Seattle Indian Health Board
For the Love of Native People
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Testimony of Esther Lucero, MPP
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Chair 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, the third generation in my family to be living outside of our reservation, and I strongly identify as an urban Indian. I serve as the President & Chief Executive Officer of the Seattle Indian Health Board (SIHB), one of 41 Indian Health Service (IHS) designated urban Indian organizations (UIO) nationwide designed to serve the health needs of the 76% of American Indian and Alaska Native (AI/AN) people residing in urban areas. I am also a delegate to the Washington state American Indian Health Commission, a member of the King County Board of Health, the City of Seattle Indigenous Advisory Council, and the AstraZeneca Health Equity Advisory Council. I have had the privilege of serving SIHB for eight years, during which time I have increased the organization's operating budget by $36 million. It is transformative to have provided 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 an increase to $977.4 million to the Urban Indian Health line item, which continue our momentum to address the chronic underfunding of the Indian healthcare system.

Secure Mandatory Funding for IHS

I am thankful to the members of this subcommittee for your leadership to secure advance appropriations for IHS for FY 24-25. This historic passage has brought greater certainty, parity, and protections to the Indian healthcare system and protected us from the looming fear of government shutdowns. I implore you to work with the same urgency to secure mandatory funding for the IHS. Mandatory funding will lead to greater financial sustainability, long range planning, secured service delivery, and frankly, will advance the efforts toward fulfilling the fiduciary obligation and trust responsibility.

In the past year, SIHB has advanced the operation of 3 clinical expansion projects, restructured and adapted our workforce to meet growing needs, and expanded critical culturally attuned health care services. To address the growing opioid and fentanyl crisis, we will re-open Thunderbird Treatment Center (TTC), our 92-bed in-patient residential treatment program, in February 2025. At TTC, we will dedicate 15 beds to serve pregnant and parenting people, where each person will be able to bring 2 children with them (up to the age of 5). This effort will help us save our next generations from being removed from their homes and allow families to heal from addiction together.

SIHB has expanded to 29 different workforce development programs. While others in the community health center world were struggling to hire Medical Assistants, we started a Medical Assistant Registered program designed to train on the job (fully paid) and acquire clinical experiences necessary to pursue advanced careers in health care. The program was so successful it had a wait list, helping us address a critical gap in support services. Last year we had 6 participants in the program go on to medical school, nurse practitioner school, and nursing school. We cannot limit our vision to the current appropriations cycles and must actively seek mandatory funding for IHS.

UIOs Impacted by COVID-19 Supplemental Funding Recission

I am frustrated by IHS' inability to effectively obligate and distribute $419 million in supplemental funding for the Indian healthcare system to continue combatting and alleviating the impacts of COVID-19. I am particularly disappointed in the failure to invest these resources in the establishment, expansion, and sustainment of a public health workforce at a time when it is so critical to our community's well-being. Throughout much of the pandemic, AI/AN communities faced the highest mortality rates among all racial and ethnic groups;[1] and even as recently as summer 2023, we saw an uptick in deaths in AI/AN communities.[2] SIHB has been resourceful and our relatives (patients) of all ages and the community have low barrier access to COVID-19 vaccinations, booster vaccines, and testing at our clinics. Our Tribal Epidemiology Center (TEC), the Urban Indian Health Institute (UIHI), has sent out COVID-19 support packages to UIOs nationwide. This $419 million shows that the large-scale investments are achievable, but this funding was rescinded before it could reach our most impacted communities.

Advance Legislation and Appropriations to Expand Workforce Development

To address the longstanding and worsening workforce gaps in the Indian healthcare system, I urge the subcommittee to introduce a companion bill for S. 3022 – the IHS Workforce Parity Act of 2023, which would authorize IHS scholarship and loan recipients to meet their service obligations through half-time clinical practice. It would help AI/AN students enter the healthcare workforce, which remains financially inaccessible for many. I further ask that you work to amend the IHS Loan Repayment Program to increase administrative FTE allocation from .2 to .3 administrative time, to support leadership development and training opportunities.

Further, I request new investments in community-based and culturally attuned workforce training programs and the expansion of paid workforce development opportunities for AI/AN students across the healthcare and public health sectors. SIHB was the first UIO to establish a family medicine residency program and now operates 29 different workforce development programs to develop the next generation of Native and Native serving healthcare and public health professionals. For 30 years, SIHB has offered one-on-one time with providers, dedicated training space, mentorship opportunities and a fully integrated cultural experience. Each year, we invest at least

[1] Sabo, S., and Johnson, S., Males and the Hispanic, American Indian and Alaska Native Populations Experienced Disproportionate Increases in Death During the Pandemic. United States Census. (2023). Retrieved from: https://www.census.gov/library/stories/2023/06/covid-19-impacts-on-mortality-by-race-ethnicity-and-sex.html
[2] APM Research Lab. (2023). The Color of Coronavirus: COVID-19 Deaths by Race and Ethnicity in the U.S. Retrieved from: https://www.apmresearchlab.org/covid/deaths-by-race

$500,000 in our medical residency program, while our residency partner only invests 50% of our residency site director's salary. Our other limited funding sources cover our internship and fellowship programs. For the first time in 2022, we received new funding worth $161,000 from a private partner, which still does not cover total program costs. Additionally, we began our MSW practicum program 6 years ago and today all our mental health providers are Native. We have a lot of pride in that outcome.

Congress must authorize IHS to have cross-state credentialing, which would allow for the preemption of state requirements for health care professionals to deliver services in a state other than the health care professional's state of licensure, registration, certification, or other state requirement. This best practice modeled by Veterans Health Administration, was critical to ensuring veterans' health care needs were met throughout the COVID-19 pandemic.[3] This administrative solution would increase access to and portability of mental health and substance use disorder (SUD) professionals across the Indian healthcare system.

Invest in Behavioral Health Workforce, Infrastructure, and Care

Despite leveraging many funding streams, we face a $3 million funding shortfall that is threatening a timely opening of TTC. We look to our Congressional partners to ensure that all Indian behavioral health care providers have access to increased reimbursement rates, capital and operating investments, and a quality workforce. As we plan for our long-term services, we are among the providers nationwide calling for federal investments to cover the true costs of behavioral healthcare.

National Maternal Mortality Review Committee data has shown that mental health conditions, including deaths by suicide and overdose/poisoning related to SUD, was the leading underlying cause of pregnancy related death among AI/AN people in 36 states from 2017-2019.[4] We fear that the fentanyl crisis will only further deepen the inequitable maternal and infant health outcomes AI/AN parents face. Therefore, TTC will offer specialty services for pregnant and parenting adults, integrated Traditional Health Services, and medication-assisted treatment (MAT), while providing wrap around care through our clinic services. Within our clinic, we secured $2 million, from HRSA, for our Indigenous birthing sovereignty project that considers the impact of SUD. It is necessary to ensure innovative and culturally attuned behavioral health models are developed to create meaningful and lasting change for the health and well-being of our people.

Support Traditional Health Services Innovations

The IHS is working with Centers for Medicare and Medicaid Services (CMS) on a Medicaid traditional health care practices framework, and we request Congressional support for the inclusion of UIOs and reimbursement of traditional pharmaceuticals. CMS is following reimbursement guidelines under title XIX of the Social Security Act that allows for Federal medical assistance percentage (FMAP) of 100 percent to IHS and

[3] Veteran Affairs Department. (2020). Authority of VA Professionals to Practice Health Care. Federal Register. Retrieved from: https://www.federalregister.gov/documents/2020/11/12/2020-24817/authority-of-va-professionals-to-practice-health-care

[4] Trost, S., Beauregard, J., Chandra, G., Njie, F., Harvey, A., Berry, J., and Goodman, D. Centers for Disease Control and Prevention. (2022). Pregnancy Related Deaths Among American Indian and Alaska Native Persons: Data from Maternal Mortality Review Committees in 36 States from 2017-2019. Retrieved from: https://www.cdc.gov/reproductivehealth/maternal-mortality/erase-mm/data-mmrc-aian.html

tribal facilities, but it excludes UIOs. During the CMS consultation held on April 3, 2024, many tribes and UIOs were in favor of extending FMAP to UIOs that is proposed by H.R. 6533 Urban Indian Health Parity Act, and it must be championed to pass in the House of Representatives. We have also requested CMS set a mandate for the participation of Managed Care Organizations (MCO) to further use across all states.

Our Traditional Health Services have grown significantly in the past eight years and our Tribal Health Practitioners are now integrated into our core care teams in our main clinic, expansion sites, and provided through home and hospital visits. We offered 1,825 traditional health encounters to 662 relatives between December 2021 and March 2024. Initial evaluation reveals that traditional health services decreased anxiety symptoms, depressive symptoms, alcohol consumption, and suicidal ideation. We are among the first providers to integrate our traditional health services into electronic health records (EHR). We are establishing the framework for third-party reimbursement nationwide, partnering with the Community Health Plan of Washington, a local MCO, to pilot the system. They have agreed to pay for our services as a value-added benefit. Traditional Health Services represent the future of integrated health services that center culturally attuned services to complement western healthcare.

Permanently Reauthorize the Special Diabetes Program for Indians (SDPI)
I request this subcommittee support permanent reauthorization of the SDPI, the only culturally appropriate programming for diabetes proven to treat and prevent Type-2 diabetes and reduce Type-2 diabetes complications in AI/AN communities.[5] Each year, UIHI conducts the Urban Diabetes Care and Outcomes Audit and publishes the results online. The audits track diabetes care and outcomes for AI/AN people served by UIOs. In 2023, we found that urban AI/AN patients have positive indicators in patient kidney health, hypertension management, and increased access to eye, foot, and dental examinations.[6] Nationally, the prevalence of diabetes among AI/AN adults has grown at a slower pace than other racial or ethnic groups from 2006 to 2012; in addition, obesity and diabetes rates have not increased among AI/AN youth for over a decade.[7,8] After 23 years of SDPI, we have remarkable reductions in diabetes-related mortality, kidney failure, hospitalization, and diabetic eye disease rates. Now is the time to permanently reauthorize SDPI and protect our advancements in diabetes treatment and prevention.

Thank you for allowing me to offer some insights into the day-to-day of service and I look forward to continued partnership to strengthen healing within our communities. I hope you join us in our unwavering passion to serve, “for the love of Indian people”.

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President & CEO

[5] Indian Health Service. (2020). Special Diabetes Program for Indians 2020 Report to Congress: Changing the Course of Diabetes: Charting Remarkable Progress. Retrieved from: https://www.ncbi.nlm.nih.gov/books/NBK571291/
[6] Urban Indian Health Institute. (2023). Special Diabetes Program for Indian: Impact for Urban Indian Organizations. Retrieved from: https://www.uihi.org/projects/urban-diabetes-care-and-outcomes-audit/
[7] Indian Health Service. (2014). Changing the Course of Diabetes: Turning Hope into Reality. Retrieved from: https://www.ihs.gov//sites/newsroom/themes/responsive2017/display_objects/documents/RepCong_2016/SDPI_2014_Report_to_Congress.pdf
[8] Bullock A, Burrows NR, Narva AS, Sheff K, Hora I, Lekiachvili A, & Espey D. Vital signs: Decrease in incidence of diabetes-related end- stage renal disease among American Indians/Alaska Natives - United States, 1996-2013. MMWR. 2017; Morbidity and mortality weekly report, 66(1), 26–32. doi:10.15585/mmwr.mm6601e1