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Testimony of Esther Lucero, MPP
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Subcommittee on Interior, Environment and Related Agencies
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Chairman Simpson, Ranking Member Pingree, and members of the House Committee on Appropriations – Subcommittee on Interior, Environment, and Related Agencies, my name is Esther Lucero. I am Diné, of Latino descent, and third generation in my family living outside of our reservation, I strongly identify as an urban Indian. I serve as the President & CEO of the Seattle Indian Health Board (SIHB), one of 41 Urban Indian Organizations (UIO) nationwide. I have had the privilege of serving SIHB for seven years and have been providing testimony to this Subcommittee for the past five years. I am honored to have the opportunity to submit my testimony today, including a request of $973.5 million to the Urban Indian Health line item. The recent investments in the Indian Health Service (IHS) are beginning to address the chronic underfunding of the Indian Health Service/Tribal 638/Urban Indian Health Program (I/T/U) system of care. However, I am growing increasingly concerned that these allocations are expected to solve the problem. It is important to acknowledge that tribes and Urban programs deserve full funding given that health care is one component of the benefits defined by the fiduciary obligations established through hundreds of ratified treaties resulting from the cessation of land. These are prepaid benefits and should be funded to meet the growing demand for culturally attuned health services for American Indian and Alaska Native (AI/AN) people.

Increasing Funding for Urban Indian Organizations (UIO)

I would like to extend our gratitude to the Subcommittee for the passage of advance appropriations for the IHS for Fiscal Year (FY) 2024 in the FY 2023 Consolidated Appropriations Act. Advance appropriations will prove critical in ensuring that there are no disruptions to our critical health care services and protection over our finances and operations. In the past, the Indian healthcare system has been disproportionally affected by government shutdowns. For SIHB, if it was not for a donation from another community-based organization, we would have had to close our Elders Program, which sees 75-100 elders per day, 40% of whom are homeless. We encourage the Subcommittee to enact permanent advance appropriations to the IHS for FY 2025 and beyond. Permanent authorization of advance appropriations will ensure IHS, tribes, tribal organizations, and UIOs always maintain culturally attuned, patient centered, and accessible care for our relatives and future generations.

As part of the Indian healthcare system, UIOs make up 13% of all Indian healthcare facilities[1] and support the 76% of AI/AN residing in urban areas but continue to receive

[1] Indian Health Service. (2020). IHS Profile: Based on 2015-2020 data – Numbers are approximate. Retrieved from: https://www.ihs.gov/newsroom/factsheets/ihsprofile/

less than 1% of the IHS budget. The requested $973.5 million would only result in the 41 UIOs each receiving $23,178,571. The enacted appropriations for the Urban Indian Health line item for FY 2023 is only $90,419,000, far from a full-funding level. I would like to emphasize that we are not looking for funding to be diverted away from Tribal IHS programs to benefit UIOs, but rather for the whole IHS system to be fully funded. This request is in alignment and support by our Tribal partners in the Northwest Region.

As a result of the recent investments in health care and infrastructure, SIHB expanded our services by adding two new clinic sites, and through a Health Resources and Services Administration (HRSA) grant we launched a mobile clinic to reach and serve homeless and rural AI/AN, who typically have limited access to care. This allows us to reach far more people in Washington State, by meeting them where they are, to offer them culturally attuned medical, dental, and pharmacy services. SIHB is prepared and committed to reducing the significant disparities for AI/AN people. We can only do this with increased allocations.

Investing in Behavioral Healthcare Access and the Indian Healthcare Workforce

The pandemic created challenges for individuals to access and receive behavioral health care services leading to an increase in demand for mental health and substance use disorder (SUD) services. In 2019, 10% of AI/AN reported a SUD and 5% reported opioid misuse.[2] In 2020, the overdose rate was worse for AI/AN than any other group[3] and in King County, our people have been disproportionally impacted by Fentanyl overdoses. For over 40 years, SIHB has been responding to behavioral health needs in our community, but in 2020, SIHB had to temporarily pause our 65 bed in-patient residential treatment services due to an aging facility (beyond repair) – leaving a gap in behavioral health services for Washington State and Indian communities. Prior to our pause of in-patient behavioral health services, we had 61% of patients complete the program, and 69% of those patients identified as AI/AN.

The American Rescue Plan Act (ARPA) of 2021 extended 100% Federal Medical Assistance Percentage (FMAP) to UIOs through a 2-year pilot project. As you know, 100% FMAP results in state cost-savings for clinics working with high-cost populations. Before 2021 only tribes were eligible for 100% FMAP. Prior to the passing of ARPA, Washington tribes, SIHB, and the Native Project in Spokane, Washington, worked with Washington State to establish the Indian Health Reinvestment Account. The 100% FMAP cost-savings were held in this account to be reinvested in the I/T/U system of care. We are grateful to our Washington tribes and their advocacy for transferring $11 million from the100% FMAP cost savings to SIHB to support the purchase and expansion of our in-patient facility. Our new program will expand to 92 beds, with 10 beds dedicated to serving pregnant and parenting people. Without this investment, SIHB would have had to overwork our resources to secure this amount of funding that would have likely resulted in significant delays in service. It is urgent for the Subcommittee to support the permanent authorization of UIO eligibility for 100% FMAP and to create

[2] SAMHSA. (2020). National Survey on Drug Use and Health: American Indians and Alaska Natives. Retrieved from: https://www.samhsa.gov/data/sites/default/files/reports/rpt31098/2019NSDUH-AIAN/AIAN%202019%20NSDUH.pdf.
[3] CDC. (2021). Drug Overdose Deaths in the United States, 1999-2020. Retrieved from: https://www.cdc.gov/nchs/products/databriefs/db428.htm

dedicated funding for behavioral health facilities to address the substance abuse issues existing in Indian Country. This is especially critical without a dedicated IHS–Health Care Facilities/Construction line item for UIOs or behavioral health facilities. Without this funding reaching Indian Country, the behavioral health crisis is likely to intensify.

Congress must also consider investments in specialized services for pregnant and parenting adults. In the lower 48 states, there is only one in-patient facility with 10 dedicated beds for pregnant and parenting adults. In the U.S., rates of suicide, suicidal ideation and self-harm during pregnancy have increased from 1.8% to 9.3% over the past decade.[4] From 2008-2019, 33.3% of pregnancy associated suicides were linked to SUD with pregnancy associate suicide deaths being highest for AI/ANs.[5] To protect birthing individuals and future AI/AN generations, Congress has an obligation to invest in culturally attuned facilities for Native beneficiaries. With the threat of the overturning of the Indian Child Welfare Act, it is critical for the Subcommittee to invest in facilities that keep Native families together while offering holistic care through medical, behavioral health, pharmacy, dental, and social services.

It is important to remember that services are not possible without skilled service providers. I strongly urge the Subcommittee to further invest in the Indian healthcare workforce. Due to underfunding and sometimes stigmatized work of behavioral healthcare, Indian healthcare clinics are experiencing a shortage of behavioral healthcare providers to address the rising demand of services. A HRSA report identified Washington state as a Mental Health Professional Shortage Area (HPSA), estimating that only 16.8% of mental health needs are being met.[6] The Tribal Budget Formulation Workgroup recommends an investment in the social-behavioral workforce to serve the Indian population while providing adequate funding for behavioral health training and community educational programs. To meet the demand, I request members of the Subcommittee to support the recruitment and retention of behavioral healthcare professionals capable of serving AI/AN people in a culturally appropriate manner.

In efforts to improve AI/AN representation within public health careers, SIHB offers 28 workforce development programs that connects individuals with trainings, mentorships, and internships to explore the healthcare field. Too often, healthcare training programs are competitive and do not consider the disparities faced by AI/AN students in accessing such programs. At SIHB, we have cultivated an irrigation system that recognizes the gifts and talents within our community members to participate in our programs and work with our relatives. We must strive to uplift the careers of Native students and individuals, by investing in their futures through opportunities to work alongside AI/AN providers within the Indian healthcare system.

Investing in UIO Infrastructure

Providing our relatives with the highest quality of care at our three locations has required SIHB to maintain over 70 grants and contracts. Under my leadership, I have

[4] American College of Obstetricians and Gynecologists. (2022). Pregnancy-Associated Homicide and Suicide: An Analysis of the National Violent Death Reporting System, 2008-2019.
[5] Ibid.
[6] Kaiser Family Foundation. (2021). Mental Health Care Health Professional Shortage Areas (HPSA). Retrieved from: https://www.kff.org/other/state-indicator/mental-health-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

increased SIHB's operating budget by over $23 million through a unique braided funding system that identifies gaps and opportunities for complementary funding across our integrated care services. However, there is a significant lack of investment for UIO infrastructure including funding for special projects.

SIHB is in the processes of establishing the first ever Sexual Assault Nursing Examiner (SANE) Examination operated by an UIO. Due to the alarming rates of violence our relatives' experiences, it is absolutely critical for SIHB to establish this program. It has been a devastating experience for our relatives to share their stories of violence and having to refer them to another clinic. Despite the amount of care our case managers, providers, and traditional apprentices care for victims and survivors it is not enough. The establishment of the SANE examination is too often necessary that SIHB is creating this service out of demand to ensure we support our relatives during their most vulnerable stages of violence and recovery.

Permanently Authorize the Special Diabetes Program for Indians (SDPI)

There are over 300 Special Diabetes Program for Indians (SDPI) programs across Indian Country that serve appropriately 780,000 AI/AN people. Since 2009, our research division – Urban Indian Health Institute (UIH) has analyzed diabetes data from 30 UIOs, with the number of UIOs in each year's audit changing annually. In 2022, UIHI released the *Urban Diabetes Care and Outcomes: Audit Summary Brief*.[7] From the data collected from AI/AN patients with diabetes across 27 UIOs, 52.3% of patients audited were aged 55 or older and 98.7% of patients had type 2 diabetes. Other key findings from the 2016-2020 audit include 69.8% of patients received education on diabetes topics other than nutrition and physical activity like blood glucose monitoring, medication taking, and healthy coping skills. Additional data for audited patients includes 69.7% of patients had an estimated glomerular filtration rate of 60 mL/min/1.7m2 or higher, indicative of no chronic kidney disease and 72% of patients had blood pressure levels meeting the 2020 IHS Government Performance and Results Act target of 60.5%. To support the improvement of health outcome benefits for urban AI/AN with diabetes, Congress must permanently reauthorize the SDPI and increase funding to $250 million per year. The SDPI program is authorized until FY 2023 at $147 million annually.

However, current funding levels have been reduced after a mandatory sequestration of $3 million beginning in FY 2022, which reduced SDPI funding levels from $150 million. As a health spending program alongside programs like Medicaid and Social Security, SDPI was the only program that received a reduction in funding. In some clinics the reduction of funding alongside the impacts of COVID has led to challenges in being able to purchase diagnostic equipment and difficulty supporting diabetes outreach, education, and prevention materials and programs. It is not only pertinent that Congress increase funding for SPDI to $250 million but allow for flexible spending for tribes, tribal organizations, and UIOs to spend the funding as needed for our respective areas.

[7] Urban Indian Health Institute. (2022). Urban Diabetes Care and Outcomes Audit Summary Brief, 2020. Retrieved from: https://www.uihi.org/resources/urban-diabetes-care-and-outcomes-audit-summary-brief-2020/.