July 20, 2021
House Subcommittee for Indigenous Peoples of the United States
Legislative Hearing on H.R.3496
Testimony of Sonya Tetnowski (*Makah Tribe*), President-Elect,
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Chairman Leger Fernández, Ranking Member Young, and Members of the House Subcommittee for Indigenous Peoples of the United States, thank you for the opportunity to testify today on the vital topic of urban Indian health facilities. My name is Sonya Tetnowski, I am a member of the Makah Tribe, and currently the President - Elect of the National Council of Urban Indian Health (NCUIH), which represents the 41 Urban Indian Organizations (UIOs) with 77 facilities in 22 states. UIOs provide high-quality, culturally competent care to the more than 70% of American Indians and Alaska Natives (AI/ANs) that reside in urban areas, also referred to as Urban Indians. I also serve as the Chief Executive Officer of the Indian Health Center of Santa Clara Valley (IHC) in San Jose, CA. IHC provides culturally sensitive health and wellness services including comprehensive medical care, dental, behavioral health, fitness, nutrition, and family programs to our nearly 27 thousand AI/AN patients annually, representing over 180 different tribes.

I testify today in support of the *Urban Indian Health Providers Facilities Improvement Act*, H.R. 3496, which will expand the use of existing IHS resources under Section 509 of the Indian Health Care Improvement Act (IHCIA) (25 U.S.C. § 1659). This legislation would enable IHS urban Indian health dollars to be spent where they are needed, including for necessary facilities maintenance and renovation, ultimately improving patient care without any added cost. As it stands, UIOs can only use our IHS funding for facilities expenses if the renovation or maintenance is undertaken to meet a specific accreditation standard, which is inapplicable to the vast majority of UIOs. In effect, we are left without the ability to use our funding efficiently and most effectively to best serve our patients. I will speak to you today about the importance of the technical fix to this restriction and how it would improve health care outcomes for the IHC community, as well as the larger UIO system and, ultimately, the more than 70% of AI/AN people that reside in urban areas.

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For the reasons stated herein, we urge the Members of this Subcommittee to include this priority in your requests to leadership for the infrastructure package. In addition, we respectfully request a markup on this bill as soon as possible to allow for floor consideration. Finally, to demonstrate a strong showing of commitment to improving urban Indian health, we ask all Members to cosponsor H.R. 3496.

Background

UIOs are a critical part of the Indian Health Service (IHS) system, which includes IHS facilities, Tribal Programs, and UIOs. This is commonly referred to as the I/T/U system. Unfortunately, UIOs experience significant parity issues as compared to the other components of the I/T/U system as well as other federally funded health care systems, which greatly impact their services and operations. This includes the inability to use IHS funding for facilities improvements or maintenance, even if that is where the dollars are most needed.

IHC is the UIO serving the San Jose and Santa Clara Valley area, serving more than 26,569 AI/AN patients annually. Since IHC's creation in 1970, the demand for quality health care has steadily increased, and the clinic has grown in response. Because of the restriction preventing UIOs from using IHS funds for facilities, we have multiple times throughout our history been forced to make difficult decisions to keep up with demand – having to use limited funding pools and divert revenue from AI/AN patient care in order to have adequate space to provide critical services.

The inability to use IHS funds for essential facilities renovation and maintenance expenses impacts patient care, with patients paying the ultimate price. For example, as UIO medical and behavioral health facilities age alongside the increased demand for services due to the COVID-19 pandemic, associated building equipment and components are deteriorating to a point of failure. This, combined with the decreasing availability of replacement parts on aged equipment, significantly disrupts health care service delivery – making it exceedingly difficult to meet the increased needs for medical and behavioral health services.

This impacts all UIOs and their patients and there is broad support for resolving this unnecessary burden. For example, NCUIH and 29 other tribal organizations recently included this fix in a joint letter urging Congressional leaders to address Indian Country's infrastructure priorities. The National Congress of American Indians also

passed a resolution in support of the UIO facilities fix this past June. This broad support makes one thing clear – the need is real and now is the time to act. Inadequate facilities and safety issues are never something I, nor any other UIO, want impacting the care we give our patients. We are in a race against time and we need this legislative fix now.

Remove Facilities Restrictions on UIOs

I applaud Representatives Ruben Gallego and Don Bacon for introducing the *Urban Indian Health Providers Facilities Improvement Act* (H.R. 3496) to allow us to make critical facility updates and pave the way for increased investment in renovation and construction of our facilities. Specifically, this bipartisan bill corrects an oversight in Section 509 of IHCIA (25 U.S.C. § 1659) that effectively prohibits us from using our IHS funding on infrastructure and facilities improvement projects unless the project is undertaken to meet accreditation standards from The Joint Commission (TJC), which is no longer the most used accreditation body among the vast majority of UIOs. In fact, 40 of 41 UIOs do not utilize TJC accreditation, with many utilizing other, more applicable accreditation bodies.

For instance, IHC has received full primary care practice accreditation by the Accreditation Association for Ambulatory Health Care (AAAHC) for more than 20 years. AAAHC is a nationally accepted accreditation body, which is even recognized by IHS with an IHS circular dating back to 1997 encouraging UIOs "to obtain and maintain accreditation" through a "choice among nationally accepted accrediting/certifying bodies[,]" including AAAHC.[1] IHS even holds AAAHC trainings for UIO staff. However, despite IHS's express encouragement of UIOs choosing to maintain accreditation through AAAHC, this accreditation nonetheless effectively bars IHC from utilizing IHS funds for any facilities improvements because Section 509 only expressly mentions TJC, which IHS has interpreted to exclude UIOs that are not utilizing TJC for their accreditation.

Ultimately, this restriction impacts the provision of services to our Native patients. For instance, during the COVID-19 pandemic, UIOs were unable to use IHS funds to make critical facility renovations to safely serve patients despite the immediate need for updates like transitioning to telehealth, air circulation updates like negative pressurizing rooms and air purification systems, and redesigning or adding space to allow for social

[1] Indian Health Service Circular No. 97-01, Accreditation/Certification of Hospitals and Health Centers (effective March 6, 1997).

distancing. One UIO was even denied a request to use its IHS funding to purchase a new HVAC system. In other words, a health facility could not use its funding from a health agency to make air purification changes amidst a global pandemic of an airborne virus that could kill its patients and staff. Solely because of the restriction this bill seeks to fix.

Moreover, this issue predates the pandemic, which only highlighted the existing problem of an absence of an avenue for UIOs to use existing resources for infrastructure improvements. In fact, in a NCUIH survey, 86 percent of UIOs surveyed reported a need to make facilities and infrastructure upgrades, while 74 percent reported unmet needs for new construction to better serve patients. These needs include, but are not limited, to the construction of urgent care facilities and infectious disease areas, capacity expansion projects, ventilation system improvements, and upgrades to telehealth and electronic health records systems. All of these upgrades are vital to patient care.

The *Urban Indian Health Providers Facilities Improvement Act* would remove this prohibition, immediately allowing UIOs to use their IHS funding more effectively and efficiently. This bipartisan bill has widespread support, including within Indian Country as mentioned earlier, and also among policymakers. The House Appropriations Subcommittee on Interior, Environment, and Related Agencies included the UIO facilities fix in its FY22 bill; as did the President's FY22 IHS budget, noting it has a zero score. All this support makes one thing clear – we must act now to pass this urgent and no-cost legislative fix.

Conclusion

H.R. 3496 is an essential parity issue for UIOs that ensures that AI/ANs residing in urban areas continue to have access to high quality, culturally competent health services. For too long, urban Indian health care has been burdened and limited by an unnecessary restriction on UIO funds that prohibits us from making critical upgrades. The U.S. has the trust obligation to provide health care for AI/AN people residing in urban areas and we request your support in removing this barrier to get closer to meeting that responsibility.

We therefore urge the Subcommittee to pass this legislative fix and continue to prioritize urban Indian health, thereby enabling UIOs to continue providing high quality, culturally competent care to AI/AN people, regardless of where they live.

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