RESPONSE OF THE GREAT PLAINS TRIBAL LEADERS HEALTH BOARD TO THE REQUEST FOR FURTHER INFORMATION BY THE HOUSE NATURAL RESOURCES COMMITTEE SUBCOMMITTEE ON INDIAN AND INSULAR AFFAIRS FOLLOWING THE TESTIMONY OF JERILYN LEBEAU CHURCH DURING THE "CHALLENGES AND OPPORTUNITIES FOR IMPROVING HEALTHCARE DELIVERY IN TRIBAL COMMUNITIES" HEARING ON MARCH 29, 2023

1. **How has telehealth improved access to care? Do you have any information on how that has been different between tribally run healthcare facilities and Indian Health Service (IHS) run facilities?**

    a. **What data can you share with the committee on how telehealth may have improved access to care?**

- Telehealth is used heavily in tribal communities across the country, with telehealth visits making up 60 percent to 70 percent of their healthcare services.[1]
- IHS provides specialty services at 19 facilities in the Great Plains Area including behavioral health, cardiology, maternal and child health, nephrology, pain management, pediatric behavioral health, rheumatology, wound care, ear, nose and throat care, as well as dermatology.[2] Many of these specialty care services are provided through telehealth.
- One study found that for every dollar spent in telehealth, $11.50 was saved in travel and child-care expenses and without any decrease in quality. In order to receive specialty care (which is often unfunded in Indian Health Service (IHS) facilities), those living on reservations must travel great distances, as reservations are typically geographically isolated. One study examining access to cancer support groups noted that trips often require between 2 to 5 hours of travel each way, with travel costs alone ranging from $50 to $200.[3]
- A study conducted in Nome, for example, found that, prior to use of telemedicine for audiology and ear, nose, and throat (ENT) services, 47% of new patients would wait five months or longer for an in-person ENT appointment. After the introduction of telemedicine, this rate dropped to 8% of all patients in the first three years, and less than 3% of all patients in the next three years.[4]
- Attracting and retaining behavioral health professionals in rural or remote areas is a significant challenge. Behavioral health providers are typically in short supply

[1] Bailey, 2021. *Tribal Communities See Benefits and Challenges in Using Telehealth.*
[2] Indian Health Service, 2016. *Great Plains Area Tribal Leaders Briefing Summary & Follow-up.*
[3] Kruse, Clemens, et al, 2016. *Telemedicine Use in Rural Native American Communities in the Era of the ACA: a Systematic Literature Review.*
[4] Hays, Carroll, et al, 2014. *The Success of Telehealth Care in the Indian Health Service.*

in any community and have numerous employment opportunities in urban, higher-paying, and more desirable locations. The telehealth model allows behavioral health professionals to live where they like and still provide services equivalent to in-person care to high-need, remote communities.

- According to the IHS Tele-Behavioral Health Center of Excellence (TBHCE) the clinical telebehavioral health program noted that patients are 2.5 times more likely to keep their telepsychiatry appointments than in-person psychiatry sessions.[4]
- The TBHCE also found that in fiscal year 2013 the telebehavioral health program allowed IHS patients to avoid more than 500,000 miles of travel, which translated into over $305,000 in savings for them. Since the telebehavioral health program was available to patients in 2013, these patients saved more than 16,450 hours of work or school that would otherwise have been missed to travel for appointments.[4]

2. <u>Could you further expand on the challenges the Great Plains Area is facing regarding workforce shortages for both IHS and tribally operated facilities:</u>

First, it is important to note that finding, hiring, training, credentialing, and retaining sufficient staff to meet the needs of clients and provide treatment services are all critical staffing issues.[5] Without qualified staff and providers, we are prevented from fulfilling our statutory and ethical obligations to our patients.

Specific workforce challenges currently facing the Great Plains Area include:

- An aging workforce at Indian health facilities throughout the Great Plains Area.
- Out-migration of workforce members (people who leave the workforce and simply stop working) in large part due to a shift in attitudes regarding work and life brought on by the COVID-19 pandemic that has led to a decrease in the available labor pool
- Small local labor pool size. For example, the Oyate Health Center is located in Rapid City, a city of just over 76,000 people. The small populations in our region do not provide and adequate staffing pool, so facilities in the Great Plains Area are often forced to recruit from other markets.
- Housing shortages. Lack of availability of housing throughout the region but especially on Reservations, has made it difficult to recruit qualified individuals from other areas to the Great Plains Area.
- Cost of housing. Again, using the Oyate Health Center as an example, rising housing costs in the Rapid City region make it too expensive for younger potential workforce members to move to the Rapid City area and purchase homes.

[5] Great Plains Tribal Leaders Health Board, 2020. *Tribal Treatment Services Needs Assessment Report.*

- Inflation in the wider economy means workforce members have fewer resources available to move to the Great Plains Region for work.
- Finally, potential applicants have reported procedural issues such as difficulty understanding job postings, the posted salary not reflecting the actual wage, or difficulty contacting hiring officials to obtain an interview.

a. What are the greatest challenges to maintain an effective workforce for tribal health programs?

- Lack of a competitive salary structure. When Tribal health programs lag in their review of salary structures, and do not remain competitive, non-Indian facilities will jump at the opportunity to pry employees away.
- Lack of remote or modular work opportunities, which could be offered when appropriate.
- Lack of technology enhancements to increase services. Technology like telehealth, virtual reality, wearables, AI, personalized medicine, and smart clinic management, if done correctly, could lead to expanded services. The resulting revenue could then be used to employ the correct size workforce.
- Lack of Congressional appropriations sufficient to meet federal treaty and trust obligations to tribes. Because of persistent underfunding, Tribal health programs are left without the required capital to employ an appropriately sized workforce and enhance or modernize services. As noted in Jerilyn LeBeau's testimony, contract support costs and 105(l) lease payments, as well as all IHS funding, should be made mandatory with a priority for contract support costs and 105(l) lease payment funding.
- The system for recruitment and retention, especially in IHS facilities, is archaic and does not keep pace with modern job flexibility, benefits, and salaries that are offered in private clinics or hospitals, thus making it extremely hard to compete.

b. Are there any tribally led efforts on recruitment and retention that IHS can learn from or institute?

- IHS could do a lot more with creating formalized and intentional training opportunities that create labor pool pipelines between universities, colleges, trade schools, tribal colleges, job corps, and other organizations whose mission is to educate and train young and older adults to enter or re-enter the workforce.
- IHS could establish adult vocational education training programs that occur on an annual, bi-annual or quarterly basis inviting people interested in healthcare opportunities to get introduced to health care professions in a hands-on learning

methodology where participants would gain experience working at Tribally managed facilities.

- More IHS funding could be allocated to recruit new graduates to work in Indian health organizations, while creating agreements with Tribally managed facilities to create employment opportunities for new graduates. Then new providers, especially nurses, could receive training and grow to be skilled caregivers in a culturally appropriate environment. We rely too much on hiring experienced nurses; an understanding that new graduates can be developed in the first stages of their career at a Tribal organization. These post-graduate programs would take more investment in the form of time and training up-front; but investing in new graduates could result in more individuals deciding to commit to a career in Tribal communities.

  Currently, recent graduates interested in working in Indian healthcare are too often turned away for lack of an effective preceptor program in Tribal health organizations.

3. **Can you further expand on your testimony about staffing at Great Plains IHS facilities, and what improvements in recruiting and retention will not only improve care, but eventually be cost effective.**

As mentioned above, an updated wage structure with competitive pay is the first fundamental step to attracting qualified employees. While there are still altruistic individuals who want to work in Indian Country for less than they can earn in the for-profit world, reliance on such individuals is not a successful or sustainable recruitment strategy. Indian healthcare facilities need to offer competitive and rewarding job opportunities that mirror the for-profit healthcare world around us. Recruitment efforts should also include longevity strategies, including pensions, housing, flexible schedules, and training opportunities for licensing. IHS hiring procedures, including facility certification processes, need to be streamlined to get good candidates hired quickly, and creative, clear, and broad advertisement strategies would reach a larger candidate pool.

IHS recruitment and retention plans should reflect a sincere recognition that workforce needs and realities have changed, or we will see greater and greater challenges at filling our open positions.

   a. **Would a stand up of the Community Health Aide Program (CHAP), that currently operates in Alaska and was mentioned in Ms. Platero's testimony be useful to meeting those staffing challenges?**

Yes, provided it is implemented effectively. The most successful implementation of the CHAP program has occurred in Alaska; the program there has existed since the early 1970's. Implementing the CHAP program outside Alaska will require recognition that the nurse, mid-level practitioner, and physician approach to health care is not all encompassing and the CHAP's (paraprofessional level health care providers) can and should be allowed to practice a certain level of medicine, especially in smaller Tribal or remote communities.

It would also require establishing a multi-year training program based on the Alaska model, accompanied by the appropriate funding to support trainees through their training. Essentially, the plan requires paying CHAP candidates throughout the training period, with a pay-back provision once the new CHAPs are working in their home, rural and/or Tribal. As this is already a proven program in the Alaska Area, we can list the keys to a successful CHAP program:

- Tribal community support
- American Medical Association support
- Local, regional, and statewide legislative support
- Fiscal support

b. What other creative possibilities exist that tribal organizations and IHS could implement?

4. <u>The Subcommittee has heard from many different tribes that the Purchased/Referred Care (PRC) program has several challenges:</u>

a. Can you describe some of the issues you have heard about within the Great Plains region and what challenges are your tribal members facing when dealing with the PRC program?

<u>PRC Eligibility Rules: Residency</u>

- The PRC program eligibility rules and procedure are confusing to most patients. To be eligible for PRC, a patient needs to reside within the CHSDA (Contract Health Service Delivery Area) for that Service Unit. Acronyms such as CHSDA do not help matters, but the basic problem is that any eligible Indian can receive services at an IHS-funded facility, but only those who reside in a certain territory can be referred out for specialty care. Eligibility for Purchased and Referred Care is dependent on residency.
- The residency rule is inconsistent in that the CHSDA in some IHS Areas only covers certain counties, whereas in other IHS Areas, the CHSDA is the entire

state. Oklahoma and Nevada are examples of state PRC coverage, whereas in South Dakota, only residents of Pennington County are eligible for PRC at the Oyate Health Center in Rapid City, while residents of neighboring counties can receive care at the Oyate Health Center, but cannot be referred out to a cardiologist, for example.

- Further, certain PRC programs only cover the enrolled members of that Tribe, and not other Tribes. For example, the Cheyenne River IHS Service Unit CHSDA includes the two reservation counties plus the adjacent Meade County. All members of federally recognized Tribes who reside on the two reservation counties are eligible for both services at the Cheyenne River IHS Hospital and the hospital's PRC program. But while all members of federally recognized Tribes who reside in adjacent Meade County may receive services at the Cheyenne River IHS Hospital, only Cheyenne River Sioux Tribal members in Meade County are eligible for the PRC program. An Oglala Sioux Tribal member residing in Meade County and receiving care at the Cheyenne River IHS Hospital would have to pay for their own specialty care or give up that care, unless they could prove a "close social and economic tie" to the Tribe. IHS and tribal PRC programs have wide discretion to interpret this phrase, and there is variation.
- Then again, some PRC programs choose to set a period of time the Tribal member has to reside within the CHSDA to establish eligibility for the PRC program, and those time periods, usually 30, 60, or 90 days, were inconsistent from facility to facility.

The rules for residency that establish eligibility for the PRC program are so complex that often staff at the Indian healthcare facility get it wrong. Along with the need for patient education on PRC, this puts an additional burden on ongoing staff training protocols, keeping employees up to date on an unnecessarily complex and contradictory set of rules.

Rather than attempting to educate every Tribal member and employee on this complex and limiting eligibility system, it would be much simpler, more consistent, and fair to simply expand PRC eligibility to any eligible Indian patient receiving services through that facility and to provide sufficient funding for such expanded care.

PRC Eligibility Rules: Notification

- 72 hour/30 day notification rule[6]

If a Tribal member receives emergency health services outside of an IHS or Tribal facility, they must notify their home facility within 72 hours, or for elderly or disabled patients, within 30 days. There are several problems with implementation of this rule.

First, facilities may not follow the 72-hour rule if that particular facility did not receive notice through the PRC program. While some IHS facilities consider notification to anyone in the IHS facility as notification of an Emergency Room (ER) visit, other facilities require that the patient notify "PRC and PRC only." This is inconsistent and places an improper requirement on the language of 25 U.S.C. § 1646 and 42 CFR § 136.24.

There are also inconsistent implementation issues within single IHS facilities. For example, if a patient notifies the IHS facility of an unscheduled non-IHS ER visit, some nursing staff will log a 'telephone encounter,' while others will not. If this becomes the key issue on whether IHS allows or refuse to authorize PRC Program funds for that patient, the PRC system becomes unacceptably capricious.

<u>PRC Procedure</u>

- The effectiveness of the PRC Program can be hampered by a lack of specialty providers locally. For example, there is only one private health care facility in Rapid City offering Gastroenterology (GI) services. Limited availability for services like GI and Neurology leads to long wait times—measured in months—for scheduling appointments. Better availability of telehealth in specialty areas could help with this issue.
- Lack of notification to the patient and/or Tribal facility when PRC bills are paid. IHS has contracted with Blue Cross Blue Shield (BCBS) of New Mexico to pay PRC bills, but they often do not notify patients when their PRC bills are paid. Tribal PRC programs also experience difficulties with communications with this IHS vendor.
- Communication and appeals of PRC denials. The denial letter generated in the IHS Resource and Patient Management System (RPMS)/Contract Health Services Management System (CHS-MS) software package is not patient friendly. Patients cannot review and understand the denial letter, which creates a challenge for them to understand their rights to appeal the denial in a timely manner.

[6] 25 U.S.C. § 1646 Authorization for emergency contract health services, *Indian Health Care Improvement Act of 1996* (Pub. L. 94–437, title IV, § 406, as added Pub. L. 102–573, title IV, § 405, Oct. 29, 1992, 106 Stat. 4566) and 42 CFR § 136.24, Authorization for contract health services.

- PRC health service request deferrals. As you know, budgetary limitations on PRC dollars have led to IHS implementing a ranking system where PRC service requests are categorized into levels of descending priority 1-5, a system which many Tribal health facilities inherited and still implement. While PRC committees try to approve as many levels as possible, and while most Level 1 requests will be approved, PRC requests at levels 2-5 of urgency are often deferred, sometimes temporarily, and sometimes indefinitely. It is easy to forget that every request for PRC services is made by a provider, reviewed by a care team or doctor, and is medically necessary. If the PRC budget had adequate funding to cover all PRC service requests, the level system of deferrals and denials would not be necessary. Many if not all of the problems with the PRC program could be resolved by adequate program funding.

b. And what suggestions or recommendations would you provide to the committee to make that process better?

- Staff and patient training on the PRC program should be done at each level of the IHS/Tribal/Urban facility. This includes the patient registration area, clinic rooms, urgent care, primary care, emergency room staff as well as all support staff. PRC eligibility and rules should be discussed and reviewed at staff meetings. Medical providers and nursing staff should have a thorough enough understanding of the PRC program to answer patient questions and guide them through the process with a solid understanding of the eligibility requirements.
- Staff and patients should be trained on residency eligibility specific to the CHSDA for that facility and any facility-specific rules regarding which patients are eligible for PRC and which are not.
- There should be national guidance regarding what constitutes adequate notification to the facility under the PRC 72-hour/30-day notification rule. This would reduce inconsistency both nationally and within individual IHS facilities.
- To address the availability of specialty providers for PRC services, Indian health facilities could contract with providers to conduct clinics onsite at the facility, reducing the need for PRC funding to be used for specialty care. This onsite direct care could include telehealth services.
- IHS PRC programs should be required to send written notice to patients when their PRC bill has been paid. Oyate Health Center (OHC) does this, but to the best of our knowledge, the federal sites do not.
- PRC programs should be required meet with each PRC service vendor in their service area and report on these meetings to their Tribe or Tribes. Vendors

need to understand the PRC process, know the contact for that vendor in the PRC program staff, and know that they will receive payment in a timely manner.

- The IHS RPMS/CHS-MS automatically generated denial letter needs to be scrapped and rewritten in a way that each patient understands what the facility needs from them to approve their PRC referral, for example proof of residency, whether their referral was deferred or denied and for what reason, and their appeal rights. The status of their request, who to contact with any questions, and how to contact them should be crystal clear.

5. **Your testimony and the hearing discussed how the Department of Health and Human Services (HHS) is not sharing public health data with Tribal Epidemiology Centers.**

   a. **Is there any further information you believe the subcommittee should have regarding this issue?**

   HHS is in violation of federal law regarding data sharing with Tribal Epidemiology Centers (TECs). We are not expecting that IHS will respond to the Government Accountability Office (GAO) report with expanded access to IHS data. Congress needs to hold HHS and HHS agencies accountable for the lack of data provided to TECs. In some sense, this is an easy fix. No law needs to be changed and no new law needs to be passed. HHS simply needs to follow existing federal law which clearly states that TECs are to be given access to any and all data that is held by the HHS Secretary. We refer the subcommittee to the work of the National Committee on Vital and Health Statistics which recently made five additional recommendations to the Secretary of Health and Human Services regarding sharing of data, primarily from the CDC and IHS, with Tribes and TECs.[7] These recommendations are in addition to the recommendations made in the March 2022 GAO Report regarding data sharing with TECs,[8] and the similarly-themed July 2022 Report by the HHS Office of the Inspector General.[9]

   b. **Are you aware of any changes that have happened or are in the works at IHS or HHS on their data sharing policies?**

   HHS, IHS, and Centers for Disease Control and Prevention (CDC) are developing their responses to the March 2022 GAO report regarding data sharing with TECs.

[7] https://ncvhs.hhs.gov/wp-content/uploads/2022/12/NCVHS-Tribal-Data-Recommendations-12-12-final-w-review-508.pdf
[8] https://www.gao.gov/products/gao-22-104698
[9] https://oig.hhs.gov/oei/reports/OEI-05-20-00540.asp

CDC created a "Tribal Data" page, and their response has been marked as "Closed – Implemented" by the GAO. HHS and CDC have not yet fulfilled the recommendations of the GAO and they remain open. These responses are currently being developed and will be released at some point. Outside of the responses to the GAO report, we are unaware of any other changes that have been made or are in progress related to data sharing policies at HHS.

6. **Can you provide the committee with information about facility construction in the Great Plains area, specifically how the lack of new IHS facilities has impacted delivery of healthcare for tribes in your area?**

   a. **Given the significant amount of federal funds that have been allocated to IHS's priority list in the past two years, what recommendations do you have to Congress and IHS to approach facility construction needs in the future to ensure federal funds are pushed out expeditiously?**

   While we are appreciative of increased funding for facility construction, and the very real opportunities to improve both care and outcomes as a new facility opens, the following issues continue to stymy federal construction efforts for Indian healthcare facilities.

   Funding-related construction delays.

   Some Indian health facilities were built with funds allocated under the American Recovery and Reinvestment Act (ARRA). These buildings were "fully funded," meaning the total construction dollars were released in one distribution, allowing the facility to be completed on a regular commercial timeline. Normally, IHS construction projects are not fully funded, they are "phase funded." This means the project is divided into phases and funding is distributed one phase at a time. This often results in construction delays and complications, especially when the federal government's annual budget is delayed and funded by a series of continuing resolutions. Fully funding IHS construction projects instead of phase funding them would help push those funds out in an expeditious manner.

   Tribal control over the initial process and building design.

   Another change which would both expedite construction and result in more patient centered and culturally appropriate buildings would be to ensure IHS gives Tribes the opportunity, consistent self-determination regulations, to assume the authority for the pre-planning, planning and design of construction projects,

including through the use of their own architecture and engineering (A/E) firm. Construction projects which are fully funded and where the Tribe controls the design, such as the IHS Hospital in Eagle Butte which was completed in 2012, produce a better result than the traditional IHS construction process. IHS needs to ensure that it complies with its own regulations and provides tribes such opportunities with respect to all construction funding. A requirement that IHS document that it has provided an adequate opportunity for each Tribe impacted by the new construction funding to assuming the preplanning, planning, design and construction and that it has obtain an affirmative statement from the tribal governing body that it has declined the opportunity. This should involve an informational presentation at each stage of the project's development to the proper tribal officials of the pros and cons of assuming the project responsibilities.

Other considerations in the construction process.

Even if Congress completely funded the existing IHS facilities need tomorrow, IHS's construction and engineering programs do not have the capacity to construct that many facilities in a timely fashion. Enhancing capacity in those departments, or creating a scalable project management model in IHS's construction management program, would help IHS respond to increased Congressional funding for these badly needed projects.

In summary, the following points could help Congressional funds allocated for new IHS facility construction be put to use more quickly and effectively:

- Full funding each IHS construction project, instead of phase funding
- Including sufficient money for staffing and operations, in particular adequate Maintenance and Improvement (M&I) funding for each new facility, in the staffing package for that building.
- Formalizing Tribal authority in the design and initial document process, including use of the Tribe's A/E firm.