribal Council in session on June 14, 2016 by a vote of fourteen (14) in favor, zero (0) opposed and one (1) not voting. The said resolution was adopted pursuant to authority vested in the Council. A quorum was present.

ATTEST:


Julia M. Peneaux, Secretary
Rosebud Sioux Tribe


William Kindie, President
Rosebud Sioux Tribe

ROSEBUD SIOUX TRIBE RESOLUTION NO. 2016-173

WHEREAS, the Rosebud Sioux Tribe is a federally recognized Indian tribe organized pursuant to the Indian Reorganization Act of 1934 and all pertinent amendments thereof; and

WHEREAS, in accordance with Article IV, Section 1(a), the Rosebud Sioux Tribe is governed by a Tribal Council made up of elected representatives who act in accordance with the powers granted to it by its Constitution and By-Laws; and

WHEREAS, Article IV, Section 1(v) of the Rosebud Sioux Tribe Constitution states: "The Tribal Council shall develop plans and consider implications of the decisions they make on the next seven generations."; and

WHEREAS, the Tribal Council recognizes the need for changes within the Indian Health Service to improve our tribal member's health care; and

WHEREAS, the Tribal Council on behalf of the tribal members of the Rosebud Sioux Tribe express their support and gratitude of United States Senators John Barrasso, Chairman of the Senate Committee on Indian Affairs, and Senator John Thune introduction of S. 2953, the Indian Health Service Accountability Act of 2016; and


WHEREAS, the Tribal Council on behalf of the tribal members of the Rosebud Sioux Tribe express their support and gratitude of United States Senator Mike Rounds on his cosponsoring S. 2953, the Indian Health Service Accountability Act of 2016; and


THEREFORE BE IT RESOLVED, that the Rosebud Sioux Tribal Council recognizes and extends its support and gratitude to United States Senators John Barrasso, Chairman of the Senate Committee on Indian Affairs, and Senator John Thune and Senator Mike Rounds on S. 2953, the Indian Health Service Accountability Act of 2016.

CERTIFICATION

This is to certify that the above Resolution No. 2016-173 was duly passed by the Rosebud Sioux Tribal Council in session on June 14, 2016, by a vote of twelve (12) in favor, zero (0) opposed and one (1) not voting. The said resolution was adopted pursuant to authority vested in the Council. A quorum was present.

ATTEST:


Julia M. Peneaux, Secretary
Rosebud Sioux Tribe


William Kindie, President
Rosebud Sioux Tribe

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. MIKE ROUNDS TO
MARY WAKEFIELD

Tribal/Residual Shares for Great Plains Area

Questions 1, 2, 3a. Can you tell us when you would be able to provide our tribal leaders with information about the potential allocation of shares for the Great Plains Area? Why isn't this information public already? Is there a reason you are withholding this information or that it is not transparent?

Answer. Consistent with the IHS Tribal Consultation policy, the Great Plains Area (GPA) consults annually on the IHS budget formulation activities and includes Tribal representation from the GPA in the IHS Budget Formulation Workgroup. In these meetings, IHS openly discusses and shares information related to IHS headquarters, Area, and program or Service Unit level budgets with the tribes. These consultations and meetings may include other topic areas, such as IHS investments, initiatives, human capital, etc. The availability of information may vary depending on the timing of annual appropriation bills or other actions impacting federal appropriations. This information cannot be shared until the full-year appropriations bill is enacted.

In addition to these recurring meetings, in April and May of 2016, the GPA Office held meetings to specifically provide technical assistance related to tribal shares, as defined by the Indian Self-Determination and Education Assistance Act (ISDEAA) (25 U.S.C. 5301 *et seq.*), with the GPA Tribal Leaders and their subject matter experts. On March 23, 2016, invitations to attend these meetings were sent to all tribes in the GPA for those tribal consultation topics that are relevant to the respective tribes. For example, the IHS held a GPA Tribal Leaders Briefing in Sioux Falls, South Dakota on April 5–7, 2016 to provide an update on the progress addressing the delivery of health care services in the GPA, and to provide an opportunity for Tribal Leaders to voice their specific concerns. IHS provided a summary of this briefing to GPA Tribal Leaders via letter dated May 9, 2016.

Throughout the year and at the request of a Tribe, the GPA met on an individual basis with several Tribes to provide tribal shares information and ISDEAA technical assistance. IHS informed Tribes that they may contact the GPA Office, the Office of Direct Service & Contracting Tribes or the Office of Tribal Self-Governance at headquarters to schedule individual technical assistance meetings.

Question 3b. Why would tribes need to use FOIA to request this info?

Answer. The IHS makes every effort to maintain a clear balance between transparency and information sharing as it relates to applicable requirements for protecting privacy. In general, information regarding tribal shares and residual is shared annually or through individual technical assistance as noted above. In addition, IHS provides information relating to budgets, initiatives, and updates to Tribes on an on-going basis throughout the year through various forums from Tribal advisory committees, workgroups, and boards to press releases, letters to Tribal Leaders, and Congressional reports. The IHS values transparency in parallel to its stewardship duty of safeguarding records and data. As a general practice, when information is not publically available, IHS adheres to the requirements of the Freedom of Information Act (FOIA).

Question 4. Shouldn't this information be based upon how the Great Plains Area's budget is distributed today and isn't that information readily available to you?

Answer. The Indian Health Service, in consultation with tribes, has developed formulas for distribution of HQ, Area, and Service Unit funding known as "tribal shares tables." These formulas are not based on actual expenditures from year to year. This was deliberate because tribes wanted the formulas set in order to ensure predictability in funding to continue to allow tribes to exercise self-determination in how they receive healthcare. This allows tribes to make their determinations continue to either receive services directly from the Indian Health Service or through an ISDEAA contract based on the tribal needs.

This residual amount is described here in an April 1995 communication:

https://www.ihs.gov/ihtm/index.cfm?module=dsp_ihm_sgm_main&sgm=ihtm_sgm_9502

This provides a clear distinction between the funding a Tribe or Tribal organization is entitled to under the ISDEAA and the operational budgets of an IHS Area Office. A residual is portion of the IHS budget related to inherently federal functions necessary for the execution of the agency's programs and are not issued as shares to tribes. The split between residual and not inherently governmental funds are determined by IHS based on the legislative history of each appropriation act and executive branch wide definitions of inherently governmental functions.

The IHS is committed to ensuring accurate financial information is shared in a timely and transparent manner, through consultative processes and efforts described above. One key driver of delay in getting information to the tribes is the annual appropriations process. IHS cannot provide final tribal share information until our appropriation is enacted by Congress. These bills have been delayed from mid-December to as late as mid-March. Once the bill is enacted, IHS can compare this to the planned President's Budget and determine the correct categorization for any new amounts, either eligible for tribal shares or designation as residual. This process involves review of the bills legislative history and potentially decisions issued by the IHS Director.

Question 5. Are these shares the product of statute or administrative rule?

Answer. The IHS implements the Indian Self-Determination and Education Assistance Act (ISDEAA), (25 U.S.C. 5301 et seq.), as amended, which recognizes the unique legal and political relationship between the United States and American Indian and Alaska Native peoples. Titles I and V of the ISDEAA provide Tribes the option to exercise the right to self-determination by assuming control and management of programs, services, functions, and activities (or portions thereof) previously administered by the Federal Government.

Per the ISDEAA regulations, Tribal share means an Indian Tribe's portion of all funds and resources that support secretarial PSFAs that are not required by the Secretary for the performance of inherent Federal function. The ISDEAA regulations and Tribal Consultation (at Headquarters and Area levels) helped shape the methodologies utilized today. The methodologies range: (1) Direct Shares are precisely determined when financial accounts record actual spending for PSFAs for a Tribe, e.g. IHS funds at a local site serving one Tribe; (2) Program Measures may be calculated in proportion to workloads, services, or patient counts for each Tribe. These formulas are most common for PSFAs associated with the Office of Environmental Health and Engineering; and (3) Proxy formula that calculates shares in proportion to indirect measures such as user counts, number of Tribes, or other general distributive factors.

Question 6. Information on tribal shares are already published in the annual budget book for 10 of the 12 IHS service areas. Why is this information not published for the Great Plains Area?

Answer. The IHS Congressional Justification (CJ) includes self-governance funding tables. For the first time, a Tribe from the Great Plains Area successfully entered into a self-governance compact in 2016, after the February 2016 publication of the FY 2017 CJ. Because of this, the Great Plains Area will be included in the self-governance funding tables in future years.

Contracting/Staffing (Contracting/Quality Offices)

We are frustrated by the lack of transparency, consultation and communication in the process for both issuing the RFP and selecting the vendor for the Winnebago/Omaha, Pine Ridge and Rosebud Emergency Departments. We believe that had there been more awareness that the RFP was issued and had IHS responded to the interested local health care providers, a local health care entity may have submitted a legitimate bid for consideration. Furthermore, we understand that AB Staffing Solutions has a mediocre to poor history at being able to staff IHS facilities in the past, specifically:

- The San Carlos Apache had AB Staffing at their facility in Arizona. AB Staffing did not meet the tribe's expectations and were fired.
- We have heard reports that AB Staffing supplied staff at our Pine Ridge and Rosebud facilities and that the staff members that AB Staffing supplied were responsible for the shortcomings and poor quality that led to the CMS violations.
- We have heard reports that AB Staffing regularly recruits health care professionals from global regions that do not have the same or equal quality medical training and certification standards as United States medical training and certification.

Question 7. What information can you give me about your confidence in AB Staffing's ability to be successful in their contracts in the Great Plains Area?

Answer. IHS is committed to providing quality care at its emergency facilities in the Great Plains Area. IHS is working to provide oversight and support to the contractor and to the hospitals served by the contractor to help facilitate a successful implementation. The challenges are complex in these specific areas of quality improvement. IHS is continually working to improve the quality of care provided at our facilities and to ensuring the improvements made can be sustained over time.

Question 8. Ultimately, if they are not able to perform successfully, what recourse do our tribes have in canceling and rebidding the contracts?

Answer. A recent modification has been issued to the AB Staffing contract to more clearly define requirements, provide additional qualifications for health care providers, and enhance contractor accountability. The modification also provided additional funding in order to recruit and retain quality personnel. Tribes with concerns about AB Staffing's performance should contact the Great Plains Areas Director who can notify the Contracting Officer's Representative (COR) for the contract and Indian Health Service will assess the situation and if appropriate, take action pursuant to the Federal Acquisition Regulations.

Vacancy info (OHR)

Of the 846 Healthcare Professionals in the Great Plains Area, only 637 of those positions were filled at the time of the report this spring. This is a vacancy rate of 25 percent.

Question 9. Presumably there is money allocated for the salaries of those positions that are not filled. How is that money allocated every year; is it redeployed and if so, how?

Answer. Positions are funded through the annual appropriations allocated to the Area and each Service Unit. Third party collections within each Service Unit may also be used to fund healthcare positions. Any funds available due to vacancies are used for the provision of health care services including but not limited to medical supplies and equipment and temporary contracted healthcare providers.

Question 10. Can you provide the vacancy rates/information as of June 17, 2016 for the Great Plains Area?

Answer. As of June 15, 2016, total number of vacancies and the vacancy rates for IHS GPA are as follows:

- The total number of GPA positions was 2,782. Of the 2,782 GPA positions 549 were vacant. Therefore, the overall vacancy rate for GPA was 20 percent (1936 total non-health professional positions and 846 health professional positions).
- The total number of health professional positions was 846. Of the 846 health professional positions 209 were vacant. Therefore, the vacancy rate for health professional positions was 25 percent. Health professional positions include, Medical Officers/Physicians, Nurses, CRNAs, Midwives, Nurse Practitioners, Dentists, Physician Assistants, and Pharmacists.
- The total number of non-health professional positions was 1,936. Of the 1,936 non-health professional positions 340 were vacant. Therefore, the vacancy rate for non-health professional positions was 18 percent. Non-health professionals positions include, for example, medical support staff, Area Office, admin staff, custodians, clerks, Engineers, Behavioral Health, HR, Finance, Business Office, etc.).

