# Seattle Indian Health Board

*For the Love of Native People*

TESTIMONY OF ESTHER LUCERO
EXECUTIVE DIRECTOR
SEATTLE INDIAN HEALTH BOARD
FOR
HOUSE APPROPRIATIONS SUBCOMMITTEE
ON INTERIOR, ENVIRONMENT AND RELATED AGENCIES
Thursday, March 17, 2016, 11:00 a.m.

Chairman Calvert, ranking member McCollum, members of the House Appropriations Subcommittee on Interior, Environment, and Related Agencies, my name is Esther Lucero. I am the Chief Executive Officer for the Seattle Indian Health Board. I am of Navajo and Latina descent. I am a third generation urban Indian. I appreciate the opportunity to present testimony today.

The Seattle Indian Health Board is a contractor and grantee with the Indian Health Service under authority of the Indian Health Care Improvement Act. Our goal is to improve the health of American Indians and Alaska Natives living in cities through the provision of culturally relevant health and human services. The Health Board has been in continuous operation since 1970. We offer a comprehensive array of primary health care services including medical, dental, mental health, substance abuse, nutrition, pharmacy, and traditional health services to more than 4,000 Indian people annually representing more than 250 different Indian tribes. We manage Thunderbird Treatment Center, one of the largest residential chemical dependency treatment centers in Washington State.

Beyond our clinical services, the Health Board operates the only American Indian/Alaska Native, allopathic, ACGME accredited family medicine physician residency training program in the nation. We also manage the Urban Indian Health Institute, one of the Indian Health Service's tribal epidemiology centers with a focus on the health of urban Indians from across the nation.

I am here seeking your support for improved funding for the urban Indian health program with the Indian Health Service. I would like to thank the subcommittee for recommending and getting approved the $1.85 million increase for FY-2016. Your recognition of our work by appropriating an increase in 2016 illustrates the growing recognition of the health disparities witnessed among urban Indians and the need to invest in improving services to aid in addressing this crisis.

We are particularly heartened by the recent request from the Indian Health Service for a $3.55 million increase for FY-2017, and encouraged by the FY-2018 IHS budget formulation process, where 8 of 12 regions recommended increases to the urban Indian health program line item. As the subcommittee

knows, the Indian Health Service has not sought reasonable funding for urban Indian health in years past. Despite the fact that 7 of 10 of all American Indian/Alaska Native people now living in urban areas, and 3 out of 4 in the state of Washington, the urban Indian health program line item still only accounts for approximately 1% of the IHS budget. While we have seen some positive trends in how the administration, the Congress and the IHS are addressing the needs of the urban AI/AN population, the IHS is burdened with serving tribal communities with a budget that fails to adequately address the alarmingly persistent health disparities suffered by our AI/AN people. This continues to occur despite the obligations of a federal trust responsibility to address the needs of AI/ANs in the realms of health, housing and education. While we absolutely support the need to expand resources for tribal communities, in that same vain, it is important to recognize that a growing number of Indian people now call major American cities home, and it has become the responsibility of agencies like the Seattle Indian Health Board to overcome the social, cultural, and historical factors that make accessing essential, health services difficult. We are more than a health service provider. We ensure that urban AI/AN people have a home-away-from-home, a place where they can access culturally relevant services and build community. Community is the core of our resilience.

The Indian Health Service is seeking $2.4 million in support for current services, and we thank the committee for the increase in the IHS budget to address the needs of our urban AI/AN population, but this number is still inadequate for the urban Indian health programs to address the needs of a tribally diverse, dispersed and disenfranchised urban AI/AN community. $5 million would bring us closer to meeting the growing need. We would be able to build the infrastructure and strengthen the services for the three types of UIHP (Comprehensive, Limited, and Outreach and Referral). This would begin to provide a foundation to adequately serve the needs of the 1 million AI/ANs who live in their service areas. This is why we wholeheartedly support the $1.15 million request to conduct a strategic plan for the urban Indian health program. We have for years felt that there are sufficient differences between tribal communities and the demand of urban life that require a more specific understanding that a strategic plan might produce. This is a task that has been needed for quite some time. A strategic plan will help us understand the current status of the urban Indian health condition and provide guidance for how we might best address the barriers that have prevented any significant progress toward retarding and reversing the disparity findings. We ask that the leadership of the urban Indian health organizations play a key role in directing the plan to assure that the integrity of the on-the-ground operations are represented in the findings. All too often reliance on data and secondary assessments fail to appreciate

the priorities in local communities driven by community factors and resource availability. Bringing these elements into the plan will greatly improve the prospects that solutions will be more likely to succeed. We hope also that the plan includes cities with sizable urban Indian populations that do not currently have an urban Indian health organization presence. As the nature of these cities is understood we believe the subcommittee will see the virtue of expanding urban Indian funding for new programs as resources become available.

In summary, we thank the committee for recognizing that there is a funding disparity in the IHS budget to address the health needs of AI/ANs living in urban areas. As UIHPs it is very important that we work with our tribal communities to best meet the needs of all AI/AN people, particularly when they migrate or relocate to urban environments. We ask that the budget formulation process better reflect the health care needs of the urban AI/AN community and that the strategic plan identify a feasible budget to adequately combat the health disparities experienced by our AI/AN population regardless of where they reside.