S. HRG. 110–393

THE STATE OF FACILITIES IN INDIAN COUNTRY: JAILS, SCHOOLS, AND HEALTH FACILITIES

HEARING

BEFORE THE

COMMITTEE ON INDIAN AFFAIRS
UNITED STATES SENATE

ONE HUNDRED TENTH CONGRESS

SECOND SESSION

MARCH 6, 2008

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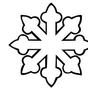

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THE STATE OF FACILITIES IN INDIAN COUNTRY: JAILS, SCHOOLS, AND HEALTH FACILITIES

THURSDAY, MARCH 6, 2008

U.S. SENATE,
COMMITTEE ON INDIAN AFFAIRS,
Washington, D.C.

The Committee met, pursuant to notice, at 10:00 a.m. in room 628, Dirksen Senate Office Building, Hon. Byron L. Dorgan, Chairman of the Committee, presiding.

OPENING STATEMENT OF HON. BYRON L. DORGAN, U.S. SENATOR FROM NORTH DAKOTA

The CHAIRMAN. We are going to begin the hearing. This is an oversight hearing on the state of facilities in Indian Country: jails, schools and health facilities by the Senate Committee on Indian Affairs here in the United States Senate.

My colleagues will join me shortly, but because of time constraints, we need to begin. We will likely have a Senate vote at about 10:45 this morning. We will have to have a brief recess when that occurs.

Today, the Committee will examine the current state of health facilities, schools, detention facilities and more in Indian Country. We will receive testimony from the agencies responsible for administering the programs to build new and to repair existing facilities. We will also hear about the obstacles they face in trying to complete these facilities.

Early in the Federal Government's relationships with Indian tribes, the Government itself owned and operated facilities for health care, education and, to a lesser extent, for detention. Over the past 33 years, however, many tribes have contracted or compacted with the United States to take control of these facilities and their operations.

Nevertheless, the primary source of funds for the construction of and the operation of these facilities still remains the Federal Government.

Before touching on the three areas—schools, health care and detention facilities—that are the subject of this hearing, I want to highlight the erratic and insufficient funding and the nature of Federal spending in dealing with these issues. Taking health care as an example with chart 1—I am going to show a number of charts this morning—over the last 25 years, annual Federal spend-

ing has ranged from under $15 million to almost $140 million for health care facilities.

Chart 1

The Administration's budget request for the 2009 fiscal year is extremely low, at the low end of this at the $15.8 million range, yet the amount necessary to fund the facilities on the current priority list of the Indian Health Service for Fiscal Year 2009 through the out years is an estimated $2.6 billion. Let me repeat, the funding needed for the facilities on the current priority list is $2.6 billion, yet in 2009, the Administration is requesting little more than one half of 1 percent of that amount. At that rate, final funds for facilities on the current priority list would be available at the end of 165 years.

With respect to schools, the Bureau of Indian Affairs funds approximately 4,500 schools or school facilities in Indian Country. Most of these are found at 184 Indian schools and 27 tribal colleges. What I meant to say was 4,500 buildings or facilities that are attached to those schools.

These facilities provide more than 60,000 students with facilities for education. The greatest concentration of Bureau schools is in the Southwest, the Great Plains, and the Northwest. As of the year 2000, half of the school facilities in the BIA's inventory exceeded their useful lives of 30 years, and more than 20 percent were over 50 years old.

The Interior Department's Inspector General recently visited 13 BIA schools located just in the State of Arizona. The Inspector General found severe deterioration that directly affects the safety and the health of Indian children. Deterioration ranged from leaking roofs to classroom walls buckling and separating from their foundation. The Inspector General warned, in issuing a flash report in

May of 2007, that the failure to mitigate these conditions will likely cause injury or death to children and/or to school employees.

Here are some examples of the conditions of schools in Indian Country taken from the Inspector General's report. Chart 2 is a montage of deterioration—a broken cinder block in a wall, a corroded sink, a buckled sidewall, an abandoned dormitory seen through a broken window. The Keams Canyon School in Keams Canyon, Arizona was constructed in 1928. On the grounds are condemned buildings that have not been properly boarded up, which is seen now in chart 3. Those are buildings that have not been boarded up that have been condemned.

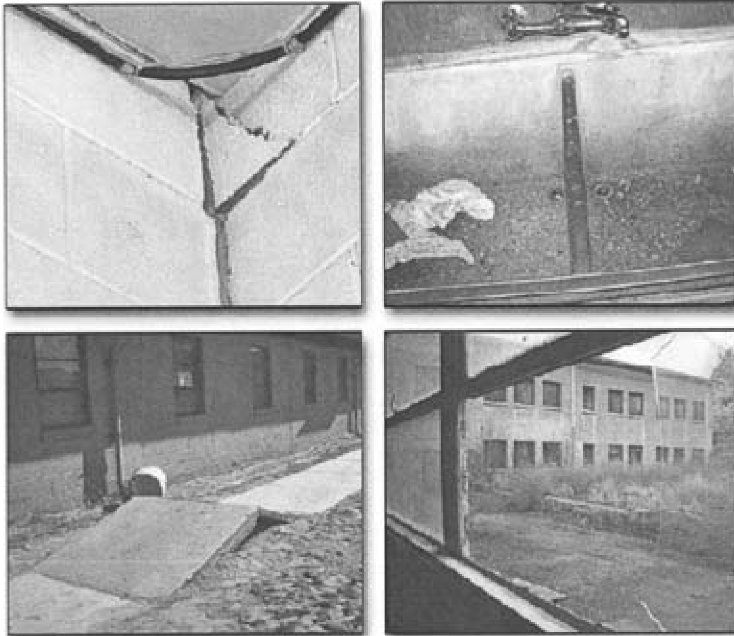


Chart 3

CONDEMNED DORMITORIES

Keams Canyon School, Arizona

In chart 4, you will see that leaking water has significantly damaged ceilings. In both chart 4 and chart 5, you will see in this case damaged ceilings from water. In chart 5, you will see that the main boiler has been leaking. The boiler was last inspected in 2002. It failed inspection and still displayed the "failed" tag, but it is still in operation.

Chart 4

WATER DAMAGED CELIING

Keams Canyon School, Arizona

Chart 5

LEAKING BOILER WITH FAILED TAG

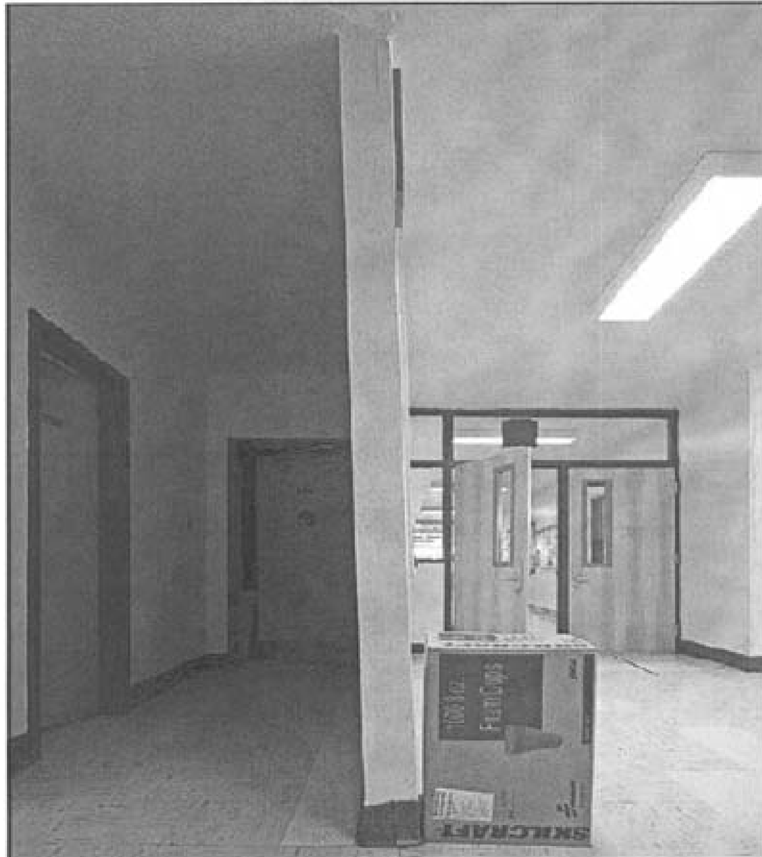
Keams Canyon School

The boarding school in Many Farms, Arizona, has a crumbling foundation. You will see that in chart 6. And the crumbling foundation has actually resulted in a moving wall, which is chart 7. If you look at the bottom, you will see that the entire wall has moved in this particular building. Note the widening gap between the vertical side of the box and the slanting wall.

Chart 6

CRUMBLING FOUNDATION
Chinle Boarding School, Arizona

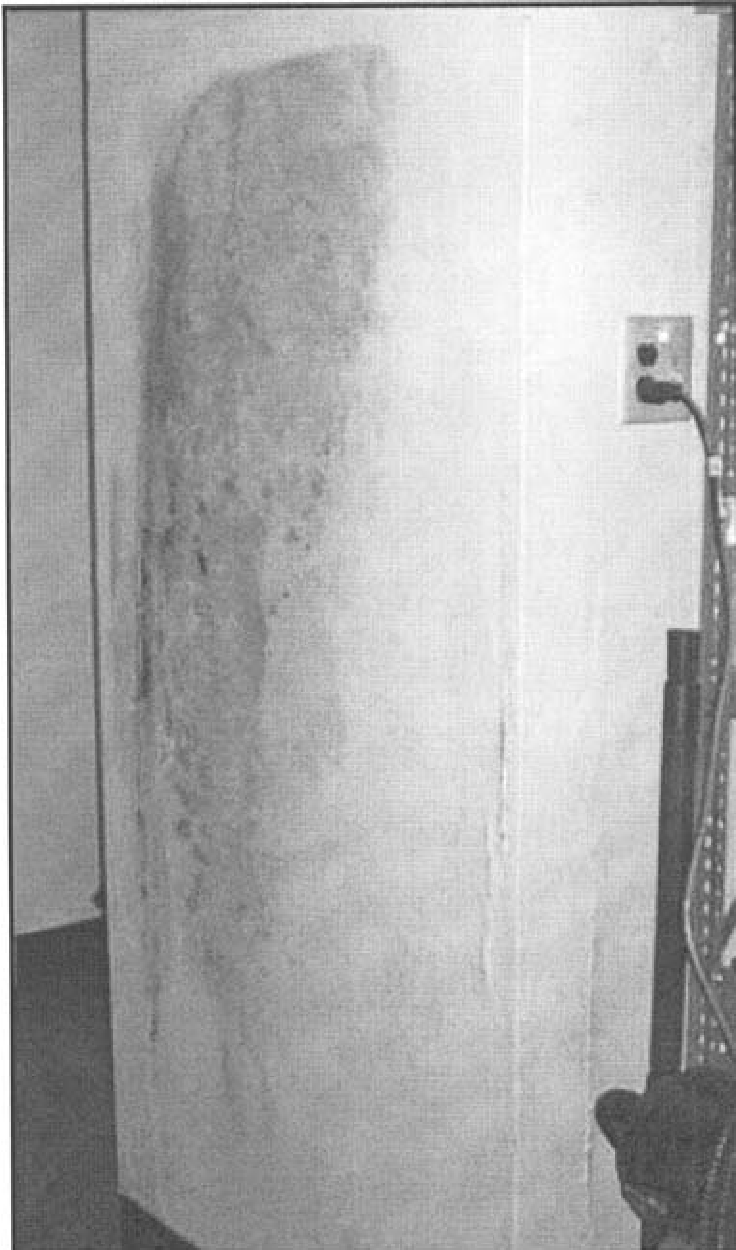
Chart 7



CRUMBLING FOUNDATION = MOVING WALL
Chinle Boarding School, Arizona

At the Kayenta Boarding School, mold covered an office wall. That is chart 8. These are from the Inspector General's report. That same school with mold on the wall had water leaks near electrical outlets and buckled sidewalls.

Chart 8



MOLDLY WALLS
Kayenta Boarding School, Arizona

Well, I don't need to go through more of those charts that show these problems, but we have very serious facility problems in health care, in education, in juvenile detention and jails. The detention facilities are a longstanding problem. Let me talk about them just for a moment. Back in 1998, the Attorney General testified before this Committee that the 73 small jails that exist in Indian Country are severely inadequate and antiquated. Most Indian Country jails are in such poor condition they are completely out of compliance with building codes and professional jail standards.

The Interior Inspector General reported this to the Committee in June of 2004. He said the condition of Indian jails was in desperate shape. He deemed the state of Indian jails a "national disgrace." That problem remains unsolved, and we will hear from tribal officials today about that. One tribe that will testify today says they have a new detention facility and it is only staffed now at minimum capacity, which is another problem and an issue.

I am going to, when we discuss this later, ask Mr. Ragsdale who is with us, and Mr. Rever, questions about a consulting study that has been done that has not been made available to this Committee. There was a consulting study that follow on the Inspector General's report given to this Committee in 2004. The report was, "Neither safe nor secure in assessment of Indian detention facilities." In February, 2006, two years ago, the BIA contracted with Shubnam Strategic Management Applications to visit 38 Indian jails and assess the conditions, and provide a cost analysis.

In March of last year, Mr. Rivera testified before the Prison Rape Elimination Commission about the state of Indian Country jails. He indicated that the Shubnam report is in preliminary stages. Once it has gone through Director Ragsdale, it will be open for public information. I think it will be a month or two months, that was March of 2007.

The Committee staff met with Mr. Ragsdale to discuss this issue. He stated the report should be ready by December. That report is not ready. It has not been made available to this Committee. My understanding is it is 1,000 pages. Interior now says it was just made available to them, which contradicts what we heard last year.

So I talked to the Interior Secretary personally to ask that it be made available to this Committee. It seems to me when you are holding a hearing on the very subject, the taxpayers have paid for the consulting report, and the report was described to us last March as awaiting Mr. Ragsdale's review, and would be done in a matter of months. Mr. Ragsdale said it would be done in December.

I don't understand why this Committee does not have that information today. I think it is arrogant and it is wrong. This Committee should have been provided that information. I will give Mr. Ragsdale and others a chance to respond to that and answer some questions about it.

My colleagues have joined me. Mr. Barrasso, do you have an opening statement? I indicated we are going to have a vote I think at 10:45 a.m., so we will proceed with opening statements, and then have the witnesses begin, and we will have to take a short recess.

STATEMENT OF HON. JOHN BARRASSO, U.S. SENATOR FROM WYOMING

Senator BARRASSO. Thank you very much, Mr. Chairman. Yes, I would, and I want to follow up on some of the examples that you have given because that is exactly what I have seen in Wyoming as well, Mr. Chairman.

On the Wind River Reservation in Wyoming, different buildings sit condemned, vacant due to gas leaks, due to fires, general maintenance issues. Meanwhile, our law enforcement department already is stretched to the maximum: short staff, large areas to cover. It operates out of a building that is shared with four other offices.

The Fort Washakie Health Center operates today for 11,000 users out of a building that was built in 1877 for the cavalry. So what is happening there is absolutely unacceptable and I am thankful, Mr. Chairman, that you have scheduled this hearing and I look forward to working with you and making sure we can revamp those broken programs.

With that, Mr. Chairman, I will reserve for questions.

The CHAIRMAN. Senator Barrasso, thank you very much.

Let me call on Senator Johnson.

STATEMENT OF HON. TIM JOHNSON, U.S. SENATOR FROM SOUTH DAKOTA

Senator JOHNSON. Thank you, Mr. Chairman.

In light of the 10:45 vote, I will submit my statement for the record.

[The prepared statement of Senator Johnson follows:]

PREPARED STATEMENT OF HON. TIM JOHNSON, U.S. SENATOR FROM SOUTH DAKOTA

Thank you Chairman Dorgan and Vice-Chairwoman Murkowski for holding this hearing. The provision of adequate educational, health and law enforcement facilities are essential to upholding our treaty and trust responsibilities to American Indians. It is also a moral obligation. There are nine BIA schools in my state that have been found to be in need of "Major Repairs or Replacement." The conditions at these schools are shocking; they include inadequate fire protection, outdated electrical systems, improperly maintained furnaces and condemned buildings.

The affects of these conditions on tribal children are even more shocking. This past December school had to be canceled at Cheyenne River-Eagle Butte because temperatures in the building had dropped to 48 degrees due to problems with the heating system and the increased costs of heating fuel. At the Crow Creek School, children are living and taking classes in trailers because the lack of resources has prevented construction of a new dormitory to replace the one lost in a fire. Simply put, the health and education of tribal children are at risk because their schools are literally crumbling down around them.

To try to address these challenges I, along with Representative Pomeroy, have introduced the Indian School Construction Act. This bill has passed the Senate before and would create a tax credit bonding program for tribal schools, similar to the Qualified Zone Academy Bonds, to allow an additional funding mechanism for the construction of BIA schools. The tribes in my state are not asking for much, only a safe and productive place for their children to learn, which we are obligated to provide by treaty, trust and moral obligations. While the Indian School Construction Act is not under the jurisdiction of Indian Affairs, I hope the members of this Committee will support the bill and help take this important step to improve education facilities in Indian Country. Thank you.

The CHAIRMAN. Senator Johnson, thank you very much.

We are joined today by a number of witnesses. I want to begin to call on them in the following order. First, Mr. Pat Ragsdale, Director of the Office of Law Enforcement Services, accompanied by Mr. Jack Rever, Director of Facilities at the Department of Interior.

Then, I will call on Mr. Randy Grinnell, Indian Health Service Deputy Director of Management Operations, accompanied by Gary Hartz, the Director of the Office of Environmental Health and Engineering, and Dr. Rick Olson, Director of Clinical and Prevention Services. And finally, we will call on Mr. Domingo Herraiz, Director of the Bureau of Justice Assistance, United States Department of Justice. Mr. Herraiz will discuss the Indian jail construction program.

Mr. Ragsdale, you may proceed.

STATEMENT OF W. PATRICK RAGSDALE, DIRECTOR, OFFICE OF LAW ENFORCEMENT SERVICES, BUREAU OF INDIAN AFFAIRS, U.S. DEPARTMENT OF THE INTERIOR; ACCOMPANIED BY JACK REVER, DIRECTOR OF FACILITIES

Mr. RAGSDALE. Good morning, Mr. Chairman. If I may, I will defer to Mr. Rever to provide the Administration's statement.

The CHAIRMAN. Mr. Rever?

Mr. REVER. Good morning, Mr. Chairman and members of the Committee. My name is Jack Rever and I am the Director of Facilities, Environmental, Cultural Resources, Safety and a couple of other things within the Bureau of Indian Affairs.

The Bureau owns or provides funding for a broad range of buildings and other facilities across this Nation. The Bureau's construction and maintenance program is multifaceted and the operation is challenged with meeting facility needs in the areas of education, public safety and justice, dams and irrigation projects, and general administration.

I am here today to discuss the status of the education and justice facilities in Indian Country.

Bureau-owned to funded education facilities serve 184 schools and dormitories that provide educational opportunities for approximately 44,000 students, including almost 1,600 resident-only boarders. From 2002 through 2008, the Administration invested more than $1.7 billion in the maintenance, repair and construction of education facilities across Indian Country.

The Bureau operates or funds detention and law enforcement facilities throughout Indian Country to support Bureau and tribal law enforcement programs. There are currently 84 detention facilities across Indian Country. Of these, 38 are owned and operated by the Federal Government, five are owned by the tribes and operated by the Federal Government, and 41 are owned and operated by tribes.

Through its appropriations, the Department of Justice from Fiscal Year 1997 to Fiscal Year 2002 provided funds to tribes on a cost-sharing basis for major projects. This funding has enabled various tribes to build 21 new detention centers. The construction center is responsible for correcting identified code and standard deficiencies at BIA facilities.

In order to accomplish this, the BIA has established a facility condition index—we call it an FCI—to track and report the status of facilities. The FCI is a Government-wide performance measure to describe the condition of a facility or group of facilities and it is calculated by dividing the cost of correcting the deferred maintenance work by the cost of replacing the facility at its current size and capacity.

The FCI is used to develop and revise the BIA five year deferred maintenance and construction plan and monitor performance in maintaining assets. The plan provides the Bureau with a clear strategy for addressing facilities with the greatest needs. Each fiscal year plan reflects the projects in priority ranking order based on critical health and safety requirements.

Over the past seven years, there has been significant progress in improving the condition of Bureau Indian education schools. In 2001, 120 of the 184 schools and dormitories were ranked as being in poor condition as measured by the FCI. When all of the construction work authorized by Congress through the Fiscal Year 2008 and proposed by the President for 2009 is completed, 50 schools will have been improved from fair to good condition, or a total of 114 schools of the 184 schools.

The BIA prioritizes education construction projects separately for replacement of the entire campus, replacement of separate facilities on that campus, and projects to improve and repair buildings. The priority in each category is given to the facility with the most critical fire and life safety issues. The replacement school priority list was established in the year 2004 and includes the replacement of 14 schools. The replacement facilities construction list is prioritized every year, with a two year projection. Improvement and repair projects are prioritized annually.

In September, 2003, as you have mentioned, sir, the Inspector General found that the BIA's process for forecasting future student enrollments was not adequate, resulting in new construction with excess space and unwarranted cost. As a result, BIA has adopted an enrollment projection methodology in 2004 to right-size school projects.

This methodology uses the past 10 year enrollment history to predict future enrollments. This new methodology provides realistic assessments of the future enrollment for BIA schools to prevent schools from being over- or under-built.

Indian Affairs has also taken steps to create consistent and efficient school designs for construction. In 2005, the BIA revised the space guidelines that define the needs of schools based on academic curriculum and projected student enrollment, and in 2006 Indian Affairs published the first architectural and engineering standards for design and construction to establish common design elements for classrooms, cafeterias, gymnasiums, heating and cooling systems, and other operating systems.

In addition, Indian Affairs adopted the U.S. Green Building Council's leadership in energy and environmental design, commonly called LEED, as goals for energy-efficient design in our schools. In fact, Indian Affairs schools were the first ones built in both Arizona and in New Mexico to achieve designation as LEED-

compliant schools, criteria now adopted by those States in their education construction programs.

Beginning in 2006, Indian Affairs adopted new procedures and methods of school construction programming. Indian Affairs started a plan to design projects in the two years prior to requesting of funds for construction, with the goal of beginning construction on major projects in the year of appropriation.

This strategy has multiple benefits. Projects have been completed. Planning and design are ready to begin construction when funds are available. And projects that start on time minimize the construction cost and the cost of inflation. The new procedures have already increased the annual obligation rate for our funds from 44 percent to 87 percent, thereby significantly reducing the carryover and therefore the cost of our program.

Many of the school construction projects funded since 2001 have been delayed for a variety of reasons. That created the need for additional funding due to inflation. In 2007, Indian Affairs created a shortfall recovery plan to permit the construction of all school projects at their authorized scope of work as specified in the revised space guidelines. The plan proposed delaying the start of a few schools in construction and reprogramming those funds to address the shortfalls.

We are pleased and grateful that the Fiscal Year 2008 appropriation bill authorized the execution of our shortfall recovery plan. We are even more pleased to report that the plan continues on schedule to eliminate the shortfall by the end of the current fiscal year. We anticipate that we will achieve our mutual objective to build schools at scopes of work necessary to meet educational objectives.

In the area of public safety and justice facility construction, recently the BIA concluded a two year master planning effort to accomplish three objectives regarding the needs of justice systems across Indian Country: one, assess the condition and current operating standards of the Indian Country justice system; two, prepare a comprehensive plan of justice facilities including size, estimated construction cost, and estimated cost to operate the facilities, including staffing and preferred location of justice system facilities; and three, establish standards for the operation, design and organizational structure of the justice system.

The effort took two years and we visited 38 justice system facilities including law enforcement, detention and tribal courts, both tribally and federally-owned, and we conducted telephone interviews with law enforcement and detention staffs from both Indian Affairs and tribal programs. Based on the demographic and facility information collected, BIA formulated a comprehensive solution to address justice facilities in Indian Country, and it is under review at the present time. Those results will be provided to the Committee at a later date.

We will work with the tribes and in consultation with the Department of Justice to ensure that any future construction or renovation of justice system facilities meets the needs of the tribes for an efficient and effective law enforcement court and incarceration program.

Mr. Chairman, thank you for the opportunity to appear before you today. I will be happy to answer any questions you may have.

[The prepared statement of Mr. Rever follows:]

PREPARED STATEMENT OF JACK REVER, DIRECTOR OF FACILITIES, BUREAU OF INDIAN AFFAIRS, U.S. DEPARTMENT OF THE INTERIOR

Good morning, Mr. Chairman, Ms. Murkowski, and Members of the Committee. My name is Jack Rever. I am the Director of Facilities, Environmental, Safety, and Cultural Resources Management in the Bureau of Indian Affairs in the Department of the Interior. The Bureau owns or provides funding for a broad variety of buildings and other facilities across the nation. The Bureau's construction and maintenance program is a multifaceted operation challenged with meeting facility needs in the areas of Education, Public Safety and Justice, Dams and Irrigation Projects, and General Administration. I am here today to discuss the status of education and justice facilities in Indian Country.

Bureau-owned or funded education facilities serve 184 schools and dormitories that provide educational opportunities for approximately 44,000 students, including almost 1,600 resident only boarders. From 2002 through 2008, the Administration invested more than $1.7 billion in the maintenance, repair and construction of education facilities across Indian Country.

The Bureau operates or funds detention and law enforcement facilities throughout Indian Country to support Bureau and Tribal law enforcement programs. There are currently 84 detention facilities across Indian Country. Of these, 38 are owned and operated by the Federal Government, 5 are owned by Tribes and operated by the Federal Government, and 41 are owned and operated by Tribes. Through its appropriations, the Department of Justice from FY 1997 to FY 2002 provided funds to Tribes on a cost sharing basis for major projects. This funding enabled various Tribes to build 21 detention facilities.

The construction program is responsible for correcting identified code and standard deficiencies at BIA facilities. In order to accomplish this, the BIA has established a Facilities Condition Index (FCI) to track and report the status of facilities. The FCI is a Government-wide performance measure to describe the condition of a facility or group of facilities. It is calculated by dividing the cost of correcting deferred maintenance work by the cost of replacing the facility at its current size and capacity.

The FCI is used to develop and revise the BIA Five-Year Deferred Maintenance and Construction Plan and monitor performance in maintaining assets. The plan provides the Bureau with a clear strategy for addressing facilities with the greatest need. Each fiscal year plan reflects the projects in priority ranking order based on critical health and safety requirements.

Education Construction

Over the past seven years, there has been significant progress in improving the condition of Bureau of Indian Education (BIE) schools. In 2001, 120 of the 184 schools and dormitories were rated as being in poor condition as measured by the FCI. When all of the construction work authorized by Congress through FY 2008 and proposed by the President for FY 2009 is complete, 50 schools will have improved to fair or good condition, for a total of 114 schools.

The BIA prioritizes education construction projects separately for replacement of an entire campus, replacement of separate facilities and projects to improve and repair buildings. Priority in each category is given to facilities with critical fire and life safety issues. The Replacement School Construction priority list was established in 2004 and included replacement of 14 schools. The Replacement Facilities Construction list is prioritized every year with a two year projection. Improvement and repair projects are prioritized annually.

In September 2003, the Inspector General found that BIA's process for forecasting future student enrollments was not adequate, resulting in new construction with excess space and unwarranted costs. As a result, BIA adopted an enrollment projection methodology in 2004 to right size school projects. This methodology uses the past ten year enrollment history to project future enrollments. The new methodology provides realistic assessment of the future enrollment for the BIE schools to prevent schools from being over- or under-built.

Indian Affairs has also taken steps to create consistency and efficiency in school design and construction. In 2005, the BIA revised the Space Guidelines that define the needs of the school based on academic curriculum and projected student enrollment and in 2006, Indian Affairs published the first architectural and engineering standards for design and construction that established common design elements for classrooms, cafeterias, gymnasiums, heating and cooling systems, and other operating systems. In addition, Indian Affairs adopted the U.S. Green Building Council's

Leadership in Energy and Environmental Design (LEED) goals for energy efficient design. In fact, Indian Affairs schools were the first ones built in Arizona and New Mexico to achieve designation as LEED compliant schools, criteria now adopted by those states in their education construction programs.

Beginning in 2006, Indian Affairs adopted new procedures and methods of school construction programming. Indian Affairs started to plan and design projects in the two years prior to requesting funds for construction with the goal of beginning construction on major projects in the year of appropriation. This strategy has multiple benefits. Projects that have completed planning and design are ready to begin when funds become available and projects that start on time minimize the impacts of inflation. The new procedures have already increased the annual obligation rate from 44 percent 87 percent thereby significantly reducing carryover.

Many of the school construction projects funded since 2001 have been delayed for a variety of reasons, which created a need for additional funding due to inflation. In 2007, Indian Affairs created a shortfall recovery plan to permit the construction of all school projects at their authorized scope of work as specified in the revised space guidelines. The plan proposed delaying the start of a few school construction projects and reprogramming project funding to address project shortfalls. We are pleased and grateful that the Fiscal Year 2008 appropriation bill authorized the execution of our shortfall recovery plan. We are even more pleased to report that the plan continues on schedule to eliminate the shortfall by the end of Fiscal Year 2008. We anticipate that we will achieve our mutual objective to build schools at scopes of work necessary to meet education objectives.

Public Safety and Justice Facility Construction

Recently, the BIA concluded a two year master planning effort to accomplish three objectives regarding the needs of justice systems in Indian Country:

1. Assess the condition and current operating standards of the Indian Country Justice System;
2. Prepare a comprehensive plan of justice facilities, including size, estimated construction cost, the estimated cost to operate the facilities including staffing and preferred location of justice system facilities; and
3. Establish standards of operation, design and organizational structure of the justice system.

The effort took two years as we visited 38 justice system facilities, including law enforcement, detention facilities and tribal courts, both tribally and federally owned and conducted telephone interviews with law enforcement and detention staffs of both Indian Affairs and tribal programs. Based on the demographic and facility information collected, BIA formulated a comprehensive solution to address justice system facility requirements in Indian Country. A draft Master Plan for justice facilities in Indian Country is under review, and the results will be provided to the Committee at a later date.

We will work with the Tribes, in consultation with the Department of Justice, to ensure that any future construction or renovation of justice system facilities meets the needs of the Tribes for an efficient and effective law enforcement, court, and incarceration program.

Mr. Chairman, thank you for the opportunity to appear before you today. I will be happy to answer any questions you may have.

The CHAIRMAN. Mr. Rever, thank you very much.

Next, we will hear from Mr. Randy Grinnell from the Indian Health Service, who is accompanied by Gary Hartz, the Director of the Office of Environmental Health and Engineering, and Dr. Rick Olson, Director of Clinical and Prevention Services.

Mr. Grinnell, you may proceed.

STATEMENT OF RANDY GRINNELL, DEPUTY DIRECTOR, MANAGEMENT OPERATIONS, INDIAN HEALTH SERVICE, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; ACCOMPANIED BY GARY HARTZ, DIRECTOR, OFFICE OF ENVIRONMENTAL HEALTH AND ENGINEERING, AND RICK OLSON, DIRECTOR, CLINICAL AND PREVENTION SERVICES

Mr. GRINNELL. Good morning. I am Randy Grinnell, Deputy Director for Management Operations in the Indian Health Service.

As you mentioned, today I am accompanied by Dr. Rick Olson, Acting Director of the Office of Clinical and Preventive Service; and Mr. Gary Hartz, Director, Office of Environmental Health and Engineering.

We are pleased to have the opportunity to testify on the state of health facilities in Indian Country. The mission of the Indian Health Service, in partnership with American Indian and Alaska Native people, is to raise their physical, mental, social and spiritual health to the highest level. In supporting that goal, IHS and tribes provide optimum availability to functional, well-maintained and accredited health care facilities and staff housing.

Collectively, the IHS and tribes currently provide access to health care services for American Indians and Alaska Natives through a total of 679 facilities, including 48 hospitals, 304 ambulatory health centers, 166 Alaska village clinics, 143 health stations, and 20 school health centers. During regular reviews of IHS and tribal hospitals by the Joint Commission on Accreditation of Health Care Organizations, the Accreditation Association for Ambulatory Health Care and the Centers for Medicare and Medicaid Services to ensure the provision of quality patient care, the area most frequently cited for improvement relates to physical structure and efficiency.

The average age of these facilities is 33 years old, as compared to 9 years old for health care facilities in the United States. The Indian Health Service has identified a backlog of deferred maintenance of approximately $370 million to maintain these facilities within their current footprint. Issues such as modernization or expansion due to population growth are addressed through the health care facilities construction priority system and the priority list it established.

The IHS currently estimates that completing the 22 facilities on the current priority list totals $2.6 billion. To expand access, tribes have successfully partnered with IHS under the joint venture program and small ambulatory program. These programs complement the health care facilities construction priority list by providing mechanisms for tribes to become involved in the acquisition of facilities.

From 1998 to present, seven tribes have entered into joint venture program agreements to construct facilities and lease them to the IHS at no cost. In exchange the IHS agreed to equip, staff and operate these facilities. Five of these facilities have been completed, and 27 tribes have received funding through the small ambulatory program to provide improved facilities space for health care programs.

Mr. Chairman, this concludes my statement and I would be happy to answer any questions that you may have.

Thank you.

[The prepared statement of Mr. Grinnell follows:]

PREPARED STATEMENT OF RANDY GRINNELL, DEPUTY DIRECTOR, MANAGEMENT OPERATIONS, INDIAN HEALTH SERVICE, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Good Morning. I am Randy Grinnell, Deputy Director for Management Operations in the Indian Health Service. Today I am accompanied by Dr. Richard Olson, Acting Director of the Office of Clinical and Preventive Services, and Mr. Gary Hartz, Director, Office of Environmental Health and Engineering. We are pleased to have the opportunity to testify on the state of health facilities in Indian Country.

The mission of the Indian Health Service, in partnership with American Indian and Alaska Native people, is to raise their physical, mental, social, and spiritual health to the highest level. In supporting that goal the IHS and Tribes provide optimum availability to functional, well maintained and accredited health care facilities and staff housing. Currently the IHS provides access to healthcare services for American Indians and Alaska Natives through 31 Hospitals, 50 health centers, 31 health stations and 2 school health centers. Tribes also provide healthcare access through an additional 15 hospitals, 254 health centers, 166 Alaska Village Clinics, 112 health stations and 18 school health centers.

The Joint Commission on Accreditation of Healthcare Organizations, the Accreditation Association for Ambulatory Health Care, and the Centers for Medicare and Medicaid Services regularly conduct in-depth quality reviews of IHS and Tribal hospitals. IHS has consistently maintained 100 percent accreditation of all hospitals and facilities and expects to continue to do so in FY 2009. This is an ambitious goal but one that IHS considers critical to ensuring that high quality patient care is being provided.

During these reviews, the area most frequently cited for improvement is related to the physical structure and efficiency. The average age of IHS facilities is 33 years as compared to 9 years for healthcare facilities in the United States; many are overcrowded and were not designed in a manner that permits them to be utilized in the most efficient manner in the context of modern healthcare delivery. The condition of these facilities varies greatly depending on age and other factors. Some are in need of maintenance. In addition to maintenance, there is a need for modernization or expansion to address population growth, to accommodate modern equipment, or to meet the needs of rapidly changing health care delivery protocols. The process that the IHS has used since 1991 to evaluate healthcare facilities need and prioritize projects for funding is the Healthcare Facilities Priority System (HFCPS) and the Priority List it established. The IHS currently estimates that completing the new or replacement facilities on the current Priority List totals $2.6 billion. The 22 facilities on this Priority List are those facilities with the greatest need.

The IHS continues to improve access to services by replacing old facilities or constructing new ones. In FY 2007, the IHS opened three Federally-owned healthcare facilities to increase access to services at Clinton, Oklahoma, Sisseton, South Dakota, and Red Mesa, Arizona. The IHS also increased access to substance abuse treatment with a new regional youth treatment center in Wadsworth, Nevada. These new health facilities are designed to serve 22,100 American Indian and Alaska Natives, which is an increase of 50 percent in access to health care in those communities.

We have also partnered with Tribes to expand access under the Joint Venture Program and the Small Ambulatory Program. These programs complement the Healthcare Facilities Construction Priority List by providing mechanisms for Tribes to become involved in the construction of facilities. Since 1998 under the Joint Venture Program, 7 Tribes have entered into agreements to construct facilities and lease them to the IHS at no cost; in exchange, the IHS agreed to equip, staff, and operate these facilities. Five of these facilities have been completed. Under the Small Ambulatory Program, 27 Tribes have received funding to provide improved facility space for healthcare programs since 1998.

In the House Report accompanying the FY 2000 Appropriations Act, Congress directed the IHS, in consultation with the Tribes and the Administration, to review and revise the existing HFCPS. IHS has been working with Tribes and the Department on a revised system.

We anticipate this revision would provide an assessment of health services and facilities needs today and would rank those facilities needs based upon contemporary criteria developed through extensive consultation of IHS and the Tribes.

Mr. Chairman, this concludes my statement and I would be happy to answer any questions you may have. Thank you.

The CHAIRMAN. And you are Mr. Hartz?

Mr. HARTZ. Yes.

The CHAIRMAN. Mr. Grinnell, thank you.

Mr. Hartz has been with us before. I am sorry about that. Thank you.

Mr. HARTZ. No problem. I am not in uniform today.

[Laughter.]

The CHAIRMAN. And Mr. Domingo Herraiz, the Director of the Bureau of Justice Assistance at the U.S. Department of Justice. Mr. Herraiz, you will be discussing the Department's Indian jails construction program.

STATEMENT OF DOMINGO S. HERRAIZ, DIRECTOR, BUREAU OF JUSTICE ASSISTANCE, U.S. DEPARTMENT OF JUSTICE

Mr. HERRAIZ. Chairman Dorgan, Vice Chairwoman Murkowski and members of the Committee, the Department of Justice appreciates the opportunity to testify before this Committee regarding priorities for correctional facilities in Indian Country.

The Department recognizes the critical role of planning to ensure the construction and renovation of tribal correctional facilities are appropriate for the intended population, supportive of cultural and traditional values, safe and secure when completed, and adhere to the Bureau of Indian Affairs' standards regarding correctional operations programs and design.

The Attorney General and the Department remain committed to partnering with tribes to cost-effectively plan for and renovate facilities associated with incarceration and restoration of juvenile and adult offenders subject to tribal jurisdiction.

My name is Domingo Herraiz and I am the Director of the Bureau of Justice Assistance. BJA has the privilege of administering tribal programs to help reduce and prevent crime and violence in Indian Country. Based on BJA's involvement in these vital initiatives, I would like to provide you an update on four key areas: cooperation with tribes and related partners; the state of tribal correctional facilities; factors considered for funding tribal correctional facilities; and strategies to maximize the effectiveness of tribal correctional facilities.

The President and the Attorney General remain committed to addressing the most serious criminal justice problems in Indian Country and to ensure the federally-recognized Indian tribes are full partners in this effort. It is in the spirit of partnership that BJA has been a principal supporter of the Office of Justice Programs in departmental tribal consultation, training and technical assistance sessions. These sessions have expanded to include five Federal departments.

At each of these sessions, BJA, OJP, and our Federal partners have offered expertise to participants for training workshops and technical assistance. Through tribal consultation sessions, we have solicited priorities for detention and corrections in their communities. After consulting with tribes about challenges and barriers to accessing OJP grant resources, BJA and OJP implemented a new tribal grant policy. The new policy will help Native communities

seeking OJP resources through our competitive grant solicitation process.

BJA has also had an active role in the Justice Programs Council on Native American Affairs, which includes all senior-level OJP leadership and representatives from other Department of Justice agencies.

Partnerships also provide the foundation for BJA's administration of the Department's construction of correctional facilities on tribal lands discretionary grant program. BJA staff meet regularly with the OJP Senior Advisor for Tribal Affairs, Department of Health and Human Services' Indian health representatives, the Office of Juvenile Justice and delinquency prevention tribal staff, and Substance Abuse and Mental Health Services Administration representatives to discuss the wide range of issues impacting Indian Country, including correctional facilities and construction projects.

Equally as important is the partnership these agencies have with tribal organizations and tribal grantees who share invaluable information through focus groups and other forums regarding ways to better support criminal justice systems in Indian Country.

This information reflects the criminal justice system in Indian Country's clear need of better management. In 2004, the Department of Interior's Office of Inspector General issued a report, Neither Safe Nor Secure: An Assessment of Indian Detention Facilities, indicating that many of the more than 72 tribal detention and correctional facilities in Indian Country were outdated and unsafe for both staff and inmates, serving only as detention facilities and providing little in the way of rehabilitation or programming services.

Simply replacing all correctional facilities is not the answer. Other cost-effective strategies for construction of tribal correctional facilities must be examined. We are looking closely at these issues, including the use of correctional alternatives or non-custody programs, renovating existing buildings for correctional-related functions, and the provision of less expensive lower security beds.

Joint county, tribal and regional tribal solutions should also be considered when sites are in close proximity to strengthen services and save resources. DOJ's Tribal Construction Grant Program has provided resources to 26 American Indian and Alaska Native communities between 1998 to the present. Of these awards, 22 have gone to communities for new correctional facilities. Four awards have been made for renovation of existing facilities.

By April 2007, 17 tribes had completed construction of their new facilities, five were actively engaged in design and construction, and four tribes were renovating existing structures to achieve Federal compliance and become fully operational. Today, DOJ is in the process of awarding 25 grants to tribes to facilitate construction efforts, while eight tribes will receive funding for the renovation of existing structures and another 17 tribes will receive awards for construction planning.

Key elements of the application process for each new construction grants includes tribes must demonstrate a capacity need, provide a development plan to help prevent overcrowding, discuss the involvement of an executive level planning team, including the

tribe's capacity to oversee the project and manage costs, and submit a reasonable budget for the proposed design.

Likewise, applicants for DOJ's renovation of tribal correctional facilities funding are required to provide details regarding BIA's assessment supporting the renovation request and a cost-effective design for completion within a rigorous 18 month time frame, thus demonstrating that the renovation will lead to continued BIA support for operation and maintenance of the facility, and the tribe's capacity to successfully sustain the facility in the future.

The comprehensive planning process is also well established with the construction of correctional facilities of the tribal lands discretionary grant program. To support planning efforts, BJA provides training and technical assistance from experts dedicated to correctional issues tribes face to maximize the cost-effectiveness of construction projects and to plan for the long-term effectiveness of the tribal justice system.

We are constantly listening and learning from our tribal partners. Best practices emerge from lessons learned. Knowing what one tribe has discovered does work allows us to share that knowledge with others experiencing similar issues to save critical time and resources. Offering locally based training to correctional officer staff and engaging a wide range of tribal partners to develop policies and procedures for tribal correctional facilities will also serve to strengthen related services in Indian Country.

Community-based alternatives to help reduce the burden of overcrowding while offering many offenders a hopeful solution to breaking the cycle of alcohol and substance abuse, and linking efforts to results, the Department will continue to seek ways to improve its programs in practical ways that tribes themselves have helped to identify and design.

This concludes my statement, Mr. Chairman. I welcome the opportunity to answer any questions from you or the Committee.

[The prepared statement of Mr. Herraiz follows:]

PREPARED STATEMENT OF DOMINGO S. HERRAIZ, DIRECTOR, BUREAU OF JUSTICE ASSISTANCE, U.S. DEPARTMENT OF JUSTICE

Chairman Dorgan, Vice-Chairman Murkowski, and Members of the Committee: The Department of Justice (DOJ) appreciates the opportunity to testify before the Committee regarding priorities for correctional facilities in Indian Country. The Department recognizes the critical role of planning to ensure that the construction and renovation of Tribal correctional facilities are appropriate for the intended population, supportive of cultural and traditional values, safe and secure when completed, and adhere to Bureau of Indian Affairs (BIA) standards regarding correctional operations, programs, and design. The Attorney General and Department remain committed to partnering with Tribes to cost effectively plan for and renovate facilities associated with the incarceration—and restoration—of juvenile and adult offenders subject to Tribal jurisdiction.

My name is Domingo S. Herraiz, and I am the Director of the Office of Justice Programs' (OJP) Bureau of Justice Assistance (BJA). BJA is committed to preventing and controlling crime, violence, and substance abuse, and improving the functioning of the criminal justice system. BJA has the privilege of administering Tribal programs to help reduce and prevent crime and violence in Indian Country. Based on BJA's involvement with these vital initiatives, I would like to provide you an update in four key areas:

1) Cooperation with Tribes and related partners;

2) The state of Tribal correctional facilities;

3) Factors considered for funding Tribal correctional facilities; and

4) Strategies to maximize the effectiveness of Tribal correctional facilities and improve planning, construction, and renovation programs.

The President and the Attorney General remain committed to addressing the most serious criminal justice problems in Indian country and to ensuring that federally recognized Indian tribes are full partners in this effort. It is in this spirit of partnership that BJA has been a principal supporter of OJP's Interdepartmental Tribal Consultation, Training and Technical Assistance Sessions held in FY 2007 and FY 2008. These sessions have expanded to include five federal departments and ten of their agencies, several of which, have direct responsibility or touch on this area. At each of these sessions, BJA, OJP and our federal partners have offered our expertise to all participants for training workshops, technical assistance, general session panels demonstrating challenges as well as cooperative opportunities available, and through tribal consultation sessions, we have solicited tribal priorities for detention and corrections in their communities. Our latest session began yesterday in Washington, D.C. and will conclude tomorrow.

After consulting with tribes about challenges and barriers to accessing OJP grant resources, in September 2007, BJA and OJP implemented a new Tribal Grants Policy. The new policy will help Native communities seeking OJP resources through our competitive grant solicitation process. We are implementing the policy starting with the Fiscal Year 2008 grants solicitations.

BJA also has an active role in the Justice Programs Council on Native American Affairs, which includes all senior-level OJP leadership and representatives from other Department of Justice offices and agencies. The council coordinates OJP's efforts on behalf of tribes and serves as a liaison with other Department of Justice components on Tribal issues.

Another important outcome from our Council efforts and Tribal consultations has been our establishing a Tribal Justice Advisory Group (TJAG). The TJAG provides advice and assistance to me and other OJP leadership on Tribal justice and safety issues. It convened its initial meeting in November and will meet again tomorrow.

Partnerships also provide the foundation for BJA's administration of the Department's Construction of Correctional Facilities on Tribal Lands Discretionary Grant Program. BJA staff meet regularly with the Senior Advisor for Tribal Affairs from the Office of Justice Programs' Office of the Assistant Attorney General; Department of Health and Human Services' Indian Health representatives, Office of Juvenile Justice and Delinquency Prevention (OJJDP) tribal staff, and Substance Abuse & Mental Health Services Administration (SAMSHA) representatives to discuss the wide range of issues impacting Indian Country, including correctional facilities and construction projects. Equally as important are the partnerships these agencies have with Tribal organizations and Tribal grantees, who share invaluable information through focus groups and other forums regarding ways to better support the criminal justice system in Indian Country.

This information reflects that the criminal justice system in Indian Country is clearly in need of better management. In 2004, DOI's Office of the Inspector General issued a report, "Neither Safe Nor Secure: An Assessment of Indian Detention Facilities," indicating that many of the more than 72 Tribal detention and correctional facilities in Indian Country were outdated and unsafe for both staff and inmates, serving only as detention facilities and providing little in the way of rehabilitation or programming services. Underscoring these concerns, BIA shared information indicating that many of the Tribal detention and corrections facilities are in disrepair.

Simply replacing all correctional facilities is not the answer. Other cost effective strategies for construction of Tribal correctional facilities must be examined. We are looking closely at these, including the use of correctional alternatives, or non-custody programs; renovating existing buildings for correctional-related functions; and provision of less expensive, lower security beds. This last strategy can be very cost effective, and relies heavily on thorough needs assessments and population profiles. Finally, joint county-Tribal and regional Tribal solutions should be considered when sites are in close proximity to strengthen services and save resources. In addition, the Department has worked closely with the Tribes to expand the scope of its Tribal programs to include training and technical assistance to Indian Country.

DOJ's Tribal construction grant program has provided resources to 26 American Indian and Alaska Native communities, between 1998 to the present. Of these, 22 awards have gone to communities for new correctional facilities, and 4 awards have been made for renovation of existing facilities. By April 2007, 17 Tribes had completed construction of their new facilities; were actively engaged in design and construction; and 4 Tribes were renovating existing structures to achieve federal compliance and become fully operational.

Today, DOJ is in the process of awarding grants to 25 additional Tribes to facilitate construction efforts. While 8 Tribes will receive funding for the renovation of existing structures, another 17 Tribes will receive awards for construction planning. BJA anticipates these awards will be made in April 2008.

The following are key elements of the application process for each new construction grant: Tribes must demonstrate a capacity need for the new facility; provide a developed plan to help prevent overcrowding of the projected facility by tapping into community-based alternatives; discuss the existence and involvement of an executive-level planning team—including the Tribe's capacity to oversee the project and manage costs; and submit a reasonable budget for the proposed design. Likewise, applicants for DOJ's renovation of Tribal correctional facilities funding are required to provide details regarding a BIA assessment supporting the renovation request and a cost-effective design for completion within a rigorous 18 month timeframe, thus demonstrating the renovation will lead to continued BIA support for operation and maintenance of the facility and the Tribe's capacity to successfully sustain the facility in the future.

A comprehensive planning process is well established with the Construction of Correctional Facilities on Tribal Lands Discretionary Grant Program. Tribes must: (1) examine population projections; (2) demonstrate a need for the facility, determine operational costs, and the ability to cover these costs; (3) determine the ability to recruit, train, and retain qualified staff; (4) explore the use of alternatives such as sanction programs, pre-trial release, day reporting,treatment, and electronic monitoring; (5) determine the availability of treatment and other services such as substance abuse, health, mental health, education, employment, and housing; and (6) demonstrate that Tribal leaders and other community stakeholders have fully participated in the planning and needs assessment process.

To support planning efforts, BJA provides training and technical assistance at no cost from experts dedicated to the correctional issues Tribes face to maximize the cost effectiveness of construction projects and to plan for the long-term effectiveness of the Tribal justice system. For example, more than a dozen *Tribal Construction of Correctional Facilities Project Guides,* from "Selecting an Architect," to "Site Selection," and "Population Profiles, Population Projections and Bed Needs Projections," have been published and distributed to Tribes to guide them throughout their planning, construction, and renovation efforts.

To ensure our programs remain relevant to the needs of Indian County, the Department continues to seek ways to improve and enhance its Tribal grant initiatives. For example, the President's proposed Fiscal Year 2009 budget consolidates multiple funding streams and burdensome requirements to create four new competitive grant programs that will provide states, localities, and Indian Tribes with the flexibility they need to address their most critical criminal justice needs. A total of $200 million is requested for the Byrne Public Safety and Protection Program in Fiscal Year 2009. Another new initiative in the President's proposed budget is the Violent Crime Reduction Partnership Program to help communities suffering from high rates of violent crime form law task forces including local state, Tribal, and federal agencies. A total of $200 million is requested for this program in Fiscal Year 2009. The Department has taken other steps, as well. In the past two years alone, training and technical assistance to Tribes has increased and further collaborations have been built toward regional and multi-service facility exploration and development.

We are constantly listening and learning from our Tribal partners. Best practices emerge from lessons learned. Knowing what one Tribe has discovered does *not* work allows us to share that knowledge with others experiencing similar issues to save critical time and resources. Offering locally-based training to correctional officer staff, and engaging a wide range of Tribal partners to develop policies and procedures for Tribal correctional facilities will also serve to strengthen related services in Indian Country. Community-based alternatives help to reduce the burden of overcrowding while offering many offenders a hopeful solution to breaking the cycle of alcohol and substance abuse. Linking efforts to results, the Department will continue to seek ways to improve its programs in practical ways that the Tribes themselves have helped to identify and design.

This concludes my statement Mr. Chairman. I would welcome the opportunity to answer any questions you or other Members of the Committee may have. Thank you.

The CHAIRMAN. Mr. Herraiz, thank you very much.

I thank the entire panel. We have testimony from the BIA, from the Indian Health Service, and the Department of Justice.

I am trying to understand. I have looked at the President's budget on these issues and you all have painted a pretty optimistic picture. I think, frankly, the picture is pretty pessimistic. So I want to ask a few questions about that.

Mr. Rever, the replacement school construction program went from $83 million down to $46 million, now down to the President's budget request of $22 million. We have a $1.8 billion backlog and we cut it in half and cut it in half again, and you are telling me that, gee, things are pretty optimistic here. I don't understand that. Why is this funding being cut in half when the need is so great?

Mr. REVER. Mr. Chairman, if I may answer. The entire program of 184 schools are being addressed in accordance with our priority list of facility conditions. We certainly have made huge progress in correcting those in the most serious condition. That is where we concentrated our budgets in the first few years of this program.

As we have moved forward and as we have assessed the facilities themselves, and as we have gone back and taken a look at do we really need to replace every school in the entire campus because there is a question here on do we really need to replace the entire campus. I personally have toured a number of schools and facilities, and it is my personal professional opinion, having been in this business a long time, is that maybe we don't have to replace the entire campus. Maybe we can take some of the buildings that are made out of concrete block and they have adequate roof structures and the design is current, that we ought to take a look at the way we are programming the replacement or replacement of individual facilities, and repair and upgrade of the existing facilities.

The CHAIRMAN. I understand what you are saying, but did you recommend these budgets be cut? Notwithstanding what you just said, we still have replacement requirements. In the context of that question, the flash report by the Inspector Report of your department on May 31, 10 months ago, went out and looked at a number of schools and said these are severe deficiencies that have the potential to seriously injure or kill students and faculty, and require immediate attention to mitigate the problems.

We have very serious problems, and it takes an Inspector General to go find them? I don't understand that. Why would you not have found these and corrected them?

Mr. REVER. Well, in fact, Mr. Chairman and members of the Committee, I personally have found publication of that report by the Inspector General addressing those 14 schools, led a team of investigators, including safety officials and engineers, on a tour of every one of those facilities to take a look at the findings of the Inspector General. I will be more than happy to provide the Committee of our response to the Inspector General, including my trip report from that event.

What I found was that we have what I would call a satisfactory process to identify all of the deficiencies listed in that report. In fact, when I went back and checked to make sure that we had identified and had corrective action plans in place for all of those facilities, that is what we found. Our database, and if I may, sir, the one that comes to mine immediately is the Chin-Lee Boarding School. I visited the Chin-Lee Boarding School because that was

the one that the Inspector General pointed out as having the greatest life-threatening deficiencies.

What I found when I arrived on site were two structural engineering reports assessing the deterioration of the facility, making recommendations for repair and arrest of the subsidence that was evidenced in the foundations, and establishing a risk factor that was satisfactory to their professional judgment and opinion that were good enough to last for at least seven years, from five years to seven years, and the design and engineering contract to accomplish those corrective actions was already in place.

So in fact, sir, we did know exactly what the condition of those facilities were. So we did the thing that all engineers do. We did a risk assessment. We relieved that risk. We have now programmed the replacement of that facility in our replacement facility construction program, and in the Fiscal Year 2009 budget it is in our program.

The CHAIRMAN. I understand your answer. I don't understand, you come to us and you speak in positive terms after you have cut in half and cut in half again the school replacement program for Indian schools that have a requirement of $1.8 billion backlog. We have Inspector General reports. I have been to these schools. All of us have been to these schools. The fact is, Indian kids are going to schools that are in disrepair. There is a big backlog, and you come to us suggesting we cut the budget in half last year, suggesting we cut it in half again with the President's budget, and you are happy with that.

I understand you are paid to represent the President's budget, but I am telling you I think it shortchanges kids in these schools.

Now, well, just let me go through this again. The Indian Health Service, all of us understand the backlog here. The suggest in the President's budget is let's cut that in half. Let's cut the funding in half for the facilities construction program in Indian health. That stands logic on its head.

BIA jails repair and renovation program, let's cut that by 30 percent. Department of Justice Tribal Jails program, let's zero that out. Let's not do anything. I mean, the fact is this makes no sense to me.

Now, let me go back to this issue of jails, if I might. I have been to an Indian jail and seen a young teenage kid intoxicated laying on the floor of that jail in which adults are moving around incarcerated as well. We all understand what is going on. We have enough reports that will fill a library telling us what is going on.

Now, Mr. Ragsdale, I said when I started, the fact is we had the Inspector General report. Then the Americans taxpayers have paid for a consulting study. In testimony, one of the BIA employees said that was going to be done, this was last March. Mr. Rivera testified before the Prison Rape Elimination Commission. He said the consultant report, the Shubnam Strategic Management Application report, which the taxpayers paid for, he said that is going to be ready. It is going through Director Pat Ragsdale, and then it will be open for public information I think in a month or two. That was a year ago. That was March a year ago.

Now, my Committee staff met with you in August of last year to discuss these issues. We asked you about the Shubnam report. You

said it would be ready by December. I called Carl Artman and talked to the Interior Secretary in preparation for this hearing, saying I want that released for this hearing. I want to find out what that consulting company found about the 38 Indian jails that they assessed. Both said it is not going to be made available.

I think that is arrogant. We paid for that report, and I don't understand why, if in March of last year you were apparently in possession of the report and your BIA folks said it was going to be released in a couple of months, and then you tell us it is going to be released in December, why are we sitting here in March of this year not able to access information about 38 different Indian detention centers?

Mr. RAGSDALE. First, Mr. Chairman, I will tell you that my projection that the report would be completed by December was my best estimate at the time. It has taken longer than that to fully review the report.

With respect to Mr. Rivera's, not to be confused with Mr. Rever, statement before the commission, I think what Mr. Rivera was referring to—he was the head of corrections at the time, and I was the Director of the Bureau at the time and had been kept informed about the progress of the report—I think what Mr. Rivera was referring to was the first part of the report, the phase one part of the report.

But I have been kept apprised of the progress of the report. We took our first look at the preliminary report, which was fairly complete——

The CHAIRMAN. When was the report contracted?

Mr. REVER. Mr. Chairman, the report was contracted in the year 2006.

The CHAIRMAN. What did the contract require with respect to completion?

Mr. REVER. The contract was modified several times.

The CHAIRMAN. What did it require originally as a completion date?

Mr. REVER. One year, sir.

The CHAIRMAN. And so, when would it have been done?

Mr. REVER. It would have been done in 2007, but if I may, sir, what happened was that it was two-phased and always planned to be a two phase report. One was a condition assessment of existing detention centers across Indian Country. We wanted to know what the condition was, not only the condition, but the operation concepts that were going on on tribally owned and BIA-owned and operated jails because we wanted to confirm what we knew, but expand the concept.

We then took a look at what was being discovered as our consultant visited these jails. For the first time, we have had a chance to look at the combination of facilities and their condition, and the condition of those, and unfortunately the deteriorated condition of those facilities, had on the operation of the detention centers.

We don't have heliports. We don't have adequate detention facilities. We have looked at the fact that we are putting more offenders in jail than we ever have before and we are letting some go. The statistics that we were getting for what the need was was much

greater than what we anticipated because we didn't know, and now we do know.

So in addition to that, it became very apparent to us that we can't just address the detention aspect of a justice system. That is why I talk about justice systems. It is the law enforcement and policing. It is the court system and then eventually the incarceration.

The CHAIRMAN. Mr. Rever, I am sorry to interrupt you. All of us understand that. We understand that. I am asking you about a 1,000 page report that the taxpayers have paid for, and you have decided you would not share with this Committee because someone hasn't yet reviewed it. I am so tired of the bureaucracy and I am especially tired of the bureaucracy in the BIA. The fact is, we ought to have access to find out what did they discover about those 38 facilities. We paid money to discover that. We were told it was going to be available, and when we scheduled this hearing we expected it to be made available to us and it has not been. As you can tell, I am not happy about it because I think it is arrogant.

Now, the fact is you come to us, all of you come to us, and say things are really swimmingly good. You know that they are depressing with respect to facilities in Indian Country on jails, health care and education. And you are recommending budget cuts—I don't know if you believe in them or not—but you come here and defend them. I mean, it is unbelievable to me.

Well, I have taken more time. I have more questions, but we will have a second round.

Senator Murkowski?

STATEMENT OF HON. LISA MURKOWSKI, U.S. SENATOR FROM ALASKA

Senator MURKOWSKI. Thank you, Mr. Chairman.

To continue with the Chairman's line of questioning on the report, recognizing that the report isn't here, I would agree with Chairman Dorgan, you have to question why. I think it is unacceptable that this many months after the fact we still don't have the report.

But Mr. Rever, you have indicated that the assessment that you have made, or that you have been part of, recognizes that these facilities in, your word was "deteriorating" condition. So I think we can all assume that when we get this report, it is not going to be a pretty report. It is going to tell us what we know, and that is that these facilities are in deteriorated condition. They are completely inadequate. They were built for an era that has passed many decades ago. These inadequacies lead to a potential public safety crisis in Indian Country.

I am not convinced that we are going to find anything in this report that is going to be a positive. I think we are going to learn that it is, as you say, a deteriorated condition and perhaps even worse. We know that.

So the question then is, if you know that it is bad and is getting worse, why has the Administration asked for so little funding to make is work? Now, the Chairman has indicated in his comments that I think you said it was a 30 percent decrease in detention funding. I have just asked, and apparently there is some discrepancy in terms of the numbers, but whether it is a 30 percent de-

crease or whether it is a $600,000 increase over last year, the question is why has the Administration not sought adequate funding, whether it is in this year's budget or beginning seven years ago when we recognized that we were going to be faced with this really terrible problem?

Mr. REVER. I would like to take the opportunity to answer that, Senator.

First of all, I have to clear up the purpose of the report. The purpose of the report was not to discover the condition of the facilities. We know what the condition of the facilities are. We do an annual inspection to determine what the condition of those facilities are. What the purpose of the report is is to identify the need. Nobody that I am aware of, that we have spoken to, has ever been able to quantify the deficiencies in detention facilities, law enforcement facilities, and tribal facilities across this great Nation of ours.

We took the opportunity to do a master plan. What this is is a plan to correct what is this deficiency. We start out by determining what is the existing condition, and that took a year.

Senator MURKOWSKI. So are you saying that until you have a plan that recognizes the full extent of the situation that you are in, you are not willing to start work on some of the most clearly deficient facilities and increase that budget to allow for correction of that? That you are going to hold off until you know entirely what the full analysis is of all these facilities?

Mr. REVER. Not at all, Senator. What we are looking at is a plan to integrate across Indian Country a cost-effective solution to the justice problem we have to address the rising crime rate on Indian reservations. It is a monumental task to be able to do that.

We believe, and I think we are supported consistently by the Department of Justice, that we can't just solve individual problems. This is such a big problem that we have to look at the way the justice system works along Indian Country. Until we know what the need is and come up with a cost-effective solution—for instance, we know as a result of our study, that we are only incarcerating about 50 percent of the offenders that truly should have been incarcerated.

Now, that number will not be reflected in any report that I see or Mr. Ragsdale sees because until you go out and actually visit the detention center and the law enforcement center and see that they take in offenders in the morning and release them before dawn to keep the count down because of health and other considerations, when we put four times and five times as many offenders in a jail than it was built for—until we knew that we wouldn't be able to identify the need.

Now, this plan simply identifies the need. It identifies where we should have detention centers, and we created tiers, what should be locally——

Senator MURKOWSKI. But recognizing that you are waiting for a plan that clearly identifies the need without allowing for increases in the budget to take on what you know you are going to be faced with, I think is closing your eyes to the reality of your own report. You are going to get this report in a month or two or maybe more, and will be dealing with a budget that is hopefully not what the President has recommended, but it will have been your rec-

ommendation that we don't need to increase the budget at this point in time. So you basically put yourself yet another year behind.

I want to ask one quick question of Mr. Herraiz, if I may. This is to the budget request that would, again, eliminate the tribal set asides for the grant allocations for detention construction, and instead would require that tribes basically compete with States and local governments for construction funding.

I understand that there is a new tribal grant policy, but I am not quite sure what it says or what it does. What is this policy and what is the Department doing to make sure that the tribes can compete on an equal footing with the States and local governments as they go after these facilities construction funds?

Mr. HERRAIZ. Senator Murkowski, members of the Committee, I became Director of the Bureau of Justice Assistance in 2004. I came from a background of working at the State level doing exactly what I do now in Washington for the Department of Justice, overseeing grant administration, linking the public policy.

One of the experiences I have had has been recognizing that many times grant application processes are very cumbersome, require a lot of red tape solicitations that have way too much information and are confusing to the average person at the local level in tribal communities as well. So in 2005, I sponsored, with the Department, a listening tour if you will. We held a session in Alaska. We held two in the Lower 48, to focus on tribal issues, to figure out what are some of the concerns they had with the Indian Alcohol Substance Abuse Initiative that we had, Tribal Courts program that administered, as well as tribal construction.

Within that context, a lot of the feedback we received was burdensome, the cumbersome process, not unlike I had heard before in my career. So working with the OJP tribal policy, the tribal initiative, the first piece that we were able to address is just that issue, to streamline the grant process and to make sure that burdensome requirements are not in there.

Certainly, we have the requirements to partnership with BIA and make sure that those requirements are met, but in particular as it relates to the requirements of other things that we absolutely have in control that may be guidelines on our end, but are not regulations and are not statute that you all have created, we bypass that.

So within that context, we have also created since I have been at BJA a tribal justice unit, as well as we have a tribal justice unit in the Office of Justice Programs, to oversee specifically those requests. What that means to you is that we can concentrate our effort, not diminish the results of other corrections programming that we have in BJA or other law enforcement initiatives, but absolutely concentrate specifically on tribal communities, so that we can address whatever planning issues, whatever construction issues, whatever translates.

Drug courts, we have found in this time period, don't work the same, but healing to wellness courts do. So we need to tailor to the needs and conditions of the tribes to make sure that those resources are spent effectively.

Senator MURKOWSKI. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Johnson?

Senator JOHNSON. Between high schools, jails and schools, I don't know where to begin. But Mr. Rever, a specific example of the Lower Brule Indian Tribe is an excellent jail facility built by the Department of Justice, and it is woefully understaffed. The problem is there are no women, no juveniles, and a small amount of males allowed in the jail. The BIA police aren't even allowed to move their offices to the facility.

Do you ever talk to the Department of Justice about that? How do you explain that?

Mr. RAGSDALE. Thank you, Senator.

With regard to Lower Brule, let me first of all say that Chairman Jandreau, the leader of the Lower Brule Tribe, has exercised a lot of forbearance, and we do have a schedule to make the facilities fully operational, including moving the police department into the facility, which the tribe wants us to do.

We have had difficulty fully staffing the facility. In the report that we talked about that has not been released, we address some of the other ancillary problems that we have in staffing when we have a lack of housing and so forth. I regret that we have not been able to fully staff the facility, but we do have a plan and a schedule to do that that we have shared with your staff, and we have made significant progress.

With regard to the police department being allowed to move into the facility, we have had some difficulty with GSA, who is the responsible office to authorize leasing of space for Federal agencies. We have not been granted a delegation of authority from GSA to lease the space, even though the Chairman has graciously offered to give us a $1 lease or a no-cost lease to staff the facility. We are anxious to move our police department in there, but have not been able to do so thus far.

Senator JOHNSON. What is your estimation of the time line to get the police department folks in there?

Mr. RAGSDALE. Well, I believe that we do have the staffing for the adults, and we just have so many different schedules for facilities and operations. I don't recall the specifics, but we did provide that to your assistant just this week. We had a full meeting and gave him a progress report, so I would rather defer.

Senator JOHNSON. Do you understand the terrible inefficiency of hauling prisoners hundreds of miles away, utilizing the police for to transport the prisoners? The police force is already understaffed in too many cases.

Mr. RAGSDALE. Yes, sir. I totally agree with you. It is inefficient, and it does put a strain on the limited law enforcement personnel that we have to have to transport not only for Lower Brule, but for many other tribes, inmates and juveniles for hundreds of miles.

Senator JOHNSON. Mr. Chairman, I have no other questions.

The CHAIRMAN. Thank you.

Senator Barrasso.

Senator BARRASSO. Thank you, Mr. Chairman.

I share the concerns and we have problems in Wyoming with health facilities, with schools, with the same things we are talking

about in terms of law enforcement, and continue to ask questions, and I will continue to ask questions about that.

We look at our two health care facilities and our centers in Wyoming. The Fort Washakie Health Center, as I mentioned earlier, was built in 1877 to house cavalry units. Tribal leaders tell me that it was renovated in the late 1990s, but just with the addition of some exam rooms. This is not adequate. The conditions that we have really don't meet the needs of our 11,000 users of the reservation's health system so it can operate.

Mr. Grinnell, could you explain to me how the Indian Health Service is working to provide a fair system to make sure that the Indian health care facilities in Wyoming are updated to meet a reasonable standard of care?

Mr. GRINNELL. I would like to defer to my colleague, Mr. Hartz, please.

Mr. HARTZ. Thank you, Senator.

The facilities are in good shape from a maintenance standpoint, we look at the supportable space, the health space that the tribes run as well as what we run, and we distribute resources based on the space identified in each of the locations.

As far as addressing the needs of facilities to be replaced or to build new, we have direction from the Congress to develop a priority system to take a look at all of the health services and facilities needs across Indian Country. First looking at what the health service requirements are, health services needs, and then from that determination, whether in fact there is a need for replacement of a health facility or a new one or some other means by which the health services would be addressed. But it is a comprehensive effort that is underway per congressional direction, sir.

Senator BARRASSO. Mr. Chairman, I have additional questions. Maybe I could submit those, because I know the vote has been called and Senator Tester hasn't had a chance yet. So with your permission, I would defer.

The CHAIRMAN. Senator Barrasso, thank you.

Senator Tester?

STATEMENT OF HON. JON TESTER,
U.S. SENATOR FROM MONTANA

Senator TESTER. Senator Barrasso, you are too kind.

Thank you, Mr. Chairman. I really appreciate it.

Just to recap real quick, Mr. Rever, you are facilities for jails and schools, correct?

Mr. REVER. Yes, sir.

Senator TESTER. And Mr. Grinnell, you are IHS facilities for medical facilities, right?

Mr. GRINNELL. Yes, sir.

Senator TESTER. How many years have you been on the job, Mr. Rever?

Mr. REVER. I have been on this job two and a half years.

Senator TESTER. Two and a half years?

Mr. REVER. Yes, sir.

Senator TESTER. Mr. Grinnell?

Mr. GRINNELL. Six months in this position.

Senator TESTER. Six months in this position.

Can you give me any idea, Mr. Rever, how many dollars have been spent on construction during your two and a half year tenure?

Mr. REVER. Yes, sir. We have put in the ground upwards of $300,000 a month. So I would say over the last two years, we have been able to, about $280 million.

Senator TESTER. At $300,000 a month, that correlates to $280 million?

Mr. REVER. I am extrapolating to cover other items as well. We spend a lot of money on architect, engineer, design studies.

Senator TESTER. I am talking about building facilities, not architecture, not design, none of the stuff—actually building a facility. How many dollars have been spent?

Mr. REVER. Sir, I may ask——

Senator TESTER. Bricks and mortar.

Mr. REVER. Schools only?

Senator TESTER. Schools and jails.

Mr. REVER. Schools and jails. I haven't built any jails since 1993. That is not part of our purview, but we are putting $8 million a year into improvements and repairs over the last two years.

Senator TESTER. Okay. And this isn't architectural stuff; this is actually hiring the people to lay the foundations and build?

Mr. REVER. Yes, sir. And probably over the last two years, put about $300 million in the ground.

Senator TESTER. Okay, $300 million you have spent on bricks and mortar?

Mr. REVER. Yes, sir.

Senator TESTER. What was the $8 million for?

Mr. REVER. The $8 million was improvement and repairs to detention facilities, sir.

Senator TESTER. Improvement. How many dollars have been spent on studies?

Mr. REVER. Just on the study that we have completed, probably $40,000 or $50,000 all together.

Senator TESTER. About $40,000 or $50,000 all together.

Mr. REVER. Yes, sir.

The CHAIRMAN. Senator Tester, if you would yield, what was the cost of the Shubnam Report?

Mr. REVER. I don't know, sir, in exact dollars. I will have to provide that to you.

The CHAIRMAN. That can't be included in your estimate.

Mr. REVER. No, sir, it was not.

The CHAIRMAN. That would be a very large contract, I assume, or a significant contract. This is a California consulting company that worked for you. So that is not a part of your answer, right?

Mr. REVER. No, sir. It was a very reasonably cost study, sir.

Senator TESTER. And that $300 million you spent is over your two and a half years in this job?

Mr. REVER. Yes, sir.

Senator TESTER. Could I get a list of those projects?

Mr. REVER. Yes, sir. You certainly may.

Senator TESTER. Okay.

How about you, Mr. Grinnell? Can you give me an idea on what you spent? I don't know. It has been six months, so it is kind of

a null and void. Let me get to my point, because we do have a vote going.

It appears to me just from the limited testimony that I have seen here today, and I want to tell you something. I come out of the Montana legislature, and the last people I want to attack are people who work for the government. Truthfully, I appreciate your being here and I appreciate the job you do. But, and this is a big "but," when you get out of bed in the morning you have to ask yourself how you are going to make things better in Indian Country because there are a lot of things that need to be made better.

In your particular area, it is about construction of schools and medical facilities and jails. I am going to focus on schools and medical facilities, although jails are probably equally as important. If we don't have adequate medical facilities, it doesn't matter how much money we pump into Indian health care. It is not going to improve.

The same thing with schools. In Montana, every at-risk kid in the State of Montana is Native American. That is the one thing No Child Left Behind has done that is good. And part of that is the people in the classroom, but the other part of it is the classroom.

And so when you get out of bed in the morning, I would hope you say to yourself, if somebody above you is saying, you know what, we are going to cut school reconditioning from $83 million to $46 million to $22 million, that you protest violently. Because I think every one of you people have skills and if they fire you for that reason, that is a reason to get fired. And it is the same thing for health care facilities.

I don't mean to lecture anybody here, but we have seven reservations in the State of Montana. I am sure it applies in North Dakota. I am sure it applies to Wyoming. Alaska's got a little different thing going, but it probably applies to Alaska, too. We have major problems. And when we send dollars out and they are spent on study after study after study and nothing is done, that is almost criminal and it is certainly not what I would anticipate from the people who are in the positions you are in. Because we can do all the policy-making we can here, and if you don't carry it out on the ground, it is all for nought. You guys make it happen.

With that, I do have some questions. We do have a vote. I do have some questions I will submit for the record.

Thanks you folks for being here. I want the next time we come together to meet to be positive and talk about the things we have going and talk about the future and what the long-term plan is, and how we can move forward to make things better. But the truth is, the Chairman pointed it out, you can't be positive about this budget and there is no harm in saying that, because it is a wreck in Indian Country. It honest to God is a wreck. And we have to fix it and we will. With your help, we will fix it right.

The CHAIRMAN. Senator Tester, they would lose their job if they said it was a wreck. That is the problem. I mean they come here representing the Administration's budget, but the Bureau of Indian Affairs education construction account, that is not the replacement for schools. That is the go in and repair. It is to respond to what the Inspector General says in their flash warning. Kids could die, very serious problems.

The proposal, you know, we used to be $250 million a year. In 2007, it went from $205 million down to $142 million. Now, they request it down to $115 million. You are presiding over a substantial reduction in the amount of money available to meet a dramatic need. I described earlier the school replacement program cut in half and cut in half again. I mean, it just doesn't work.

I understand how you answer these questions, but I am very disappointed because we are faced with responsibilities, trust responsibilities, treaty responsibilities. And then we see these budgets and you are trying to suggest that, you know what, things are going pretty well. And frankly, they are not.

Senator Domenici last year, a year ago, asked both Justice and BIA whether you have responded. The Inspector General recommended that there be a strategic plan between Justice and BIA with respect to this issue of jail replacement and renovation. He asked for a response from you, and we would like as well a response. Have you done a strategic plan between the two? If so, what is it? Can you submit it to this Committee?

Because there is a vote ongoing, if you will just think about that. We will take a 10 minute recess, go vote and be back. We appreciate your indulgence.

[Recess.]

The CHAIRMAN. The Committee will come back to order.

Senator Murkowski?

Senator MURKOWSKI. Thank you, Mr. Chairman.

I just had one very quick question for you, Mr. Grinnell. This is on the status of the Barrow Hospital up north. Under the current facilities priority system, we have approximately five in-patient facilities. Barrow and Nome are at the top of that. The question is when do you anticipate that you will be able to finish the final stage of construction for the Barrow Hospital?

Mr. GRINNELL. Mr. Hartz, he has the specifics on that project.

Senator MURKOWSKI. Okay.

Mr. HARTZ. Thank you, Senator Murkowski.

We are pleased, as you probably well know, to announce that construction is underway with the participation of the Denali Commission. They started laying rock on the pad that IHS purchased for the new site. Our five year plan that outlines the schedule for completion of the project is obviously dependent upon the level of appropriations. The $15.8 million that we are asking for in the current fiscal year, 2009, will permit us to continue that process of moving forward on the construction of the facility.

Senator MURKOWSKI. So you haven't told me when you anticipate construction to be complete.

Mr. HARTZ. I have all this stuff here and I do have it.

Senator MURKOWSKI. If you could just provide that.

Mr. HARTZ. Here we go. No, we have it right here. I am sorry. We had so much fun at the break that I mislaid some of my papers. Here we go.

Based on our projections of how the project could proceed forward and where we have identified the mid-point of construction, we would look at the completion of the funding in Fiscal Year 2011. So we would be looking at completion of the project probably in Fiscal Year 2012, late 2012.

Senator MURKOWSKI. As you know, we are anxiously awaiting not only completion of that facility, but the one up in Nome.

Mr. HARTZ. Yes, we understand that. We are anxious, too.

Senator MURKOWSKI. Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Grinnell, describe for me again the justification for an Indian Health Services construction program being reduced from what used to be $90 million four years ago, down to last year at $30 million, and this year at half of that, down to $15 million. Describe the rationale for that.

Mr. GRINNELL. Yes, Mr. Chairman. I would like again to defer to Mr. Hartz, as he has the specifics on that.

Mr. HARTZ. Thank you, Senator.

As we all recognize, we are in tight budget times, but I would like to highlight the fact that even the facility at Fort Washakie that Senator Barrasso identified, as aged as it is, we did make major efforts to maintain accreditation of these facilities and to ensure that they qualify for Medicare/Medicaid reimbursements, et cetera. And that is really critical to the business that we are in, namely health care delivery.

Other than the fact that we are in severely tight budget times and the priorities that the agency puts on the delivery of much-needed health care, I don't have a better answer than that today, sir.

The CHAIRMAN. Could you tell me what was requested from your agency going up through the budget process? Did you request a reduction by 50 percent in Indian Health Service facility construction?

Mr. HARTZ. The agency per congressional request develops and provides a five year plan to the Congress. It is a public document that we provide. It is from that I responded to Senator Murkowski's question about what the projections are in the out years for keeping these projects moving off the priority list. As these projects develop, the designs develop, and they come ready for construction, you folks fund construction, and we get ready to identify the next phase, trying not to delay the mid-point of construction which is critical to these cost estimates. We actually do identify a could use column on our chart that is part of the public record.

The CHAIRMAN. And what does it suggest "could use" for Fiscal Year 2009?

Mr. HARTZ. For the facilities on the priority list that we have discussed over many years with the staff and the congressional delegation runs about $260 million.

The CHAIRMAN. About $260 million.

Mr. HARTZ. That is a public document that relates to priority projects.

The CHAIRMAN. I understand. That is in Fiscal Year 2009?

Mr. HARTZ. That is not a request. That is a "could use."

The CHAIRMAN. I understand.

Mr. HARTZ. Okay.

The CHAIRMAN. Well, what is it, then? I understand it is not a request, but tell me what the line is?

Mr. HARTZ. It is approximately $260 million.

The CHAIRMAN. You said it is not a request. So what is it?

Mr. HARTZ. It is a "could use," because projects progress.

The CHAIRMAN. I understand.

Mr. HARTZ. They go through varying stages and as we get closer in the development of the need, we deal with it in "could use" amounts.

The CHAIRMAN. So first of all, we have a need that we have identified. We have a total backlog of about $9 billion, regrettably. You have identified that you could use in this fiscal year $260 million and you request $15 million. Is that accurate?

Mr. HARTZ. We request the priority for the health delivery. Facilities in IHS, HHS and across Government facilities are not the priority need as other services.

The CHAIRMAN. I understand. First of all, we asked you to be here. I appreciate your coming. You serve in public service. I appreciate your service in public service. But I hope you understand that when I say I am terribly disappointed with this budget, and I would not want to be in your position, to come to a committee and try to paint this as something that is good news. It is not good news. It is not in my judgment an accurate reflection of where our responsibilities are. We are moving backwards, not forwards, on things that deal with life and death, especially with respect to health care issues.

I can tell you that I went to a facility recently that is in disrepair and crowded and so on, and they said, well, this is the space we are going to get the new x-ray machine, which is going to be a dramatic improvement for us. They said they have not been able to get it. It has been two years now since we have been able to get the request in and get it responded to.

And I said, why is that? Well, we don't know. The money was available, but it just took a long, long time to get it through the area office and the regional office. And I walked away thinking again, so we have people out in the waiting room, a full waiting room, and they don't get the access to a brand new machine, an x-ray machine that should have been there, because of the bureaucracy. It just drives me—well, I am very disappointed.

These numbers reflect in my judgment a lack of progress and a lack of recognition of the urgency and the need. I wish that you would come to us with better news. I understand and wish that you could answer my questions. Dr. Grim never would because he said he never could. But my question would be, what did you request? And if you could answer it and would, you would probably be fired for answering it on the record, but if you could answer it and told me you requested a cut by 50 percent in this Indian health care account, I would say you should not be in this job, either of you.

But I don't think that is what you requested. I think you would have requested some additional funds because you know they are needed and that it goes through the machinations and up through the crawl spaces in Government and through the Office of Management and Budget and it turns out they want to cut that particular account in half, and they send you up here to put a necktie on and a suit on to justify it. And that can't be very comfortable if you feel as I think you probably feel. So I don't mean to lecture, but I am not happy.

Mr. Ragsdale, I would tell you I am not happy at all with how this has worked out with the Shubnam report. I understand it is

a two-phase report and almost a year ago you got the preliminary report, at least in the first phase. The first phase is the most important phase for us. The first phase is the most important. Let's understand what they found in those 38 facilities. You have had that for a long period of time, and I am going to get to the bottom of that and I hope you have testified accurately about it.

Mr. RAGSDALE. Mr. Chairman, if I may. We are anxious, and I know that the Assistant Secretary is anxious to release this report. I believe this report will provide the executive and legislative bodies of this Government a blueprint of where we need to go in the future. It is a very comprehensive report. It has been reviewed internally within the Bureau of Indian Affairs, that in fairness we want to share that with the Department of Justice and go through the report, it is a very detailed report, and make it available to the Committee and to the Indian tribes as soon as possible.

I regret that it has taken longer than I thought it would, but that is just part of our process.

The CHAIRMAN. Well, the Department of Justice is no more important than this Committee, and to the extent that you are sharing things, you ought to share it with this Committee as well as the Department of Justice. I have people calling the consulting company to find out, (A) what it would cost, and (B) when did you get the two phases. And I believe you have had the first phase for a long period of time. That first phase should have been made available to this Committee for this hearing. There is no excuse for it not being made available. I spoke to the Secretary specifically and personally. I spoke to the head of the BIA personally. And we have been informed, you informed us, that it had been available last December. You informed our Committee of that, Mr. Ragsdale.

So I am a pretty unhappy guy about this because I think the BIA has stiffed this Committee. We will see.

Let me with that happy note, thank you for being here. At our request, you have come today to give us your description of where we are. I will ask if the Committee members have additional written questions they wish to submit to you that you would respond to those written questions and give us the opportunity to inquire further.

Let me thank you for being here and we will release you and ask if we can have the final set of witnesses come forward.

I would like to call up the second panel, the Honorable Wendsler Nosie, Chairman of the San Carlos Apache Tribe. From the Navajo Nation, we have Mr. Monty Roessel, Executive Director of the Rough Rock Community School in Chinle, Arizona. We have Ms. Valerie Davidson, Senior Director of Legal and Government Affairs at the Alaska Native Tribal Health Consortium located in Anchorage, Alaska. Ms. Davidson is accompanied by Mr. Rick Boyce, the Director of Health Facilities at the Consortium.

We appreciate very much you coming, and we are sorry that we have been delayed some, first by a vote and then a lengthier stay with the first panel. But you have traveled in many cases long distances to be with us to provide some of your testimony.

We will ask that you summarize your testimony. Your entire testimony will be made a part of the record. So if you would do us the service of summarizing it, we would appreciate that.

We will call first on the Honorable Wendsler Nosie, the Chairman of the San Carlos Apache Tribe. Mr. Chairman, thank you very much. You may proceed.

STATEMENT OF WENDSLER NOSIE, CHAIRMAN, SAN CARLOS APACHE TRIBE

Mr. NOSIE. Thank you, Mr. Chairman and the Committee.

First of all, I just want to again say my name is Wendsler Nosie, Sr., the San Carlos Apache Tribal Chairman in Arizona. I have with me Councilwoman Bernadette Goode and also I have Ollie Benaly, who is the Chief of Police, Todd Winger, who is the Construction Director for the new health care facility, and Paul Nosie, who is with the detention center.

What I would like to express deeply is to be very frank. I am very honored to be here, and with the chosen words of the Committee, with the amount of feeling that was put into it. At one point in your discussion, I wish I was sitting at your panel and asking questions as well, because there are many reports that we do for the Federal Government, the BIA, that are submitted, and also with IHS, which outlines the total needs of Indian problems in Indian Country. I come to wonder where do those reports go and who is reading them? Because in those reports, it outlines the great needs.

What I would like to discuss is the health care issue. The health care with the facility has been a great need, like any other tribe. I have been with the Tribal Council as a councilman for seven and a half years and served as the Tribal Chairman for one and a half years. As I travel around Indian Country, the voices are the same. The cries are the same. The great need of more funding and appropriations, that if Washington could only earmark more money to the tribes, then we would become—well, two things will actually happen. The care of our people will be taken care of, and in the future we would have a better vision of where we are going as a tribe.

It is important that all agencies understand that. One of the things that we also talk about is the government-to-government relationship, the partnership. That actually should be exercised to the fullest. As I have learned and come to understand the reports that are given here to Washington are very crucial because they tell you of Indian Country and the great needs.

Now, we can relate back to our elders to where they had discussed to us, the younger people, waiting for the time that things will be better and still waiting for health care. We have many of our elders who have passed away because of the type of services we are getting, based on lack of funding for staff. The hospital is obsolete. Just like in any other community, the numbers are rising. We are up to more than 13,000 people, and that does not include other people from other nations that live within the tribe. So it seems that funding-wise, it is never being planned for the future, for the increase in numbers.

So now we are at a point with our health facility of taking on self-determination. We have pictures here that you can see our health care what it looks like. It is important for us to become self-governing. I think in 1975, it was once passed and talked about

that self-governance is a very important policy. At this time and age, the tribes have taken that initiative to become self-governing. Why? Because if IHS was giving the services that we needed, we won't going that route, if it was acceptable.

At this point, we know that we have to establish our own destiny of where we are going to go, but it has to be in a partnership in the agreements of the long treaties that have set between the Apaches and here in Washington, but also with all tribes. So it is important that we understand, that the agencies understand, that self-governance is very important to us, to create a future for our unborn children so that we know what our greatest needs are. We know what our greatest health care should be, but we need the cooperation in order to get it done.

An example is the detention center. I can honestly say that with the funding, the agencies were able to listen, listen to the needs of what was needed for the tribe. And so building, the facility was built with a lot of cultural input, so that we can not only have it as incarceration, but also have it as a healing place as Native people, because these people here are our community members, our friends and neighbors, our children. It is important that this type of process is taking place so that we can work in a unified effort in the better need of our people.

But we have that information. That is why I go back to the very first thing I said. I kind of wonder. I see monthly reports from our 628 programs that are submitted to the BIA agency. Now, where does it go from there? Those reports outline the great needs. I have been here, as I was saying, a year and a half as the tribal chairman, and have been here several times lobbying for more funds, that your appropriation would be higher so that it could benefit all tribes across this Country.

Mr. Dorgan, I want to thank you for the bill that was passed last week. It is very important for us to know that there is people here in Washington that know the living conditions, the education conditions and the environment that we're living in is very important. Because if those issues are not addressed, it is very harming to our people, because actually what are we teaching them? What are we teaching them through the detention center. What are we teaching them through health care and education? If the Indian people have a future, then it is very, very important that the United States Government relates back to its trust responsibility.

That is basically just listening, hearing the great needs of the tribes. I realize that I sit here probably representing all of the nations that are not able to be here. I know that that is one thing that I would really stress is the appropriation of funds.

We can't live this way. We can't continue this way. We need a true partnership, a true government-to-government relationship. Because I like to see those in our community that only have so many years to live to know that the Federal Government is finally exercising the true trust responsibility that they had mentioned years and years ago.

Mr. Dorgan, again I want to thank you. I appreciate this opportunity and this hearing because it is very vital. We are talking about lives. We are talking about souls. And we are talking about

the future for Indian Country. I know we have a rightful place in this Country if we are given that opportunity.

So Mr. Dorgan and your Committee, I thank you for this opportunity and we do have our written testimony submitted.

[The prepared statement of Mr. Nosie follows:]

PREPARED STATEMENT OF WENDSLER NOSIE, CHAIRMAN, SAN CARLOS APACHE TRIBE

Introduction

Thank you, Chairman Dorgan, Vice-Chair Murkowski, and other Members of the Senate Indian Affairs Committee, for allowing me the opportunity to testify today. My name is Wendsler Nosie, Chairman of the San Carlos Apache Tribe, based in San Carlos, Arizona. We commend the Committee for holding this important hearing on the state of facilities in Indian Country so that we can shine a light on this very serious problem. The backlog for jails, schools, and health facilities is staggering. Like other tribal communities, the needs on my Reservation for adequate facilities to provide the health care, law enforcement, and educational services that my people deserve far exceed the level of support provided by the Federal Government.

My testimony primarily focuses on our experiences and struggles to build a new IHS outpatient clinic replacement facility and our recently built Adult and Juvenile Detention and Rehabilitation Center. But I would be remiss if I did not mention that I recently received information from the BIA that it plans to condemn San Carlos' police building, which houses the San Carlos Police Department, Tribal Courts, and the BIA criminal office, because of its poor condition without offering any assistance to find resources to construct a new building even though Secretary Kempthorne and the Department of the Interior have used San Carlos and its violent crime and serious methamphetamine problem as an example in its budgets in brief and press conferences over the past few years to justify increases to law enforcement. Indeed, two years ago, San Carlos testified before this Committee about the devastating effects of meth on its community. The Tribe has a self-determination contract for police services, but the BIA owns the facility and is responsible for its maintenance and operations. Due to its poor condition, the BIA wants the Tribe to assume ownership of the building.

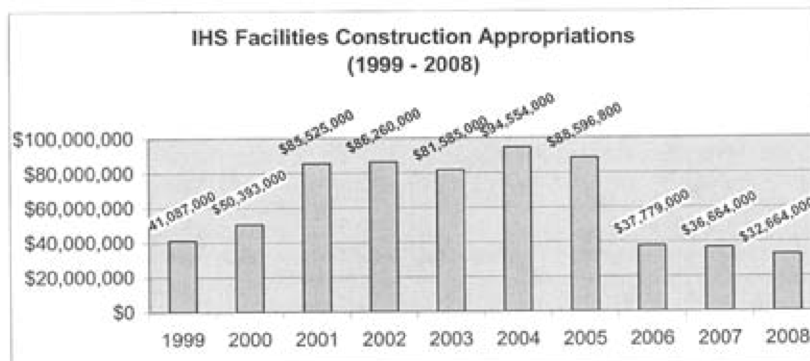
Failure of the Federal Government to Provide Adequate Facilities

The Federal Government has failed in its trust responsibility to provide adequate facilities to the San Carlos Apache Tribe and to other tribes across the country. The agencies, the White House, the Office of Management and Budget, and the Congress, have all shirked their responsibilities to provide adequate resources to Indian Country so that we can rebuild and provide for our communities.

The condition of facilities on my Reservation and in the rest of Indian Country is unacceptable in this great country of ours. Let me be clear that the San Carlos Apache Tribe supports our troops in Iraq, Afghanistan, and other parts of the world. The Apaches have many decorated war veterans that have served with distinction in the United States military throughout this country's history. However, I wonder about some of the priorities of the United States when my community needs to be rebuilt, my people need decent health care, my people need safe communities, and my people need infrastructure. When I hear about the billions and billions of dollars the United States is spending to rebuild Iraq, to build homes, jails, governmental buildings, hospitals, and schools for the Iraqi people, I wonder why the United States will do these things for the Iraqi people but not for its own citizens in the United States.

The solution to this problem is obvious. The Administration and the Congress must dramatically increase funding to construct new facilities as well as funding to operate and maintain these facilities when they go on-line. Because of the Federal Government's failure to provide adequate funding over the past decade, we are seeing astronomical backlogs. In the area of health facilities, there is an avalanche effect where tribes with unmet health facilities needs in certain parts of the country are seeking to redistribute funding for health facilities that could adversely impact other tribes, such as San Carlos, who have equally, if not more pressing, unmet health facilities needs. This unfortunate situation played out on the floor of the Senate during passage of S. 1200, the Indian Health Care Improvement Act.

For example, the appropriations for IHS health facilities over the past 9 years have been stark as illustrated by the chart below:



The President's budget requests and as well as the budget requests under the Clinton Administration for facilities construction have been deplorable. In FY 2005, the President's budget requested a moratorium on IHS facilities construction using the rationale that steel prices were too expensive. Needless to say, this explanation does not make sense when construction is going on all around us and all over the world. Unfortunately, the President's budgets' utter lack of support for IHS facilities construction has set a tone that Congress has followed over the years as the Congress has only provided minimal funding for health facilities. For example, for FY 2008, $32.6 million was allocated for facilities construction even though there are at least 24 facilities on the construction priority list ready for planning, design, or construction dollars. If you are familiar with construction, then you know $32.6 million does not go far when building new health facilities that must be able to serve the community for at least the next 60 years.

Our hope is that all of our efforts within Indian Country, in the Administration, and in the Congress can be used in a positive direction to significantly increase appropriations. We must work together and, through our collective strength, address the facilities backlog. The San Carlos Apache Tribe urges a Call to Action of the Congress from Indian Country to increase appropriations. We understand that other tribes and tribal organizations are also discussing this same idea. We stand ready to assist in this effort.

I believe that this hearing will help jumpstart the efforts to secure badly needed appropriations for facilities in Indian Country. Also, I believe it would be helpful if the Committee could hold some field hearings or listening sessions in Indian Country on this issue, so that Members could see for themselves the conditions that families, community leaders, health care personnel, social services staff, detention personnel, police officers, school administrators, teachers, and students in Indian Country must grapple with every day due to poor facilities.

In addition to improving the bleak appropriations situation, we are hopeful that this hearing and subsequent hearings and meetings will spur action within the agencies to reform their current processes to provide us and other tribes with increased flexibility, greater self-determination, less administrative burden, and greater control over the construction and operations of new health care facilities. For example, the Tribe's experience working with DOJ in constructing its Adult and Juvenile Detention and Rehabilitation Center in the late 1990's is a true success story and illustrates what tribes can achieve when given sufficient funding and flexibility. The Tribe has had, unfortunately, a less than optimal experience with the IHS in its struggle to build a new outpatient clinic due to limited funding and an overreaching construction process. The current process at IHS is not institutionalized and allows the goal post to be moved. This is problematic as it indicates to us that the sovereignty of tribes is not truly understood and that the principle of government-to-government transfer of control to tribes in the construction and operation of health care facilities is paid little heed.

Background on the San Carlos Apache Indian Reservation

To better understand the needs on the San Carlos Apache Indian Reservation as well as the Unites States' trust responsibility to the San Carlos Apache Tribe, it is helpful to know about the Reservation itself as well as the history of the Apache people. The aboriginal territory of the Apache Nation included the western part of Texas, the current states of Arizona and New Mexico, and part of the country of

Mexico. The Apache Treaty of Santa Fe in 1852 was executed by Mangus Colorado and others on behalf of the Apaches. Pursuant to the Treaty, lands within the aboriginal territories of the Apache Nation were to be set aside for a permanent Tribal homeland and the United States promised to provide for the "humane" needs of the Apache people. In exchange, the Apache Nation agreed to the end of hostilities between the two nations.

The San Carlos Apache Indian Reservation was established by an executive order of President Grant on November 9, 1871. Through the concentration policies of the United States, various bands of Apaches were forcibly removed to the San Carlos Apache Indian Reservation. These bands included the Coyoteros, Mimbrenos, Mongollon, Aravaipa, Yavapai, San Carlos, Chiricahua, Warm Springs, and Tonto Apaches. Famous Apache leaders who were located at San Carlos included Geronimo, Cochise, Loco, Eskiminzin, Nachie, Chatto, and others. Throughout history, the United States in 1873, 1874, 1876, 1877, 1893, and 1902 diminished the size of the Reservation several times by executive order due to the discovery of silver, copper, coal, water, and other minerals and natural resources.

The San Carlos Apache Reservation is located 2 hours by car from Phoenix. Our land base is 1.8 million acres, but only a small percentage of the Reservation can be used for building purposes. The remainder of the Reservation is comprised of some of the most rugged terrain in the Southwest, including deep stands of timber, jagged outcroppings, and rocky canyons. As a result, the Reservation lacks infrastructure in all but two general areas. On the western edge of the Reservation, the Tribe has 3 districts: 7-Mile Wash, Gilson Wash, and Peridot. Located on the eastern edge of the Reservation is the District of Bylas. All together, these 4 districts are home to 13,456 tribal members. Approximately 84 percent of our tribal members live on the Reservation. Although we have worked hard to develop our Reservation economy, 76 percent of our population is unemployed, and the poverty rate on the Reservation is 77 percent. The population of the Tribe continues to increase and more than 30 percent of the population is now under the age of 18 years. New young families are in desperate need of decent health care, education, and safe communities.

Struggle to Build IHS Replacement Health Facility

Antiquated Current Facility

Our existing facility is located in San Carlos in Gila County. It was built 48 years ago in 1962. It has 8 beds and its limited services include ambulatory care, emergency room, community health programs, dental, and administration. Patients requiring surgical procedures and complex medical cases are referred to the Phoenix Indian Medical Center in Phoenix or to contract health care hospitals. This means that helicopters frequently go back and forth between Phoenix and San Carlos to rush urgent care and trauma patients to hospitals in the valley.

IHS has documented numerous deficiencies at our current health care facility rendering it inadequate for present operations. The current health care facility is being used beyond its full capacity. The facility is severely understaffed and lacks adequate equipment, program services, and physical space to adequately meet the medical and other healthcare needs of tribal members. To give an idea of the space deficiencies in the clinic, IHS, based upon workloads at the current clinic, has determined that the new clinic needs 31 examination rooms. The current clinic only has 13 examination rooms. Due to lack of space, sick and elderly patients currently have to wait a long time to be examined or to get prescriptions filled. The current clinic sees on average 200 patients a day with a total of over 6,000 patients per month. The Tribe over the years has heard frequently from IHS staff that the current San Carlos health clinic is one of the worst facilities in the IHS system.

Long Road To a Project Justification Document for a New Facility

The project plan for the new clinic would allow the Tribe to bring some fundamental healthcare services back home to the Reservation as well as address unmet medical needs of the Tribe. For example, as part of the project plan, the new outpatient clinic would have a low risk birthing unit. The current clinic is not equipped for labor and delivery services even though there are a high number of births of San Carlos tribal members each year (the 2001 figures of IHS show 234 births per year of San Carlos tribal members). Currently, the women of San Carlos must travel off the Reservation and often to locations far from their homes to deliver their babies. The closest delivery service from San Carlos is 40 minutes away at Cobre Valley Community Hospital while the Bylas community is an hour from Cobre Valley and 50 minutes from Mt. Graham Community Hospital. The women of San Carlos are eager to deliver their babies at home on the Reservation and the new clinic would allow them to do so. Also, the new clinic would be equipped and staffed to provide

the following new services, which are badly needed on the Reservation: telemedicine, diagnostic imaging, expanded specialty care such as ambulatory surgery and endoscopy, physical therapy, and expanded diabetes treatment. The new facility would provide for more than 3 times the staff at the current facility. The existing facility has 118 staff and the new facility would have 358.2 staff. The size of the current facility is 3,580 square meters. The size of the new facility is proposed to be 18,767 square meters. The cost for the new facility and staff quarters, according to IHS, is approximately $110 million (but this cost will only increase as costs go up over time and given site circumstances that IHS did not factor in its initial estimates).

Our struggle for a replacement health care facility began over 20 years ago. In and around 1988, IHS evaluated IHS health care delivery programs nationwide. The proposal to construct a replacement facility to provide health care services space at San Carlos was among those selected for further evaluation. IHS assessed the health care needs of the Indian population at San Carlos and evaluated the ability of the existing health care delivery system to meet those needs. The major factors that IHS considered were the use of the existing system, the size and condition of existing space, the ability of the existing space to support an accessible, modern health care delivery system, and the proximity of other health care facilities. The findings of this evaluation concluded that the existing San Carlos Indian Hospital was inadequate and required a complete replacement.

IHS placed the San Carlos facility on its list of facilities in need of replacement in the early 1990s. It is now 2008 and we still do not have a new health care facility. For over a decade, IHS and the Tribe went round and round "negotiating" the Project Justification Document (PJD), which is the project plan that IHS must approve before a facility can be placed on IHS's health care facilities priority construction list. IHS and the Tribe could not come to an agreement over the size of the facility and the level and types of services that could be provided at the facility. The main issue was whether an inpatient or outpatient health care facility should be built. Even though the user population at San Carlos supported such a facility and San Carlos previously had an inpatient facility, IHS was firm in its position that it would not support an inpatient facility due to IHS's limited budget and because it was trending away from building inpatient facilities. Inpatient facilities offer more types of services on site than do outpatient facilities. Many tribes navigating the IHS construction process are having this same issue with IHS. Many tribes have been in the "PJD preparation" phase for many years because they are being asked to compromise on the health care needs of their people even before the shovel breaks ground.

Further, IHS informed the Tribe that, if the Tribe sought an inpatient facility, then it would be practically impossible to construct the facility in the foreseeable future due to the scarce appropriations for inpatient facilities. IHS pointed to the proposed inpatient facility at Whiteriver, AZ, for the White Mountain Apache, our sister tribe, and indicated that it would be very long time before Whiteriver would receive construction funding. The Whiteriver inpatient clinic has been on the priority construction list from the beginning, like San Carlos, and has yet to receive any appropriations to start its project.

In 2003, the Tribe, after intensive internal discussions, determined that it would consent to an outpatient facility instead of an inpatient facility. This was a very difficult decision for the Tribe because an outpatient facility will not meet all of the health care needs of its people but would certainly allow for better services and a much better facility. Even after the Tribe decided to pursue an outpatient facility, the negotiations were difficult. The Tribe felt that it had to capitulate on issue after issue because IHS, at each step, would inform the Tribe that it would not approve the PJD if the Tribe did not consent to the reduced services to be provided at the new facility. For example, the Tribe sought cardio-rehabilitation, case management, and patient advocacy services, but IHS informed the Tribe that it would have to "start all over" in the process if it continued to seek such services. IHS rejected these service requests on the basis that, even though these services are reasonable services to offer at a non-IHS facility, IHS had not developed national templates for the services and, therefore, would not allow any tribe to provide these services at their facilities.

Another example was a difference in views over the number of beds at the new facility. The Tribe sought 23 beds for the new facility. Previously, the service area had 26 beds between the 1960s and 1980s but these services were lost when the facility underwent patchwork renovations. IHS will only allow for 8 beds (the number of beds in the current facility) in the new facility due to budgetary constraints. Even with the compromises of the Tribe, IHS still was reluctant to approve the PJD because we believe it knew in 2003–2004 that the Administration was going to pro-

pose a moratorium on funding for health facilities construction in FY 2005. As perceived by the Tribe, IHS's plan was to stagger the PJD approval process so that only a few PJD's would be approved every few years. Due to congressional pressure, IHS approved the San Carlos outpatient replacement facility PJD in 2004 and placed the facility on IHS's priority outpatient construction list.

Even with the approval of the PJD and the placement of the San Carlos outpatient replacement facility on the priority construction list, the process has been extremely difficult at every turn. Without the strong commitment of the Tribe to this project and the tremendous support for this project by the Tribe's Congressman and Appropriators, this project would have languished without any funding. The Tribe received planning and design funding from FY 2005 to FY 2007 (FY 2005 Interior appropriations bill specified $555,000 for San Carlos for planning and design, the FY 2006 Interior appropriations bill specified $6.139 million for planning for San Carlos, and IHS allocated $2 million to San Carlos under the FY 2007 Continuing Resolution). Currently, for FY 2008, the Tribe is not slated to receive any funding at this point in FY 2008 from the facilities construction account as this funding was appropriated in a lump sum amount without allocations for specific facilities and IHS has determined that it will allocate this funding to Barrow, Cheyenne River, and Ft. Yuma ($36.6 million in FY 2008). IHS has indicated to the Tribe that it is looking for funding in other IHS accounts to keep the project moving along and we are hopeful that IHS can find this funding for us.

Even with funding that was allocated to the Tribe for FY 2007 in the amount of $2 million, the Tribe has had difficulties drawing down this funding. At one point, the IHS construction office stated that it would not release these funds to the Tribe until it "has a certain comfort level" with the Tribe's designs and plans. It would be more helpful if IHS could provide us with consistent, concrete guidelines and criteria to which they want us to adhere to draw down funds. When the Tribe has requested the procedures for drawing down its funds, the IHS construction office responded in an email, "Yea right." There should be consistency, transparency, and cooperation in the agency process.

Previously, the Tribe entered into a self-determination contract under P.L. 93–638 for the construction of the contract and recently submitted a notice of intent to IHS that it plans to submit a self-determination contact for the operations of the facility. We believe that IHS could improve upon its appreciation for the purpose of a self-determination agreement to provide for the government-to-government transfer of responsibility. It is our belief that the IHS construction office tends to micromanages the project contrary to the government-to-government transfer of responsibility. The self-determination agreement states that "tribal preferences will be honored," but sometimes we do not feel that this is the case. For example, we have registered design architects and engineers as part of the Tribe's project team but IHS second guesses their work and pressures us to do things their way.

Another example is the Program of Requirements (POR). The POR for the project was created by IHS for the Tribe, even though P.L. 93–638 states that the Tribe has the right to generate its own POR. Essentially, these facilities are designed as IHS wants them designed and do not necessarily reflect the true health care needs in the community. We believe that there should be a mechanism to update the POR so that the up-to-date health care needs in the community are addressed.

We recently were told by the construction branch at IHS that IHS is a "bottom up" organization and that, unless the project manger from engineering services has a personal level of comfort with what the Tribe is doing, then the project will not be supported by anyone in Washington. We have been told that we can talk to anyone we want to in Washington; but, unless the Dallas Project Manager is satisfied with the direction of the project, the project will receive no support and no funding. We have had individuals from IHS threaten not to approve the design package from the Tribe at the next approval phase, unless things are done their way. We have had the IHS project managers show up at tribal meetings with Service Unit staff uninvited, totally disrupt the meeting, insult our medical staff, and have had our meeting delayed for over an hour while we calmed them down enough so that they could sit in on the meeting without interruption.

Further, IHS recently informed us that we must alter our design to shift the burden of maintenance responsibility to the Tribe instead of IHS. IHS wants all utility systems developed for the health facility to be operated and maintained by the Tribe even though there are no funds provided for this. We believe that IHS should be responsible to maintain systems designed to exclusively support the hospital.

Suggestions for Improving the Construction Process at IHS

In addition to dramatically increased appropriations, IHS needs to be pro-active in introducing funding into the projects on the priority list, and they need to get

the message "from the top down" that the reason IHS exists is to provide better health care and new facilities for the Tribe. IHS should work to improve their construction process to fulfill the purpose of their self-determination agreements, which is to provide for the government-to-government transfer of responsibility for the construction and operations of the facility.

The IHS system needs to be re-organized to streamline the design and construction process. The projects are originated in the Phoenix area office, then are transferred to Dallas for the construction phase, then the maintenance and operations are transferred back to the Phoenix area office after the project is completed. This is extremely inefficient. There should be continuity throughout the construction process from conceptual development through design, construction, and maintenance and operations. The Dallas project managers travel to Arizona to oversee projects that the Phoenix Area Engineering staff could easily oversee. It would be most cost effective and much more efficient to originate, design, and construct these projects at the Area Office level. We find that the area office engineering staff have a high level of understanding of these projects, are very professional, and have a vested interest in providing the best buildings possible as they will be responsible for the maintenance and operation of the facility once it is built.

We understand that questions have been raised about the seeming high cost of IHS facilities construction projects. However, according to our project team that has extensive experience in hospital construction, these projects are lower in cost compared to what is spent in the private sector on hospital construction. Our budget was conceptualized before all the engineering challenges on our site were identified; and, as a result, our budget does not accurately reflect the actual project cost. There are many glaring omissions in our proposed budget as provided by IHS. These budgets need to be accurately updated in cooperation with the Tribe.

Experience Constructing and Operating New Adult and Juvenile Detention and Rehabilitation Facility

Construction of Adult and Juvenile Detention and Rehabilitation Center

San Carlos was in dire need of a juvenile detention facility and a new adult jail for many years. From 1994 until 1999, the Tribe pushed for a new facility and was placed on the BIA's "waiting list." In 1999, San Carlos attended a conference in Albuquerque sponsored by DOJ. With technical assistance from DOJ, Office of Justice Programs (OJP), the Tribe prepared an application and received funding approval for a Juvenile Detention/ Rehabilitation Center for $2,153,550.00.

While the Tribe was pleased that the juvenile project was approved for funding, the need for a new adult detention center still existed. Determined to obtain funding, the Tribe expressed its concerns about the condition of the adult facility to OJP. This effort led to San Carlos preparing a second application for both an adult and juvenile complex. On September 29, 1999, this application was approved, resulting in the Tribe obtaining a combined total of $10,787,272.00 in a lump sum to construct an Adult and Juvenile Detention and Rehabilitation Complex. From a funding perspective, the response from OJP, DOJ, was remarkable. DOJ listened to Tribal representatives, recognized the Tribe's problems and needs, and addressed them immediately. The Tribe entered into a self-determination contract to construct the facility and then later entered into a self-determination contract to operate and maintain the facility. The program at OJP back in the late 1990's should be a model for most other Federal agencies. We understand that this program is not now the program that it once was.

The next step involved the construction phase. The Tribal Planning Department took the lead in grant management and development. The first action involved preparing a Request for Proposals (RFP) for Architectural and Engineering services. The Tribe evaluated and hired a firm from Phoenix. One of the keys to success was the fact that DOJ authorized hiring a project manager from the overall budget so that the design and construction phases could go forward without any major glitches or delays. Reimbursements and advances from DOJ were timely and DOJ was very responsive to any questions posed or modifications needed. Overall, the design and engineering phase went very well. The construction of the facility was completed in 2003. The principle of self-determination worked well in the self-determination contract for construction with DOJ. The Center is an example of the timely and positive effects that can occur when tribes have flexibility and control over the construction of their facilities and they do not have to navigate a bureaucratic maze.

Obtaining funding and completing the design and construction of this complex were tremendous accomplishments, but another major obstacle needed to be addressed. Even though DOJ was responsible for the construction side of the new facility, BIA was and remains responsible for the operations and maintenance for the new facility. Here, the right hand did not know what the left hand was doing. Al-

though the Tribe had requested that the BIA include funding for the operation of the facility because the facility was ready to go on-line, the Tribe learned that the President's budget in FY 2003 did not contain funding to operate and maintain the new facility. The Interior appropriations bill for that fiscal year did not contain operations and maintenance funding for the new facility, so we had a situation where the Federal Government had constructed a multi-million dollar facility that could not be used. The Tribe did not and does not have the resources to hire staff, operate the facility, and maintain it. Fortunately, after intense lobbying by the Tribe and other tribes across the country through the formation of a coalition, the BIA agreed to reprogram FY 2003 funds so that the facilities that had completed construction could hire and train staff and furnish and equip their facilities.

For FY 2004, the coalition of tribes, including San Carlos, advocated strongly for funding for operations and maintenance in the Interior appropriations bill. The effort was successful, and the appropriations bills for FY 2004 and going forward contained funding for operations and maintenance for San Carlos new detention and rehabilitation center. However, the funding that the Tribe receives is not enough.

The annual amount the Tribe receives is inadequate to support administrative functions, basic operational costs, and the "detention" staff. For the short term, the Center is managing at a minimal level. The Tribe is able to manage at the minimum level due to the fact that the program has some carry over funding to supplement the annual budget. However, these funds will be exhausted shortly even though the Center is not operating at the recommended staffing level. If the base level of funding is not increased by the BIA, continued operation of the Detention/Rehabilitation Center will be seriously jeopardized, as the Tribe simply does not have the financial resources to supplement the estimated $1.5 to 2 million annual deficit. Even with the shortfalls in funding, the BIA honors the government-to-government transfer of control to the Tribe for operations and maintenance as contemplated in the self-determination contract, and we appreciate that.

At the present, the FY 2008 budget for the operations of the detention center is less than the budget of its employees' salaries. The current salary budget is $3.1 million; however, the budget from the BIA for the total operations for FY 2008 is $ 2.6 million. Our total budget need is $4,047,353. We are short $1,434,011 of what is needed to operate the detention center efficiently. We are not at full capacity in filling the positions that are needed and are presently short staffed. Presently, we have a total of 42 permanent employees, 22 are adult correctional officers and 11 are juvenile correctional officers. Our projected staffing needs in the beginning indicated a staffing of 64. Taking this into account, we are 22 positions short.

It should be noted that the discussion above does not include the costs associated with the rehabilitation component of the Center. In the initial planning stages, the Tribe felt very strongly, especially its elders, that it did not want a detention facility that was simply a jail, especially for juveniles. It believed that incarceration does not help individuals become healthy, happy, productive members of the community, and they wanted to ensure that rehabilitation services were an integral part of the overall program for both adults and juveniles. Most of the offenses at San Carlos are related to alcohol and substance abuse. With effective rehabilitation and reentry programs, these offenders have a chance at leading productive lives.

San Carlos is very fortunate to have the opportunity to design, construct, and operate the San Carlos Detention and Rehabilitation Center serving both adults and juveniles. While the Tribe now has a modern, clean, and functional facility, at the present time, the reality is that it is functioning as little more than a jail. This fact is discouraging to the Tribe. As stated above, the original intent of the Center was to be a place where troubled youth, adults, and affected family members could receive the services and support they need to become productive and positive members of their community.

The Detention Center staff is doing a commendable job in maintaining the facility, providing a clean and safe environment, and treating all residents with dignity and respect. However, with the exception of limited education programming and emergency medical and dental services, there is minimal on-going treatment programming taking place. The staff at the Center is extremely dedicated and spend their personal resources and time to develop programming for mentorships for the detainees, especially the juveniles. For example, with personal funds from donations, Center staff have taken the juveniles over the past few years to participate in a 300-mile sacred run, which is a relay race from Whiteriver to Mt. Graham. I help to organize in the run and run in it myself with my family. This 3-day experience focuses on teamwork, relationship building, and fun. The juveniles tell me they cherish their experience because they feel that they are part of something bigger than themselves. Our juvenile staff do such an excellent job (all of it on a shoestring with

little federal support) that they are asked to give presentations in other parts of the country and in Arizona about their innovative juvenile program.

Issues related to this situation are identified and briefly described below:

- The Tribe simply does not have the financial resources to provide the funds needed and the BIA is funding the contract at a level that meets minimal "detention" staffing and operating levels only.
- IHS has demonstrated only a willingness for finding reasons why they can not provide services to detainees rather than making an earnest effort to find solutions.
- Some grants under SAMHSA like the Tribal Capacity Expansion (TCE) grant and other federal grants that could provide at least a portion of the funding necessary to start providing treatment services require a minimum of two years experience providing treatment services to be eligible for funding consideration. As a result, it puts the Tribe in a no-win situation as they need funding to get their treatment services started but they can't obtain funding unless they have been providing treatment services for at least two years.
- Programs, such as the Arizona Health Care Cost Containment System (AHCCCS) and the SAMHSA ATR programs, could assist the Tribe greatly; but it is our understanding that they both have prohibitions regarding serving individuals in detention.
- The State of Arizona is one of a few states that allocates funding for education for juveniles in detention, but all of the funds are distributed to County detention facilities. The Detention Center is attempting to work with the local school district and the Gila County Superintendent of Schools, but what is really needed is that Tribes should receive separate, direct funding from the State.

It seems that the BIA, IHS, SAMHSA, OJJDP, and other federal agencies have the opportunity to showcase the San Carlos Detention/Rehabilitation Center and use it as a model program that other tribes can use as the foundation for designing and developing their facilities and programming. San Carlos has an excellent facility, but the provision of comprehensive, substantive programming (treatment) is a real and frustrating challenge for the Tribe. It would seem that rather than putting tribes in a position where they have to "piece-meal" a program together, some type of block grant format could be established where tribes could obtain the services (operational and treatment) they need through one proposal/application.

Conclusion

We appreciate your efforts to help us address the facilities crisis in Indian Country, and we look forward to working with you to ensure that the Apache people and other Indian people across the country have the tools that they need to help their communities become strong and vibrant.

The CHAIRMAN. Chairman Nosie, thank you very much.

This Committee will be holding a hearing in Phoenix, Arizona I believe it is two weeks from next Monday. Senator John Kyl will be joining me in Arizona. We will be holding a hearing specifically on law enforcement issues. I hope perhaps you might be there as well. I know that you come from that area.

Next, we will hear from Mr. Monty Roessel, Superintendent of the Rough Rock Community School in Chinle, Arizona, from the Navajo Nation. Thank you very much for being here. You may proceed.

STATEMENT OF CHARLES MONTY ROESSEL, SUPERINTENDENT, ROUGH ROCK COMMUNITY SCHOOL

Mr. ROESSEL. Thank you, Mr. Chairman and members of the Committee, for the invitation to speak before this Committee, not as an elected official or an issues advocate, but as a person who is directly responsible for the safety and education of more than 500 Navajo students.

My name is Charles Monty Roessel. I am Superintendent of Rough Rock Community School. Rough Rock is a K–12 residential

school located in the northeast part of Arizona on the Navajo Nation. To say that the Rough Rock Community School is in need of adequate school facilities is an understatement. Rough Rock was originally built in 1965 and opened its doors in 1966.

We were a leader in bilingual-bicultural education then and we continue to be today. Despite our substandard condition of our facilities, parents nonetheless continue to enroll their children at Rough Rock. Recent research has confirmed what many educators have always held as common sense: the quality of a school's facility has an impact on the student's academic achievement. The research on school building conditions and student outcomes finds a consistent relationship between poor facilities and poor performance.

Here are some of the facilities-related hardships we routinely face at Rough Rock. Sometimes our students wake up at 4:30 in the morning just so they can take a shower because the pipes under our two dorms have corroded to such a level that only half of the shower heads work in each dorm wing. Our middle and high school students have to share a cafeteria that was originally built for 75 students and today must accommodate more than 300. When it rains and snows or when the wind blows, as it often does, they must stand outside and wait their time to eat and sit down.

Our high school does not have a biology or chemistry lab and this puts them at a disadvantage if they want to attend college. Even worse, the quality of water is severely compromised. It is high in arsenic because the pipes are old and not compatible with the water filtering system. We must choose between high arsenic or high chlorine levels. Our school must operate its own water system, which was also built in 1965. Yes, there is a great need for adequate and safe facilities at Rough Rock.

A recent study has shown that students attending schools in newer and better facilities score 5 to 17 points higher on standardized tests. If a classroom is cold, noisy or dark, students are losing instructional time. At Rough Rock, we have classrooms and dorms that are cold because of outdated mechanical systems, dark because of old lighting systems and little daylight, and noisy from thin walls and deteriorating structures. They were built to code in 1965. The codes have changed, but the buildings haven't. Just imagine how many Bureau-funded schools could make AYP if our facilities were only adequate.

In March of 2004, the Rough Rock Community School was listed as number eight on the school construction priority list. Yet construction dollars will not be requested until 2011. It will take at least seven years before a shovel hits the ground just for the first phase of construction. This cost of inaction and slow action is hurting Indian children all across this Country. This is unacceptable and our Indian children deserve better.

Some might think that being placed on a priority ranking list for a new school is a good thing. Well, it is, but it also comes at a heavy price. Because we are now slated for a new school, many of the safety repairs I mentioned are declined by the OFMC. For example, in some buildings our high school and vocational classes do not have a fire alarm system installed. The dorm's plumbing prob-

lem cannot be fixed because the pipes have asbestos. In both cases, we are told to wait for new construction.

Every time a hear a fire alarm in the buildings that have one, my heart skips a beat. I understand the logic. Why would you put money into something that you are going to tear down? But is it right? No. We are tired of band-aid solutions and alarmed at the hazards to which our students and children are exposed.

Since our elementary school was constructed in 1965, a revolution has taken place in education. Computers have replaced and supplemented books. The internet has replaced the encyclopedia. And what was adequate 40 years ago is not anymore today.

We all know the answer is more money, and I understand that money is scarce. But rather than look at facilities as an expenditure, we need to look at them as an investment—an investment in our future and in our children. Without a commitment to our future, we will never have the willpower to ensure that every Indian child has the same opportunity as any other child in this Country. At the very least, this is an issue of fairness, and at the very most, it is a moral issue. It is time that we offer our students the best facilities possible that are safe, dependable and adequate to ensure that no Bureau-funded school student is left behind.

I was taught by my dad that you can't complain about a situation unless you at least are willing to recommend some changes to that. So I have some recommendations to streamline the process so that from start to finish it takes three years and not eight years. Right now, we are looking at 10 years passing before our school would even be open. That is almost an entire set of grades that are losing out on the brand new school. In order to speed up the process and reduce the backlog, I believe it would be beneficial to allow schools that are ready, such as Rough Rock, to jump up on the priority list.

Also, encourage standard designs. There is no reasons to continually redesign and redesign and redesign new dorms. A dorm is a dorm and the process could be streamlined and save money if people would use standardized designs. I think to create the capacity for Bureau-funded schools to utilize bonding to build new facilities and to encourage that projects be funded in phases like we are trying to do at Rough Rock to proceed at a faster rate.

On behalf of all Indian children, I thank you for looking into these troublesome construction matters, and I am happy to answer any questions the Committee might have.

[The prepared statement of Mr. Roessel follows:]

PREPARED STATEMENT OF CHARLES MONTY ROESSEL, SUPERINTENDENT, ROUGH ROCK COMMUNITY SCHOOL

Thank you, Mr. Chairman and members of the Committee for the invitation to speak before this Committee. I would like to briefly go over my written testimony and touch on a few points.

My name is Charles Monty Roessel. I am a Navajo from Round Rock, Arizona working as superintendent of Rough Rock Community School. I have held this position for eight years. Rough Rock is a K–12 North Central Association accredited residential school located in the northeast part of Arizona on the Navajo Nation. Our enrollment is around 500 with one-half of the student population staying in an elementary and high school dorm during the week. Our students come from throughout the Navajo Nation. We operate the school under a Tribally Controlled Schools Act grant (P.L. 100–297) from the Bureau of Indian Education.

To say that the Rough Rock Community School is in need of adequate school facilities is an understatement. Rough Rock was originally built in 1965 and opened its doors in 1966, as the Rough Rock Demonstration School, the first Indian community-controlled school in the country. In fact, community control of our school predated the enactment of the Indian Self-Determination Act by nine years.

Bilingual and Bicultural Focus

Rough Rock was a leader in bilingual and bicultural education then and continues to be today. The philosophy is simple and it is backed by research. If students know their culture and are proud of who they are, they are more likely to have academic success. Therefore, at the elementary school we have implemented a Navajo language immersion program. And at the high school, in order to graduate a student must take four (4) credits of Navajo history, language and culture. At the time it was a revolutionary idea to think that Indians could control their own education. Well to say the least, we have *demonstrated* and proven that Indian people can and are able to control their own education.

Despite the sub-standard condition of our facilities, parents nonetheless continue to enroll their children at Rough Rock because they highly value the benefits of our bilingual/bicultural curriculum and our focus on encouraging our students to be proud to be Navajos.

Impact of Facilities on Learning and Achievement

It would be naive to say that the quality of school facilities does not matter. Of course it does. At Rough Rock, we lack what most schools all across this country take for granted—a safe and habitable environment that enables students to enjoy learning and to achieve.

Recent research has confirmed what many educators have always held as common sense—the quality of a school facility has an impact on students' experiences and ultimately on their educational achievement. The research on school building conditions and student outcomes finds a consistent relationship between poor facilities and poor performance: When school facilities are clean, in good repair, and designed to support high academic standards, there will be higher student achievement, independent of student socioeconomic status. (AFT, 2006)

Here are some of the facilities-related hardships we routinely face at Rough Rock:

- Sometimes our students wake up at 4:30 am just so they can take a shower because the pipes under our two dorms have corroded to such a level that sometimes only half of the shower heads work in each dorm wing.
- Our middle and high school students have to share a cafeteria that was originally built for 75 students and today must accommodate more than 300. And, when it rains or snows or when the wind blows as it often does, they have to stand outside and wait for their time to sit and eat.
- Our high school does not have a biology or chemistry laboratory so that students who take these science courses learn only through books; they do not get exposure to hands-on learning. This puts them at a disadvantage if they want to attend college.
- Our students quickly learn that ceiling tiles might fall at any moment because of leaky ceilings and wind damaged roofs.
- Even worse, the quality of water is severely compromised; is high in arsenic because the pipes are old and not compatible with the water filtering system. We must choose between high arsenic or high chlorine levels. Our School must operate its own water system—which also dates back to 1965.

Yes, there is a great need for safe and adequate facilities.

A study in Tennessee has shown that students "attending school in newer, better facilities score five to seventeen points higher on standardized tests than those attending in substandard buildings" (Young, Green, Roehrich-Patrick, Joseph & Gibson, 2003). Inadequate facilities have the biggest impact on time on task. If a classroom is cold, dark or noisy, students are losing instructional time. At Rough Rock, we have classrooms and dorms that are cold because of outdated mechanical systems, dark because of old lighting systems and no daylight, and noisy from thin walls and deteriorating structures. They were built to code in 1965 but the codes have changed while our buildings have not.

Safe and modem facilities also have a huge impact on the recruitment and retention of highly qualified teachers. A study by Boston College found that the correlation between facility improvement and retention of teachers can be greater than pay increases. (Buckley, Schneider & Shang, 2004)

It is also important to note that because of Rough Rock's location, we must provide housing for our teachers, as there is no off-reservation town with a private housing market within commuting distance. Our campus housing, too, is plagued by safety issues and inadequacies.

Rough Rock School thus has to act in several critical capacities—as the local educational agency, as the municipality responsible for the water/sewer system, as the landlord for our employees and as the transportation department fixing potholes within our school compound.

Replacement School Priority List

In March, 2004, Rough Rock Community School was listed as number eight on the school construction priority list as ranked by the Bureau of Indian Affairs, Office of Facilities Maintenance and Construction (OFMC). Our project has four elements: construction of a new high school dormitory (grades 9–12) with cafeteria; construction of an elementary dorm to house students in grades 1–8; construction of a new elementary/middle school (K–8); and renovations to our existing high school building to up-grade its capabilities, repair building systems, and add wings for essential educational spaces such as science labs. We proposed to OFMC that our project—now estimated at about $30 million but originally projected at $16M in 2001—be funded and constructed in phases for maximum economy and efficiency. The dorms would be built first; then the elementary/middle school; then we will pursue the high school renovations.

In the four years since achieving our priority list ranking we inched our way up to the planning phase. Within seven months after receiving planning funds, we had that phase completed, including the identification of acreage for construction of the new buildings. Now we are poised to begin the design phase next month—April 2008.

However, our school was notified that funds for the construction phase will not be requested until, at the earliest, the budget request for Fiscal Year 2011. Even if this expectation is met and Congress appropriates the requested funds, it means from the time BIA approved the priority ranking list it will have taken 7 years before a shovel hits the ground—just for the *first* phase of our construction. Completion of that first phase will take about 2 years before students can occupy. The next phases will follow after that. Thus, it will be 12 or 13 years, if all goes well, before our full project is completed. Inaction has a cost. In 2001, our project was originally projected to cost $16M, today it is projected to be around $30M. At this rate, our project might cost $40M in 2011. This is unacceptable. Our Indian children deserve better.

Repairs on Existing Facilities Have Ceased

Some might think that being placed on the priority ranking list for new school construction is a good thing. It is. But, it comes at a heavy price. Because we are now slated for a new school, many of the safety repairs I mentioned that need to be addressed are declined by the OFMC. For example, some buildings—such as our high school gymnasium and vocational education classrooms—do not have fire alarm systems installed. The dorm plumbing problems cannot be fixed because the pipes have asbestos. In both cases, we are told to wait for new construction.

In other words, our students and parents and staff are told to endure these unsafe conditions based on the promise of being number 8 on a priority ranking list. Every night we pray that nothing happens. Every time I hear the fire alarm go off, my heart skips a beat. I cannot believe that parents in Scottsdale or Boston would allow such safety hazards to persist. And yet, this is business as usual in Bureau-funded schools. I understand the logic; why would you put money into something that you are going to tear down? But, is it right? No. We are tired of band aid solutions and alarmed at the hazards to which our children are exposed.

Poor Facilities Thwart NCLBA Mandates

Our school is being held accountable under the No Child Left Behind Act, but who is holding the BIA accountable to provide the facilities to adequately provide an education for our students? Every year new standards of accountability seem to be imposed but we must make do with the same old tools we always have had. Our accreditation is mandated by the Bureau of Indian Education and yet, our facilities do not allow us to offer the full academic programs required of us.

We all know the answer is more money. I understand that money is scarce but rather than look at our facilities as an expenditure we need to look at them as *investments*—investments in our future and in our children. Without a commitment to our future we will never have the willpower to ensure that every Indian child has the same opportunity as any other child in this country. At the very least, this is an issue of fairness and at the very most it is a moral issue.

Our staff is getting very adept at making do with less. It would be nice if we didn't have to. About a week ago, after ceiling tiles crashed to the floor (thankfully no child was injured), I was inspecting the facility with our maintenance director. When I peered through the hole I was appalled. My maintenance director just chuckled and said "old Indian trick." He was referring to pipes being held together with duct tape and bailing wire. It is sad to think that this is not the exception but the norm in Indian Country. By the Bureau's own criteria only 39 percent of its school facilities are acceptable.

Since our elementary school was constructed 1965, a revolution has taken place in education: Computers have replaced/supplemented books; the Internet has replaced the encyclopedia. What was adequate 40 years ago is not today. These old buildings were built when there were no computers and as such, their electrical systems can not handle computers in classrooms and computer labs in classrooms. Plus, adding cabling to these old buildings runs the risk of disturbing the asbestos that infests them.

Sometimes you just can't wait for your name and number to come up on the school construction priority list. This January, Rough Rock opened the doors to our new high school library. I want to thank OFMC and Congress for providing us with this much needed educational facility. They recognized the drastic need for our high school students and somehow found the money to build this essential education facility. We no longer are one of the few, if not only, high schools that did not have a library. It makes me very sad to think of how many high school students have passed through Rough Rock School over the past 42 years without the benefit of a library—a very basic educational support tool.

In Arizona, the public school system has invested millions upon millions to improve the state of their facilities. All around Rough Rock, public schools are building two story schools with gymnasiums bigger than those at many colleges. And yet, parents still choose to send their child to Rough Rock because they want their child to receive the type of educational program we offer. It is time that we offer our students the best facilities possible—not the largest gymnasiums—but the most up to date classrooms that are safe, dependable and adequate to ensure that no Bureau-funded school student is left behind.

My Recommendations

- Streamline the process so from start to finish it takes 3 years and not 8 years or more just to get funding appropriated, and 10 years before a facility can be constructed and occupied. Ten years means ten graduating classes!
- In order to speed up the process and reduce the backlog, I believe it would be beneficial to allow schools that are ready—such as Rough Rock—to move ahead of schools that are not. This would be an incentive for schools to move rapidly to complete a project in a timely manner, and also enable a school which is ready to benefits its students sooner rather than make them wait for a project higher on the priority list but slower on the progress scale.
- Encourage the use of standardized designs to speed up the construction process and more economically use the funds that are available. For example, we plan to use standardized plans for our dorm construction—with some "tweaking" to accommodate our local needs. Not only do we believe this is a sensible way to save money on design costs, it will also enable us to get the dorms built and occupied more quickly.
- Create the capacity for bureau-funded school to utilize bonding to build new facilities.
- Encourage that high-cost projects be funded in more than one phase—like Rough Rock is proposing in order to proceed at a faster rate.

Conclusion

On behalf of all Indian students, I thank you for looking into these troublesome construction backlog matters. I am happy to answer any questions the Committee has.

The CHAIRMAN. Mr. Roessel, thank you very much.

Now, we will hear from Ms. Valerie Davidson, the Senior Director of Legal and Governmental Services at the Alaska Native Tribal Health Consortium in Anchorage, Nebraska. She is accompanied by Mr. Rick Boyce.

STATEMENT OF VALERIE DAVIDSON, SENIOR DIRECTOR, LEGAL AND INTER–GOVERNMENTAL AFFAIRS, ALASKA NATIVE TRIBAL HEALTH CONSORTIUM; ACCOMPANIED BY RICK BOYCE, DIRECTOR, HEALTH FACILITIES SUPPORT

Ms. DAVIDSON. Thank you and good morning. We really appreciate this Committee's attention to the deplorable health positions as clearly evidenced by your great work in the passage of the Indian Health Care Improvement Act not only out of this Committee, but also shepherding it through the Senate and its transmittal over to the House.

Clearly, this Committee understands the deplorable health conditions, and we appreciate the attention that this Committee is giving to the status of the health facilities.

Today, I would like to be able to cover five topics very briefly: first, the state of Indian health facilities; second, the opportunities or innovation that are before us today; third, the other support needs that go into maintaining existing facilities; fourth, the impact of the lack of funding of health facilities that they have on health disparities; and finally, fifth, the new prioritization system.

This Committee, of course, is very well aware from your questions earlier and your statements about the unmet need for health facilities. As you indicated earlier, if you add the $6.5 billion unmet need for primary care health facilities to the IHS's $2.65 billion, that is of course over $9 billion just for primary health care facilities.

You asked the question earlier, how much would an appropriate amount be? And clearly, if the unmet need is almost $10 billion, anything less than $1 billion a year is simply unacceptable.

The average age of the IHS facility as indicated earlier is about 33 years, but some facilities we know are over 40 years to 66 years. Even a really new hospital like the Alaska Native Medical Center in Anchorage is over 10 years old and it is considered one of the brand new facilities in Indian Country. But the typical IHS facilities are old. They are dilapidated. They are in very, very poor condition. The Nome Hospital, for example, was constructed in 1948 with an addition in the 1970s. The replacement for that facility has been on the IHS priority list since 1991. Another facility in Barrow was constructed with wood frame construction in 1964 and it has also been on the priority list since 1991.

In addition, though, to the simple inpatient facilities, there is also a great need in other parts of the Country that don't even have hospitals at all. For example, the Portland area, which represents Washington, Oregon and Idaho, and the California area, there are no inpatient hospital facilities at all. None. And necessarily, they are contract health-dependent. Even though we have seen a shift in population to the west coast and the east coast of the United States, there are virtually no inpatient hospital facilities on either coast.

With regard to health clinics, there are some examples of health clinics that are, for one, on the Colville reservation that is over 70 years old. Also on page six of the written testimony that we have provided, you can see an example of the clinic in Nukduk, also known as Newtok, which has no running water, and you can imagine providing health care in a facility where you may have an

emergency blood and there is no running water. You can imagine the sanitation problems and the health issues that that causes.

The other, though, is that so clearly there is a huge unmet need across Indian Country, and I think you are well aware of those. That said, there tremendous opportunities for innovation development, specifically with regard to the Joint Venture Program, the Small Ambulatory Clinic Program, and a new recommendation from the Facilities Appropriations Advisory Board which is the Area Distribution Program.

You are familiar probably with the Joint Venture Program and the Small Ambulatory Program. With regard to the Area Distribution Program, though it was recommended by the FAB, it provides a methodology for allocating funds to each area office to address the highest priority projects in each area. The great thing about that program is it can also be used to match other local, State and private funds to complete a project that would take many more years if only IHS funds were used.

Now, that said, there is some disagreement across Indian Country with regard to that program, and some areas have expressed concern about projects identified back in 1991 that remain on the priority list. They question whether the area distribution fund may dilute the facilities appropriation and further delay funding for those existing projects.

What we do know, though, is that the Joint Venture and Small Ambulatory Clinic Program funding lines have been in place on the facilities appropriation and Congress has continued to provide funding for other facilities, along with the funding of individual projects on the priority list. We would ask Congress to continue that practice with the Area Distribution Program.

So that gives you a little bit of the opportunities for innovation. However, one of the things that we would be remiss is if Congress and tribes and the IHS spend all of these resources to getting these facilities built. That is only half the equation. The other half is all of the efforts that need to be undertaken to be able to make sure that those facilities continue to be viable. Those includes funds for medical equipment replacement, facility and environmental support funding, maintenance improvements, and the Village Built Clinic Program.

As one example, the medical equipment replacement fund, medical equipment should be replaced every six years. Right now with the current funding mechanism, the only funding that is provided would mean that that medical equipment couldn't be replaced for 18 years. So a baby born into the hospital has the prospect of coming back as an 18 year old adult and seeing that same medical equipment. Clearly, that is a health safety issue that cannot be tolerated.

Unfortunately, what happens is that tribes are often forced to divert direct patient care dollars into upgrading that medical equipment. It just doesn't make any sense.

The facility and environmental support funding obviously pays for maintenance staff and basic operation of health facilities including utilities. We are at a time in many parts of the Country and Alaska in particular, we are paying over $5 a gallon for heating oil.

The line item for this amount has remained flat, and in fact we are actually taking a back step in the proposed 2009 budget.

One of the things that happened is that although in Fiscal Year 2009, the President's budget proposes no change from 2008, what it actually does, if you look into the details, is it allocates $25 million out of the base funding for staffing and operational cost of new facilities that are coming online in 2009. So in addition, what that really means is that we have experienced, even though the budget shows flatline, we have experienced a $25 million net loss.

The other is of course maintenance and improvement funds. There is a $371 million maintenance and improvement backlog. It is embarrassing and quite simply it is unacceptable. The Village Built Clinic Lease Program has seen no significant improvement since the program was authorized. We estimate that it takes at least another $5.8 million to be able to meet the need.

Now, once you have that unfortunate bleak picture, let's talk about the real life impact on health disparities. The biggest impact obviously, as you identified earlier, is the decrease in access to care, which of course exacerbates already the health disparities that know exist. The things that we haven't even talked about are the needs for long-term care, including skilled nursing in assisted living facilities, residential alcohol and substance abuse facilities, and the huge unmet sanitation facilities.

Right now, we know that American Indians and Alaska Natives suffer from alcoholism and substance abuse challenges more than any other population. Right now, we have people who are lucky if they only have to wait for six months to be able to get into a residential treatment program. Using Alaska as an example, one in eleven Alaska Native deaths is alcohol induced. Alcohol contributed to 85 percent of reported domestic violence cases, 80 percent of reported sexual assault cases between 2000 and 2003, and suicide among Alaska Natives remains at two times the national average. These are almost all alcohol-related. We have people who are ready to get help, who are ready to get into treatment programs and there are not sufficient facilities to be able to meet that need.

We know that also on the inpatient side when facilities are unavailable, entire areas become dependent upon contract health. When facilities are not adequately funded, these funds will necessarily come out of funds that were originally intended for direct patient care, which we know is already grossly under-funded by about 50 percent, like the replacement of medical equipment. Chronic lack of funding also contributes to the lack of facilities, overburdening of other budget line items, and rationed health care on a systemic level.

But finally, I wanted to congratulate the Facilities Advisory Appropriations Board, as well as the IHS, who have worked over the last eight years on developing a new facility priority system that was sent out numerous times through extensive consultation. You can read the last about seven or eight pages of my written testimony to get more detail there.

In conclusion, we just wanted to let this Committee know that we know from experience, unfortunately, that as resources get tighter, individual American Indians and Alaska Natives and the

facilities that provide their care, are going to feel the impact more than any other.

As I said before, the funding really should remain in the billions. The real life task that we have to ask ourselves is not how much we do and how much the need is, but at the end of the day if individual American Indians and Alaska Natives don't get the access to the care they need, then we have collectively failed them miserably. Alaska Natives and American Indians deserve so much more than that.

We appreciate the attention that this Committee has provided to highlight some of those issues.

Thank you.

[The prepared statement of Ms. Davidson follows:]

PREPARED STATEMENT OF VALERIE DAVIDSON, SENIOR DIRECTOR, LEGAL AND INTER-GOVERNMENTAL AFFAIRS, ALASKA NATIVE TRIBAL HEALTH CONSORTIUM; ACCOMPANIED BY RICK BOYCE, DIRECTOR, HEALTH FACILITIES SUPPORT

Good morning, Chairman Dorgan, Vice-Chair Murkowski and Members of the Committee. Quyana (thank you) for the opportunity to testify today about the state of Indian health facilities.

I was privileged to work for seven years for the Yukon-Kuskokwim Health Corporation, the tribal health program that serves 58 federally-recognized tribes in a region roughly the size of Oregon, of which Bethel is the hub. I am now honored to work for over 2 years for the Alaska Native Tribal Health Consortium, a statewide tribal health program that serves all 229 tribes in Alaska, co-manages with Southcentral Foundation the Alaska Native Medical Center (ANMC), the tertiary care hospital for all American Indians and Alaska Natives (AI/ANs) in Alaska, and carries out all non-residual Area Office functions of the IHS that were not already being carried out by Tribal health programs as of 1997. With me today is Rick Boyce, Director of Health Facility Support, for the Alaska Native Tribal Health Consortium. Mr. Boyce also serves as the Alternate Alaska Representative to the Facilities Appropriations Advisory Board.

The deplorable health status of AI/ANs is clearly understood by this Committee as evidenced by your commitment to modernizing the Indian Health System through your recent efforts to advance the Indian Health Care Improvement Act (IHCIA). We thank the Committee for your efforts in highlighting the unmet needs in Indian Country and congratulate you on your successful passage of the bill in the Senate and its transmittal to the House.

We look forward to the day when we can take advantage of these modern advances. In the meantime, we know that in order to make headway on health disparities, we need to put adequate resources toward improving access to care. In addition to providing resources for direct care, we also need to focus our efforts and resources on building facilities where they do not exist, and improving facilities that are in disrepair because the maintenance and improvement needs have not been sufficiently funded.

For those of you who have not visited Indian country or seen a tribal health facility first hand, I will try to paint a picture. It will be incomplete. It is impossible to understand the diversity and challenges faced by Tribes without visiting a number of them. However, not everyone can visit. So today, I hope to help you understand why adequate health facilities are so important to the Indian health system.

The stories I will tell you come from my experience in Alaska, and from the experience of other tribes across the country, where tribal members experience the same difficulties accessing health care, and tribal governments and clinics experience the same pain of having to deny health care to people in need because there just isn't enough money to pay for it, and because there are just not enough resources to provide adequate facilities.

We specifically recommend that Congress adequately fund the full range of facility construction and operational needs, including primary health care needs, Long-Term Care Skilled Nursing and assisted living facilities, residential alcohol and substance abuse facilities, and our huge unmet sanitation facilities needs.

I. The Indian Health Service System

The Federal Government has a duty—acknowledged in treaties, statutes, court decisions and Executive Orders—to provide for the health and welfare of Indian

Tribes and their members.[1] In order to fulfill this legal obligation to Tribes, it has long been the policy of the United States to provide health care to American Indians and Alaska Natives through a network made up of the Indian Health Service programs, tribal health programs and urban clinics.

The Indian Health Service (IHS), directly and through tribal health programs carrying out IHS programs under the Indian Self-Determination and Education Assistance Act, Pub. L. 93–638, as amended (ISDEAA), provides health services to more than 1.9 million American Indians and Alaska Natives. We are members of 562 federally-recognized tribes in the United States, located in 35 different states. According to the IHS, these services are offered from the following facilities:[2]

	IHS Directly Operated	Tribally Operated
Hospitals	33	15
Health centers	54	229
Health stations	38	116
Alaska Community Health Aide (CHA) clinics	0	162

There are also 34 urban Indian health programs funded by IHS under Title V of the IHCIA that provide care to approximately 600,000 AI/ANs.[3] When health care cannot be provided through these facilities, IHS and tribal programs use funding to purchase "Contract Health Services" from providers outside of the IHS system.

The number of facilities does not really tell the story though. The Indian health system is a real system of care. It is reflected in the IHCIA, which addresses health provider workforce issues, and a full range of health care services from preventive health care services to critical inpatient care, from prenatal care and deliveries to services needed at the end of one's life.

The IHCIA also encompasses services that have been woefully inadequate or simply unavailable like nursing home services and behavioral health, including a continuum of mental health and substance abuse services. In addition, the IHCIA addresses those critical infrastructure issues that are so easily overlooked when a suffering patient and her family require immediate attention—the facilities that are needed to provide this vast array of services and basic public health services like safe water and sanitation.

There is a desperate need for additional resources even with reliance on supplemental funding through Medicaid, Medicare and SCHIP. The system simply cannot remain viable without adequate facilities.

II. State of Indian Health Facilities

The unmet need for health facilities for the IHS and tribal health system is $6.5 billion. This includes only the highest priority need for inpatient hospitals, health centers, staff quarters, and youth regional treatment centers. It does not include adult treatment centers, residential long-term care facilities, nor sanitation facilities, which are sorely needed.

Currently, the average age of an IHS facility is 32 years. Even more startling is that there are 17 installations throughout the IHS where the facility age is between 40 and 66 years.

The state of individual health facilities in Indian Country varies greatly. They range from a few "newer" health facilities to the more common old, poorly maintained facilities that are in desperate need of repair. Even more striking is that entire IHS Areas do not have certain kinds of health facilities at all.

An example of a newer inpatient hospital facility is the Alaska Native Medical Center (ANMC), jointly operated by Southcentral Foundation and ANTHC. Although it was constructed over ten years ago, it is considered a very new facility in the Indian Health System. The planning documents for this facility were completed 10 years before the facility was constructed. In the meantime, it languished on a very long "facilities list" along with other crucial but unfunded projects. The ANMC facility is a significant improvement over the previous hospital that was constructed in 1953, but it is clear that the facility is not large enough to keep up with population growth. This is a common occurrence when limited construction funds

[1] *See* Federal Basis for Health Services, January 2007 (info.ihs.gov/Files/BasisForServices-Jan2007.doc).

[2] Indian Health Service Fact Sheet, IHS/OD/PAS January 2007 (info.ihs.gov/Files/IHSFacts-Jan2007.doc).

[3] Indian Health Service Year 2007 Profile, January 2007 (info.ihs.gov/Files/ProfileSheet-Jan2007.doc).

are available to meet the need for facilities that have been sitting for years on the IHS facility list.

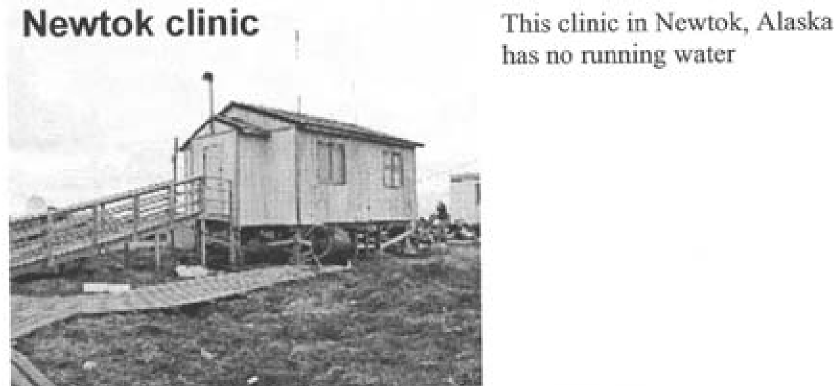
The more typical IHS inpatient hospital is old and dilapidated. For example, the Nome hospital was constructed in 1948 with an addition in the 1970s. A replacement facility has been on the IHS priority list since 1991. Another Alaskan facility, the Samuel Simmonds Memorial Hospital in Barrow was constructed with wood frame construction in 1964. Although wood framed buildings are short-lived, the Barrow hospital has been on the IHS priority list since 1991.

This hospital in Barrow, Alaska has been on the IHS facility list since 1991 and is in desperate need of replacement.

Some areas, like the Portland Area (representing Washington, Oregon, and Idaho) and the California Area, have no inpatient hospital facilities at all. Because there is no hospital for AI/AN patients in their respective IHS Area, these facilities depend on Contract Health Services (CHS) funds. In fact, despite the population shifts to the west and east coasts of the United States, there are very few IHS inpatient hospitals in the western United States. Likewise, there are very few IHS inpatient hospitals located on the east coast. There is clearly a need for additional inpatient hospitals.

Like inpatient hospitals, health centers are also in various stages. For example, health clinics in the Portland Area are an average of 40–50 years old. One clinic on the Colville Indian Reservation is over 70 years old. Other clinics in the Portland Area make do with mobile homes.[4]

[4] Testimony of Linda Holt, Chairperson, Northwest Portland Area Indian Health Board, before the Senate Finance Committee, March 22, 2007.



This clinic in Newtok, Alaska has no running water

The continuing "pause" on facility construction has delayed attempts to address the aging health care facilities within the IHS system. We strongly recommend that Congress appropriate more resources for the construction of desperately needed health facilities and to take advantage of other opportunities for innovation. At a minimum, we recommend that the 2010 budget restore funding to $93.6 million, allowing the IHS to replace its high priority healthcare facilities with modern facilities, and to significantly expand capacity at its most overcrowded sites.

III. Innovations in Facility Development

We have seen the benefit of pursuing and leveraging additional resources in the construction of sanitation facilities. Between 1986 and 1990 project contributions from other sources to IHS sanitation facilities construction projects averaged $55.7 million annually. After the Sanitation Deficiency System (SDS) was established, annual average contributions for the five years following (1991–1995) averaged $105.6 million.[5] This resulted in a $50 million annual increase in contributions from other sources. Thus, contributions almost doubled as a result of SDS.

We anticipate that these same opportunities can be replicated in making additional resources available to address the unmet need for health facilities by increasing appropriations for two successful programs and providing additional resources to implement the FAAB recommendations. Because of the limited amount of funds available for health facility construction, tribes worked with Congress to develop two innovative programs, the Joint Venture Program (JV) and the Small Ambulatory Program (SAP), to leverage other funds to get projects completed. Another opportunity yet to be realized is the FAAB's recommendation for the Area Distribution Program.

Tribes have built approximately three times more health care space than the IHS has been able to with limited funds through the Joint Venture Program and the Small Ambulatory Program.

The *Joint Venture* program was developed to help assist tribes with their unmet facilities needs. This competitive program provides the medical equipment funds and the complete staffing package for a selected facility that is constructed with tribal resources so long as it meets IHS planning requirements.[6]

The *Small Ambulatory Program* (SAP) also assists tribes with their unmet facilities needs. This competitive program provides the construction funds, facility maintenance costs, and medical equipment costs, while the tribe provides the staffing package.[7]

One recommendation from the FAAB is the creation of an *Area Distribution Program* (ADP). The ADP is intended to provide funds to each IHS area to fund projects on the national priority list that are high priorities for the Area but don't

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[5] The Indian Sanitation Facilities Act, P.L. 86–121, authorizes the IHS to provide essential sanitation facilities, such as safe drinking water and adequate sewerage systems, to Indian homes and communities.

[6] The Joint Venture program was enacted as an amendment to the IHCIA under Section 818 and authorizes Congress to appropriate recurring funds for increased staffing, operation and equipment for new or replacement facilities constructed with non-IHS funding acquired by tribes.

[7] The Small Ambulatory Program is only available to tribes who contract or compact to operate a facility under the Indian Self-Determination and Education Assistance Act, Pub.L. 93–638.

rank high enough to receive direct Congressional funding in the near future. Thus, it provides a methodology for allocating funds to Area Offices to address the highest priority projects within the Area. These funds can be used to match other local, state, and federal funds to complete a project that would take many more years to complete if they were limited to using IHS funds.

The ADP would be initiated only when Congress appropriates funds for this purpose, the fund would be another line item in the facilities appropriation just as Joint Venture, Small Ambulatory Clinic, Dental, and Priority List Construction are separate line items now.

The ADP proposal would require these funds to be distributed to the highest priority Area Office facilities where the Area and Tribes agree that only limited new staffing is required. Upon completion of ADP projects, the facility will be allocated only about 40 percent of the additional staffing and operational funds usually allocated to new facilities. As proposed by the FAAB, the ADP funds would be allocated as follows:

- In a given year, the Area Offices may not participate in the ADP if the line-item amount in the Facilities Appropriation exceeds 20 percent of the total appropriations for facilities construction.
- Those Areas that receive 20 percent or less of the annual line-item facilities appropriation are allocated a portion of the Area Distribution Program funds using a formula based on Area user population and location cost adjustments.

The benefit of this process is every IHS Area is able to participate. Other matching funds can be used to build, renovate, and expand a facility; and some staffing is provided. Each Area can complete a high area priority project, and M&I funds can now be used for code and infrastructure type projects like boilers, chillers, pumps, air handlers and life-safety code issues. More projects addressing the overall unmet needs are completed more quickly and at a lower costs since non-IHS partners like private foundations and other granting agencies contribute funding for some of the staffing and/or construction costs.

Some Areas have expressed concern about projects identified back in 1991 that are now on the national priority list. They question whether the Area Distribution Funds may dilute the facilities appropriation and further delay funding for their projects. However, the Joint Venture and SAP funding lines are already in place on the facilities appropriation and Congress has continued to provide funding to these programs along with funding individual projects on the priority list. We ask that Congress continue this practice with the Area Distribution Program so that it provides another option for Congress to allow more tribes to participate in what has been a closed priority system since 1991.

There have been 7 Joint Venture projects and 27 Small Ambulatory Program projects awarded since 1998. The JV program and the SAP are examples of the best available opportunities to leverage funds to get desperately needed facilities constructed in Indian Country, but the funds available have been very limited. We recommend that Congress increase Joint Venture funding and Small Ambulatory Program funding and add new appropriations for the Area Distribution Program to accelerate the completion of needed facilities.

IV. Facility Operational Needs

When addressing facility needs, it is important to look beyond new construction. In order for existing facilities to remain functional and provide maximum use, it is also important to adequately fund Medical Equipment Replacement, Facility and Environmental Support Funding, Maintenance & Improvement and the Village Built Clinic Lease Program. Adequate funding for these programs will ensure that the facilities we build today will be available for continued use into the future. Thus, we recommend adequate funding for these needs as more specifically described below.

A. Medical Equipment Replacement

In order to assure patient safety, medical equipment should be replaced on an average of every 6 years. Unfortunately, current funding levels cover only one-third of the level of need. Thus, equipment that should have been replaced after 6 years may continue to be used for 18 years or longer. Medical equipment maintenance and replacement presents obvious patient safety issues, and some tribes may divert funds from direct patient care to make up this gap.

The annual medical equipment funding is $21.3 million, when the annual need is actually $64 million. We urge Congress to increase IHS appropriations to this line item to ensure that neither patient safety nor direct patient care is compromised.

B. Facility and Environmental Support Funding

Facility and Environmental Support (FES) funding provides for the maintenance staff and basic operations of health facilities, including utilities. These funds also pay for Area office programs, like core staffing for health facilities, environmental health, and sanitation construction.

The level of funding has stayed relatively flat or received small increases (less than 2 percent). With the rising cost of salaries and double digit annual increases in energy costs, this funding line is not keeping pace. In fact, the FY09 President's budget proposes no change from FY08 even though it allocates $25 million out of the base funding for staffing and operational costs for new facilities opening in FY09. Historically, new funds were made available to meet these additional FES costs for new facilities in addition to any necessary nationwide programmatic increases. However, the effect of the President's FY09 budget recommendation is that new facility needs are being funded at the expense of existing programs.

We recommend that Congress increase this appropriation by $4.2 million annually to meet the current national need. We also recommend that Congress appropriate an additional $25 million recurring need for new staffing requirements associated with new facilities opening in FY09.

C. Maintenance & Improvement

Maintenance & Improvement (M&I) funds are used to maintain facilities so they can continue to be used in the future. Unfortunately, the level of M&I funding is substantially lower than what is needed. It is estimated that the base M&I funding needed to just sustain the facilities in their current condition should be funded at $80 million annually. Because funds have not kept pace with the need, there is a tremendous backlog of maintenance needs. The IHS estimates $371 million is needed just to get caught up. The FY08 M&I funding level of $52.9 million is grossly insufficient to sustain the facilities. It fell far short of the estimated $120 million needed to address the backlog.

Failing to maintain existing facilities will only hasten the need for new construction. Health programs with existing facilities have tremendous and growing maintenance and improvement needs especially those with older facilities. We recommend that the Maintenance and Improvement appropriation be substantially increased to sustain existing facilities and to address the $371 million backlog of maintenance and improvement issues.

D. Village Built Clinic Lease Program

The Village Built Clinic (VBC) Lease Program funds rent, utilities, insurance, janitorial, and maintenance costs of healthcare facilities in rural Alaska communities.[8] Despite an increase in the number and size of clinics throughout Alaska as well as the rapidly increasing fuel costs, funding for the VBC Lease Program has barely increased since 1996. Village clinics have also incurred more costs in recent years due to increases in the scope and level of medical services provided, expanded village healthcare programming, new technology, and accreditation standards. Current lease funding covers only approximately 55 percent of the current operating costs and those costs are expected to continue to increase sharply as energy costs continue to skyrocket in rural Alaska.

Without additional funding for the VBC Lease Program, Alaska villages are forced to subsidize the day-to-day operating costs of their clinics and defer long term maintenance and improvement projects. Therefore, without an increase in funding to the VBC Lease Program, village clinics will be increasingly forced to reduce clinic operations, and these clinics will continue to fall into disrepair. This situation reduces the health care available locally to village residents and threatens the almost 200-million-dollar investment in these facilities by the Federal Government, Alaska villages, and the regional tribal health organizations in the Alaska Native health care system.

Thus, we recommend an increase of $5.8 million in funding for the VBC Lease Program to the current program base of the VBC Lease Program. These funds are required immediately to sustain the program, covering the expected operating costs in FY09 as well as establishing funding for long-term maintenance and improvement. Without this funding, many of Alaska's villages will not be able to continue supporting local clinics, eventually leading to serious consequences for the health and safety of Alaska Native people.

[8] Reprinted from The Village Built Clinic Programs: Village Clinics in Crisis, Alaska Native Health Board, May 2007.

V. Impact of the Lack of Funding for Facilities & Facility Operational Needs

The biggest impact of inadequate facilities is decreased access to care, which in turn exacerbates health disparities. While we have provided a snapshot of the unmet primary health care needs, we would be remiss if we did not highlight for the Committee the lack of other types of facilities like Long-Term Care, Skilled Nursing and assisted living facilities, residential alcohol and substance abuse facilities, and our huge unmet sanitation facilities needs.

Most AI/ANs do not have access to Long-Term Care services, including skilled nursing and assisted living services. For example, in the Alaska Tribal Health System which has a relatively comprehensive range of services, there are currently no assisted living facilities and only one long term care skilled nursing facility. Public health measures, such as childhood vaccinations and improved sanitation in rural Alaska, have increased the life expectancy of Alaska Natives and we are now living longer than we ever have. From 1950 to 1997, Alaska Native life expectancy rose from 46 years of age to 68 years of age.[9] As our population is aging, there are no facilities to provide desperately needed community-based health care. For instance, if I were an elder living in Bethel, Alaska, and my family could not provide the medical care I needed at home, I would have to be sent to a nursing home in Anchorage, hundreds of miles and hundreds of dollars away from my family, community, and culture in order to get the care I need. Our elders make the daily choice to forego this care because such a separation is unconscionable in our communities. Unfortunately this situation occurs throughout the Indian health system because there are only a handful of long term care facilities to meet this need.

Many AI/ANs still do not have access to behavioral health services despite the clear need. An integrated health system requires availability of qualified and trained behavioral health providers in every community. Prevention and treatment approaches to behavioral health must be provided in a seamless integrated fashion, use best and promising practices; and they must start at the community level. The full implementation of this vision is only possible with resources that ensure services are available in the right place and the right time to prevent escalation of the need for more intensive and costly services.

Specifically, there is an overwhelming shortage of residential alcohol and substance abuse facilities for AI/AN throughout the country. Without sufficient facilities to meet this need people continue to be turned away at the door of existing residential treatment programs or wait listed for extended periods of time at the crucial moment in their addiction where they acknowledge they have a problem and are seeking help. Unfortunately, the current reality is that AI/ANs who need residential alcohol and substance abuse services, can expect to wait 6 months to a year for services. For many, treatment is simply not available. The consequences are profound. Again, to use Alaska as an example, 1 in 11 Alaska Native deaths is alcohol-induced;[10] Alcohol contributed to 85 percent of reported domestic violence cases and 80 percent of reported sexual assault cases between 2000–2003;[11] and, Suicide among Alaska Natives remained steadily at 2 times the non-Native rate from 1992–2000.[12] Many AI/ANs still do not have access to behavioral health services facilities despite the overwhelming need. An integrated and modern health system requires not only the services but the facilities in which to provide those services.

Inadequate sanitation continues to plague much of Indian Country and is especially problematic in Alaska where 26 percent of Alaska Native homes lack adequate water and wastewater facilities. It is 2008 and, despite the fact that we know that people live longer, healthier lives in communities with water and sewage systems, there are over 6,000 homes in rural Alaska without safe drinking water and about 14,000 homes that require upgrades or improvements to their water, sewer, or solid waste systems to meet minimum sanitation standards. Increased sanitation facilities will improve these statistics and the health of these communities, as well as contribute to increasing the Alaska Native life expectancy, as discussed previously.

Funding for these services have been sorely lacking even though we know that improvements in these areas can result in significant improvements in health status. For example, infants in communities without adequate sanitation facilities are

[9] Status of Alaska Natives Report, Institute of Social and Economic Research, 2004.
[10] Alaska Bureau of Vital Statistics.
[11] Status of Alaska Natives Report, Institute of Social and Economic Research, 2004.
[12] Alaska Bureau of Vital Statistics.

11 times more likely to be hospitalized for respiratory infections and 5 times more likely to be hospitalized for skin infections when compared to all U.S. infants. [13]

In addition, the lack of facilities also increases costs to other IHS budget line items. For example, tribes who are served in an IHS area in which there is no hospital to refer patients to are become dependent on Contract Health Services (CHS) resources and pay private facilities premium rates for care that is too often culturally insensitive. The CHS line item is already substantially under-funded without adding facilities inadequacies into the equation. In order to provide necessary patient care, IHS and Tribal providers are forced into "robbing Peter to pay Paul" in life and death situations. We also know that when facility needs are not adequately funded, these funds necessarily come out of direct patient care dollars especially when life-safety issues are involved, like the replacement of medical equipment. Chronic under-funding of the IHS facilities line items contributes to the lack of adequate facilities, the overburdening of the other budget line items, and rationed health care on a systemic level.

VI. Efforts to Update the Healthcare Facilities Construction Priority System

In FY 2000, Congress recognized the significant and growing unmet facility needs, and directed the IHS to consult with Tribes and the Administration to revise the Healthcare Facilities Construction Priority System (HFCPS). Congress highlighted the need "to reexamine the current system for construction of health facilities" and to develop "a more flexible and responsive program.that will more readily accommodate the wide variances in tribal needs and capabilities." [14]

Over the course of 8 years, the IHS, working with tribal leaders, undertook a major overhaul of the facilities priority system. Although the resulting proposal is a vast improvement over the current process, it has not yet been implemented by the IHS. We describe the planning process and resulting system below. We recommend that Congress direct the IHS to implement this new system and that Congress provide additional appropriations to ensure the new system is fully effective.

In early 2001, the Facility Appropriations Advisory Board (FAAB) [15] established an IHS Facility Needs Assessment and Priority Criteria Workgroup (Workgroup) to develop specific recommendations to improve the IHS construction priority system. The Workgroup, comprised of 19 tribal leaders, health directors, planners, urban health directors and regional tribal associations, worked on specific recommendations regarding:

- Criteria to be used for establishing and annually reviewing the need for facilities construction need in Indian Country;
- Criteria (and their relative weight) to prioritize competing projects of the same type; and
- Strategies for prioritizing needs of different construction programs (inpatient facilities; outpatient facilities; dental units program; Joint Venture Program; Small Ambulatory Program; the proposed Loan Guarantee Program; etc.).

The Workgroup's recommendations, IHS Facility Needs Assessment and Priority Criteria Recommendations, were forwarded to the FAAB and to the IHS in February, 2002 and became the foundation for the final recommendation for the new priority system. [16]

The FAAB spent the next two and a half years refining the Workgroup's recommendations. Extensive tribal consultation began in June 2004 when the IHS sent out a "Dear Tribal Leader" letter in June 2004 with a draft copy of the FAAB priority system proposal. The IHS received 80 responses from 11 IHS Areas containing over 1,200 total comments. The FAAB spent the next two years incorporating comments and working with IHS and tribal leaders on the final recommendation. The final recommendation was forwarded to the U.S. Department of Health & Human Services in November, 2007.

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[13] Impacts of Water and Sewer Service on the Health of Infants, American Journal of Public Health, In Press, May, 2008.

[14] Conference Report, H.R. 2466, FY00 Interior Appropriations, Congressional Record—October 20, 1999.

[15] The 14 member FAAB is comprised of a tribal representative of each of the 12 IHS Areas plus 2 IHS members.

[16] IHS Facilities Needs Assessment and Prioritization Criteria Workgroup Report on Findings and Recommendations, February, 2002.

VII. The New Healthcare Facilities Construction Priority System

The new Healthcare Facilities Construction Priority System (HFCPS) is more robust than the current system in that it is very orderly and uses reliable data. It is also based on the master plan concept which ensures that service needs of the local population are used for facility planning. It also provides for a tremendous amount of tribal involvement throughout all phases of the process. Among the highlights are the development of a Master Planning process that recognizes the needs of smaller communities, and an Area Distribution Program.

A. Area Health Services and Facilities Master Plan (Area Master Plan)

The Master Planning process is central to the new priority system. Using the IHS "Health System Planning" (HSP) software/model, the services and facilities required in individual service areas are determined nation-wide. Based upon these community-specific or service area specific HSP analyses, a community specific Master Plan would be generated to quantify the costs associated with the potential construction of expanded, replaced or new facilities.

From there, these data can then be integrated at the Area level to produce a State-wide Health Services and Facilities Master Plan. A Master Plan will help establish relative priority within an Area for construction and development of new services and support decision-making consistent with the Area-wide service delivery system, which in turn, will provide the basis for an integrated Area-wide Master Plan.

The key to this approach to master planning is facility planning and construction decisions will be based on accurate factual information about the system-wide health service needs in each Service Unit and Area. As the area wide service delivery plan is developed decisions will be made about where and how each service will be provided. Then, the discussion will move on to deciding what the facility need is and how best to meet the need. Effectively, tribes engage in an analysis of whether renovation and expansion of an existing facility or whether construction of a new facility is warranted and what will best serve their population's needs.

B. HFCPS Ranking Methodology

Once the facility requirements of each area have been identified in the Area Master Plans, these projects will then be scored according to the HFCPS. The HFCPS ranking is implemented in two phases. Phase I is designed to assess all of the facility needs through the creation of the Comprehensive National Listing of Facility Need (Unmet Needs List). Phase II is designed to further refine the application and allow innovative solutions to be applied to the scoring criteria. This two-phased process allows the IHS and the Tribes to use limited resources to both identify all of the facility needs (phase I), and to allocate the necessary time and resources for concentrating analysis on those facilities that have the opportunity to move forward to receive full funding within 5 years.

1. Process Overview

In Phase I, all health care facilities in IHS Area Healthcare Services and Facilities Master Plans are evaluated and scored by IHS Headquarters using a HFCPS formula. Facilities on this list are categorized according whether they are an inpatient hospital, health center, small clinic, or other health facility, ranked and compiled into the "Comprehensive National Listing of Facility Need."

In Phase II, facilities selected from the Comprehensive National Listing of Facility Need are reviewed by the HFCPS Validation Committee.[17] The IHS will apply the HFCPS Phase II Formula to data about these proposed facilities to develop the Priority List. Facilities are selected from the Comprehensive National Listing of Facility Need. The method for selecting facilities for Phase II review differs based on the requirements of the specific facilities construction funding program.

Six evaluation factors are employed to evaluate and score facility projects over two phases. The evaluation criteria are:

	Phase I	Phase II
• Facility Resources Deficiency	400 points	400 points
• Health Status	200 points	200 points
• Isolation	100 points	100 points
• Barriers to Care		50 points

[17] The Healthcare Facilities Validation Committee is a standing committee consisting of seven individuals appointed by the Director of IHS. Membership may include but not be limited to IHS Headquarters and Area Offices, Tribal, and other health oriented professionals.

	Phase I	Phase II
• Facility Size • Innovation	150 points	150 points 100 points
Total	850 points	1,000 points

2. Implementation of Phase I

Implementation of Phase I should take approximately 6 months. Phase I scores will be recalculated every five years to maintain a relatively up-to-date Comprehensive National Listing of Facility Need. All Area Health Services and Facilities Master Plans will be updated 24 months before Phase I is recalculated.

The data required for completion of Phase I are:

- User population from the IHS National Patient Information Reporting System;
- Existing facility size, age, and condition from the IHS Facility Data System;
- The following indicators from the Federal Disparity Index (FDI):
  - —The Birth Disparities Indicator,
  - —The FDI Percent of the population over 55 years old,
  - —The Composite Poverty Indicator, and
  - —The Disease Disparity Indicator
- The distance from the proposed facility to the nearest emergency room.
- The size of the new/expanded facility from the Area Master Plan

Validation of the data used is obtained from existing IHS databases or will be verified by qualified professionals, e.g., certified professional engineers, architects, etc.

3. Implementation of Phase II

The entire Phase II process should take approximately 1 year to complete. Phase II of the HFCPS will be recalculated every year that funding is available for one or more facilities construction program to assure an up to date list of high priority projects.

The Phase II list will reflect the changes in funding status of each project. The criteria for Phase II will be implemented and applied slightly differently for each of the congressionally authorized facilities construction programs.[18] The basic formula will remain the same, but other factors, identified in law and regulations, will be used to select projects for Phase II review. Data for the scoring is developed from the approved Program Justification Document (PJD).

For Validation purposes, each PJD is approved by the Director, Office of Environmental Health and Engineering. The HFCPS Validation Committee will review the documentation supporting Innovation and Barriers to Service proposals along with any Tribal facilities information that is not included in the Facility Data System (FDS).

The IHS applies the HFCPS formula to the approved and validated data. Finally, facilities under consideration, are prioritized according to their scores and placed on the Priority List in rank order.

Clearly the new process is based on more reliable data and improved needs based planning. It also allows greater tribal involvement throughout all phases of the process. We applaud the FAAB and the IHS on the development of the new model and implore them to implement it expeditiously. It is one more example of the opportunities in innovation that arise when the IHS and tribes work collaboratively in addressing our facilities needs. However, in order for the new system to be successful more resources are necessary. To realize the full potential of the new facilities priority system, and we urge Congress to provide such funding.

Conclusion

For those of you who deal with the size and complexities of a variety of appropriation needs a regular basis, the improvements we seek here may seem inconsequential. That could not be farther from the truth. As American Indians and Alaska Natives, we are a people with painful legacies of forced removal—to boarding schools,

[18] These programs include the line-item program authorized under Section 301 of the Indian Health Care Improvement Act (IHCIA), Public Law (P.L) 93–437; the Small Ambulatory Program, authorized under Section 316; the Joint Venture Program authorized under Section 818, etc.; and projects considered under the Area Distribution Program within each Area.

to cities, to faraway hospitals—and rampaging epidemics that disrupted families for generations. Despite this, we still have very strong ties to our communities.

We know from experience, that as resources get tighter, individual AI/ANs and the IHS facilities that provide their care will feel the impact more than any other. Why? The highest rates of unemployment are in Indian Country. We have some of the lowest income levels; some of the poorest health status; and we are primarily rural where access to care is a problem. There is a high cost of providing care, and a high cost of living where limited incomes get stretched even more. What this means is that, when our people do finally get the care they need, they have traveled farther with money they simply don't have, are sicker than the average person, and are seen in clinics/hospitals that have fewer resources than most other facilities in the country. Also, because of their rural nature, our facilities have a higher cost of providing care.

As one of the younger members of my Tribe, with the privilege and opportunity to work in our health programs, it is my duty to try to overcome this history and to assure that no AI/AN will have to make the choice to forego medical care due to a lack of facilities or to receive culturally insensitive care because we are buying care from others that we can provide for ourselves. It is my duty to be sure that we protect the health status improvements that have been made and that we accomplish more. We must leave a better health system for our children and grandchildren than we inherited. It is for that reason that I am here today to testify before you.

The strategies we are discussing today will authorize many important steps toward the goal of quality health care in our home communities and in ways that respond to our needs and respect our way of life. I know that we cannot knock down all of these barriers overnight, but these recommendations will make a significant improvement.

In closing, I want to thank the Committee again for all your work and leadership in addressing these critical issues.

Attachment

The Indian Health Service
Health Care Facilities Construction Priority System

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The Indian Health Service
Health Care Facilities Construction Priority System

I) Introduction

A) Overview

The Healthcare Facilities Construction Priority System (HFCPS) is the methodology that the Indian Health Service (IHS) uses to identify and prioritize the need for IHS and Tribal healthcare facilities. It is applied only to those facilities that are part of an IHS Area Health Services and Facilities Master Plan. The methodology determines need based on the size of the American Indian and Alaska Native population requiring access to services, hence the most significant factor in scoring and prioritizing need is a comparison of the size of the existing facility with the size of a facility required for the population. Other factors used to rank and prioritize need include:

- The population's health status,
- The isolation of the population
- the social and economic factors that hinder access to services at existing facilities,
- The size of the required facility (this factor increases the priority for smaller facilities), and
- A tribe's willingness to develop innovations for construction and/or operation of a facility.

This document provides an overview of the HFCPS methodology. The methodology formula is detailed in, Appendix II, "The Healthcare Facilities Construction Priority System Methodology," but will be implemented using an internet database. Following each application of the HFCPS, the formula (including the data, calculations and results for each facility) will be posted on www.dfpc.ihs.gov.

B) Background

In Section 301 of the Indian Health Care Improvement Act (IHCIA), Public Law (P.L) 94-437, the Congress directs IHS to provide a list of the highest priority facilities construction projects. In order to comply with this directive, IHS established the HFCPS in 1991. Other sections of the IHCIA enacted over the years have authorized a variety of other funding programs for healthcare facilities construction, including:

- The Joint Venture Program. Under this program, the IHS is authorized into enter into agreements with Tribes under which the Tribes agree to construct a facility and IHS agrees to provide staffing and operating funds.

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- The Small Ambulatory Program. Under this program the IHS is authorized to assist Tribes whose outpatient facilities meet certain requirements:
  - The facility must provide access for population of at least 500 users in a service area with more than 2,000 eligible Indians; and
  - The facility may not be part of a hospital campus.
  - Etc.;
- Other programs that have been authorized but not funded.

In addition to prioritizing projects for these authorized facilities construction programs, the HFCPS results may be used to allocate funds for other programs for which Congress may appropriate funds. One program specifically identified during the review of the HFCPS would distribute funds to Area Offices to address high priority projects within the Area.

In fiscal year 2000, the Congress directed IHS, in consultation with the Tribes, to review the HFCPS. Based on this directive, the IHS, with input from various Tribal and IHS workgroups, developed a revision to the HFCPS and presented it for Tribal comment. The discussions and consultation process generated many and diverse comments. While all of these comments could not be incorporated into this document, all were considered.

A. Scope of the HFCPS Methodology

The HFCPS methodology does two things:

- It provides a Comprehensive National Listing of Facility Need by identifying the total need for construction of IHS and Tribal healthcare facilities[1], and
- It provides a process for prioritizing that need for the authorized facilities construction programs.

The HFCPS is not intended to identify or prioritize the need for staffing and other resources, although the Congress usually provides an increase to the IHS recurring funding base when a facility is constructed.

The HFCPS does not identify or prioritize the need for staff quarters; however, this need is evaluated and addressed prior to requesting construction funding for a facility. If staff quarters are needed at a facility and if Congress appropriates

[1] Construction includes replacing, expanding and/or modernizing existing facilities and acquisition of new facilities.

funds for them, they are planned, designed, and constructed at the same time as the facility.

The HFCPS can only evaluate, identify, and prioritize facilities that are part of an Area Health Services and Facilities Master Plan and that are reporting statistical data to the IHS National Patient Information Reporting System (NPIRS).

II) Definitions

See, Appendix I, "Glossary" for definitions used in this document.

III) HFCPS Process

The HFCPS consists of two phases. In Phase I, all health care facilities documented in IHS Area Healthcare Services and Facilities Master Plans, are evaluated and scored by IHS Headquarters using the HFCPS formula. This scored listing is referred to as the Comprehensive National Listing of Facility Need. Facilities on this list are categorized according Table 10, "Facilities Categories, on page 13. In Phase II, facilities selected from the Comprehensive National Listing of Facility Need are reviewed by the HFCPS Validation Committee. Data from these facilities are applied to the HFCPS Phase II formula by IHS Headquarters to develop the Priority List.

The method for selecting facilities for Phase II review differs based on the requirements of the facilities construction funding program. For example, facilities selected for the Section 301 Priority List will be the highest scoring Phase I facilities on the Comprehensive National Listing of Facility Need; however, those selected for the Joint Venture Program will be the highest scoring facilities on Comprehensive National Listing of Facility Need, where the Tribe(s) is willing to construct a facility in return for operation assistance from IHS. See "Facilities Evaluated in Phase II" on page 13 for details on selection criteria for these and other construction programs.

Following each application of the HFCPS, the formula used (including the data, calculations and results for each facility reviewed) will be posted on www.dfpc.ihs.gov.

A) Explanation of Phasing

Implementing the HFCPS in two phases permits the IHS and the Tribes to use limited resources to review all healthcare facilities needs in Phase I, while concentrating analysis on the few facilities selected for Phase II.

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Phase I is less resource-intensive than Phase II because:

- The "Required Space" element of the "Facility Deficiency Factor" is estimated using a simple formula (see Table 2, "Phase I Required Space Formula") in Phase I, while a full application of the IHS Health System Planning Process (HSP) is used in Phase II.

- The "Innovation" Factor, which requires extensive resources to validate, is in Phase II only, and

- The "Barriers to Services" element, which requires extensive resources to validate, is in Phase II only.

In Phase I, the HFCPS methodology is used to rank all facilities based on the adequacy of the space available to provide access to services for the population. The adequacy of the existing space is determined by comparing the space available with the estimated Required Space for the population. The less adequate the space, the higher the Phase I score. Phase I results are reported as the "Comprehensive National List of Facility Need." The scores established in Phase I may not indicate the actual priority of a facility, but are used to identify facilities for a more comprehensive review and prioritization during Phase II.

In Phase II, the HFCPS methodology is applied to determine actual need for the highest scoring facilities selected from Phase I and to establish the priority of those facilities. This is done by comparing the space available with the actual space required for the population. Facilities identified as priority projects in Phase II are incorporated into the IHS 5-Year Planned Construction Budget which is used to request appropriations for construction funding.

B) The HFCPS Criteria

The HFCPS Methodology uses four criteria in Phase I and six criteria in Phase II (See Table 1, "HFCPS Evaluation Criteria and Weighting"). The weighting shown in Table 1 is the maximum that each criterion may add to the score. Weightings indicate the relative influence on the final score.[2]

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[2] The "Barriers to Service" and "Innovation" factors are not considered in Phase I because these criteria require significant resources to validate. They are included only in Phase II, when a limited number of facilities are evaluated.

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Table 1, HFCPS Evaluation Criteria and Weighting

Evaluation Criteria		Evaluation Criteria Value		Phase I Criteria Weighting		Phase II Criteria Weighting		Score
Facility Resources Deficiency		1	X	400	or	400	=	
Health Status		2	X	200	or	200	=	
Isolation/ Barriers to Service	Isolation	3	X	100	or	100	=	
	Barriers to Service	4 Phase II only	X	0	or	50	=	
Facility Size		5	X	150	or	150	=	
Innovation		6 Phase II only	X	0	or	100	=	
Maximum Possible Score			+	850	or	1000	=	(850 or 1000 Maximum)
Use this table by obtaining a value from the appropriate value from the tables listed below. Place that value on the appropriate row under "Evaluation Criteria Value." Complete the calculations to obtain a score for either Phase I or Phase II.				1. See 2. See Table 4, Calculating the Health Status Criterion Value 3. See Table 5, Calculating Isolation 4. See Table 6, Phase II Determining Barriers to Service 5. See Table 7, Facility Size Criterion Value Look up Table 6. See Table 9, Innovation Criterion.				

1) The Facility Resources Deficiency Criterion

The Facility Resource Deficiency Factor compares the existing size of a facility with the size required to provide access to healthcare services. Four pieces of data are needed to generate the Facilities Deficiency Factor. These are:

- The existing facility space in square meters (facility size)
- The facility age.
- The facility condition expressed in the cost to repair the facility.
- The cost to replace the existing facility
- The IHS User Population for the facility's service area.

The existing facility size, age and condition are used to calculate the "*Adjusted Existing Space*" for a facility. These data are obtained from the IHS Healthcare Facilities Data System (HFDS) data base. Tribes that do not participate in the IHS HFDS data base must provide this data, with documentation verified by a licensed professional (engineer, architect, etc.) For Tribes not participating in the IHS HFDS, size, age and condition data will be used as submitted in Phase I, but will be validated before used in Phase II. If there is a significant difference between data used during Phase I and the data validated during Phase II, a facility could be disqualified from Phase II. It will be re-ranked in Phase I based on the validated data.

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The cost to replace a facility is determined using the existing facility size and two factors in the IHS Cost Estimating System[3]:

- o unit cost based on facility type, and
- o a locality factor.

The value of each of the factors varies from facility to facility. It may also change from year to year based on economic conditions. The value used for each facility in a specific application of the HFCPS will be shown in the formula posted at www.dfpc.ihs.gov.

User population is used to estimate a facility's "Required Space" and is obtained from the IHS National Patient Information Reporting System (NPIRS). Only Tribes participating in NPIRS may participate in the HFCPS. In Phase I, required space is estimated using the formula in Table 2, "Phase I Required Space Formula," on page 6. In Phase II, required space is determined using the IHS HSP.

Table 2, Phase I Required Space Formula

		Base size		Population Increment				Phase I Required Space
Required Space	=	200 m^2	+ (	.8 m^2	X	user population	) =	

Table 3, "Calculating the Facility Deficiency Criterion Value," illustrates how the Facility Deficiency criterion will be calculated.

Table 3, Calculating the Facility Deficiency Criterion Value,

	Calculate the Facilities Resource Deficiency	Facility Resource Deficiency Value
Facility Resource Deficiency[4]	$= 1 - \left(\frac{\text{Adjusted Existing Space}}{\text{Required Space}} \right) =$	

2) Health Status Criterion

The Health Status Criterion provides an advantage in scoring to those locations with a low health status. The following four indices are incorporated as part of the Health Status Criterion:

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[3] The IHS Cost Estimating System unit cost is based on facility type and may change from year to year based on economic conditions. The locality factor is obtained from the Federal Budget Estimating System and may also vary from year to year based the economy. Both the unit cost value and the locality factor are determined using the historical record and data from nationally recognized, private sector construction estimating organizations, such as R.S. Means, Marshall and Swift, and the McGraw Hill Engineering News Record.

[4] See, Appendix II, "The Healthcare Facilities Construction Priority System Methodology" for details on developing the different elements of this formula.

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- o Birth Disparities Indicator (BDI),
- o Percent of the population over 55 years old (Pop>55),
- o Composite Poverty Indicator (CPI)
- o Disease Disparity Indicator (DDI).

Table 4, "Calculating the Health Status Criterion Value," illustrates how the Health Status criterion is calculated.

Table 4, Calculating the Health Status Criterion Value

Health Status Indicators from the FDI				Health Status Value
Birth Disparities Index	X	.25	=	
Percent of Population over 55	X	.25	=	
Composite Poverty Index	X	.25	=	
Disease Disparities Index	X	.25	=	
			+	
Total				Maximum of 1

3) Isolation Criterion

The Isolation Criterion provides advantage to those facilities where the population is isolated and does not have access to nearby healthcare services of any kind. It refers specifically to the amount of time it takes most people to get to a place where they can receive healthcare services. In the HFCPS, time is estimated using the distance to the nearest Level I, II, or III emergency room (Federal, Tribal or private sector)[5]. Table 5, "Calculating Isolation," illustrates how the Isolation Criterion value is calculated:

Table 5, Calculating Isolation

If the facility is:					Isolation Value
Less than 40 Km from an ER	Isolation	=	0	=	0
40-90 Km an ER	Isolation	=	Km to Alternatives ÷ 90 Kilometers	=	
More than 90 Km an ER	Isolation	=	1	=	1
Not on a road connecting to Federal or state highway	Isolation	=	1	=	1

[5] The nearness of an emergency room does not mean that this emergency room would be the primary access to services for IHS and Tribal patients. The availability of an emergency room is used as a measure of isolation because it is assumed that any place supporting an emergency room would have healthcare services available.

4) Barriers to Service Criterion

The ability to access health care may be difficult for reasons besides the distance to available services. Some IHS patients may find other hindrances to obtaining services in hospitals and clinics available to them. The Barriers-to-Care Criterion attempts to capture these situations by increasing the Priority Score by up to 50 points in Phase II. Information required to support Barriers-to-Service is documentation showing that IHS clients have been consistently turned away or not provided services at the available facilities. The documentation must show that there is a pattern of IHS clients not receiving services at the same level and with the same consistency as other patients at the available facilities.

Since determining whether or not barriers exist could be subjective, documentation will be verified and all claims validated by the Validation Committee before it is applied to the formula in Phase II. Table 6, "Determining Barriers to Service," illustrates how the value for the Barriers to Service is determined:

Table 6, Phase II Determining Barriers to Service

If the Validation Committee:			Barriers To Service Value
Does not Verify Barriers to Service	Barriers to Service	=	0
Does Verify Barriers to Service	Barriers to Service	=	1

5) Facility Size Criterion

The Facility Size Criterion increases the total Priority Score for smaller facilities[6]. Smaller facilities receive up to 150 points, while facilities serving large populations receive proportionally fewer points. The Facility Size Criterion is based on the IHS User Population for the facility Service Area. This information is obtained from the IHS National Patient Information Reporting System (NPIRS). Table 7, "Facility Size Criterion Value Look up Table," provides an approximate Facility size Criterion Value for all facilities up to 25 200 m^2. The actual value can be calculated using the formula in Table 8, "Facility Size Criterion." This table can also be used to calculate The Facility Size Criterion Value for the three or four IHS and Tribal facilities larger than 25 200m^2.

[6] The facility size is the required space. In Phase I required space is based on population for outpatient facilities and on workload for inpatient facilities. In phase II required space is determined using the HSP.

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Table 7, Facility Size Criterion Value Look up Table

Facility Required Space In Square Meters (m^2)			Facility Size Value	Facility Required Space In Square Meters (m^2)			Facility Size Value	Facility Required Space In Square Meters (m^2)			Facility Size Value
Up to 1 200			1								
1 201	to	1 600	0.976	9 601	to	10 000	0.541	18 001	to	18 400	0.345
1 601	to	2 000	0.952	10 001	to	10 400	0.524	18 401	to	18 800	0.340
2 001	to	2 400	0.928	10 401	to	10 800	0.507	18 801	to	19 200	0.335
2 401	to	2 800	0.904	10 801	to	11 200	0.489	19 201	to	19 600	0.329
2 801	to	3 200	0.880	11 201	to	11 600	0.472	19 601	to	20 000	0.324
3 201	to	3 600	0.856	11 601	to	12 000	0.455	20 001	to	20 400	0.318
3 601	to	4 000	0.832	12 001	to	12 400	0.438	20 401	to	20 800	0.313
4 001	to	4 400	0.808	12 401	to	12 800	0.421	20 801	to	21 200	0.308
4 401	to	4 800	0.784	12 801	to	13 200	0.416	21 201	to	21 600	0.302
4 801	to	5 200	0.760	13 201	to	13 600	0.410	21 601	to	22 000	0.297
5 201	to	5 600	0.736	13 601	to	14 000	0.405	22 001	to	22 400	0.291
5 601	to	6 000	0.712	14 001	to	14 400	0.399	22 401	to	22 800	0.286
6 001	to	6 400	0.695	14 401	to	14 800	0.394	22 801	to	23 200	0.281
6 401	to	6 800	0.678	14 801	to	15 200	0.389	23 201	to	23 600	0.275
6 801	to	7 200	0.661	15 201	to	15 600	0.383	23 601	to	24 000	0.270
6 801 or more			Calculated using the same formula used for Table 8. Facility Size Criterion								

Table 8, Facility Size Criterion

If Required Space is	Use							Facility Size Value
0 to 1 $200m^2$	1							1
1 $201m^2$ – 6 $000m^2$	(1	-	[(Required Space	-	1 200 m2)	X	0.00006])	
6 000 m^2 than 12 $800m^2$	(.712	-	[(Required Space	-	6000 m2)	X	0.0000428])	
More than 12 800 m^2	(.416	-	[(Required Space	-	6000 m2)	X	0.0000135)	

6) Innovation Criterion

The Innovation Criterion increases the Priority score during Phase II for Tribes and Service Units that identify and document innovative ways of providing of healthcare or acquiring healthcare facilities. For an innovation to be validated the Tribe or Service Unite must show that the innovation(s) significantly

- o Increases Health promotion/disease prevention,
- o Efficiency and/or effectiveness of healthcare services delivery, or
- o Reduces federal cost in acquiring, operating and/or maintaining healthcare facilities.

Each innovation identified is worth up to 1/5 (or 20 percent) of the Innovation Criterion value. Documentation supporting each innovation must show that it increases efficiency, effectiveness, community involvement, etc. General examples of innovation that might be used are listed below:

- o Planning/Coordination with another Tribe or PSA for sharing major Health Delivery programs with written use agreements.
- o Developing a written shared use agreement with private or other non-IHS health delivery organizations involving major diagnostic or treatment departments, e.g. one health program providing diagnostic imaging while the other would establish and maintain a burn unit.
- o Developing other health delivery innovations that involve major medical departments or programs and partnering with State or Local Health Programs.
- o Providing a portion of the cost of construction or operation (at least 15% of the total acquisition cost, or at least 15% of the annual recurring costs for the life of the facility; i.e., operation, maintenance, and staffing. A proportionally fewer number of points are assigned for lesser contributions. Greater contributions do not generate more points.
- o Reducing the new construction costs by 25% (capital investment) by reusing parts of the existing facility. Proportionally fewer points are assigned for lesser construction savings. Greater savings do not affect scoring.
- o Developing, administering, and funding a public health initiative or program.
- o Etc.

Innovation should not be limited to a pre-conceived definition of what it is. Tribes, Areas, Service Units, consortiums, etc., are encouraged to develop innovative approaches to providing services and/or facilities. These will reviewed by the Validation Committee during the Phase II process. *Table 9, Innovation Criterion*, illustrates how the Innovation Criterion Value is calculated.

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Table 9, Innovation Criterion

Innovation Elements (up to 5)		Value per Element (max of 0.2 per Element)
Element 1 Verified by Validation Committee	+	
Element 2 Verified by Validation Committee	+	
Element 3 Verified by Validation Committee	+	
Element 4 Verified by Validation Committee	+	
Element 5 Verified by Validation Committee	+	
Total		(Maximum of 1)

IV) Implementation

A) The HFCPS Formula

For each facility considered, the HFCPS Formula incorporates the weighting for each factor and sums the factors to obtain the score (see Table 1, "HFCPS Evaluation Criteria and Weighting"). In Phase I only Facility Resource Deficiency, Health Status, Isolation, and Facility Size are summed. In Phase II, these factors as well as Barriers to Service and Innovation are summed. Table 1, "HFCPS Evaluation Criteria and Weighting," on page 5 shows the weightings and how the factors are summed in both Phase I and Phase II.

B) Phase I

1. Time Line

The IHS will run Phase I of the HFCPS every five years to maintain a relatively up-to-date Comprehensive National Listing of Facility Need. During those five years, modifications to Area Master Plans may generate minor changes in the Phase I scores.

Implementation of Phase I should take approximately 6 months, after all Area Health Services and Facilities Master Plans are updated. The IHS will notify all Tribes and Areas to finalize any updates to Master plans at least 24 months prior to implementation of Phase I.

2. Facilities Evaluated in Phase I

During Phase I of the HFCPS, every facility identified on Area Health Services and Facilities Master Plans, including urban program facilities, are reviewed and ranked according to the Phase I evaluation criteria. Urban facilities are ranked on a separate list and are not forwarded to Phase II of any facilities construction program. The listing of Urban Program facilities need is provided to the IHS Urban Program for use in the budget process.

3. Data Used

The data required for completion of Phase I are:

- User population from the IHS National Patient Information Reporting System;
- Existing facility size, age, and condition from the IHS Facility Data System;
- The following indicators from the FDI:
    - The Birth Disparities Indicator,
    - The FDI Percent of the population over 55 years old,
    - The Composite Poverty Indicator, and
    - The Disease Disparity Indicator; and
- The distance from the proposed facility to the nearest emergency room.

4. Validation

Phase I data will not be validated; however, the data used is obtained from existing IHS databases or will be verified by qualified professionals, e.g., certified professional engineers, architects, etc. Data used during Phase I will be included in a database available for public viewing and assessment.

5. Application of Data

For Phase I, the IHS Headquarters Staff uses an internet based database to apply the data to the HFCPS formula shown on page 5 in Table 1, "HFCPS Evaluation Criteria and Weighting," using weighting factors in the column headed "Phase I Criteria Weighting." The "Innovation" and "Access-to-Care" criterion are not evaluated during Phase I.

The way data are applied for each facility will be viewable on the internet data base.

6. Scoring

Every facility reviewed during Phase I is ranked on the Comprehensive National Listing of Facility Need according to the Phase I scoring. They are then categorized (see Table 10, Facilities Categories) according to type of facility as identified in the Area Master Plans. This categorization may be different than the type of facility that is finally planned and constructed, but will serve to assist in making decisions about which facilities are placed in Phase II for specific programs.

Table 10, Facilities Categories

Following Phase I scoring, all facilities are placed in an initial category. This initial placement is used as a part of the selection process for Phase II.	Category	Category Abbreviation	Description
	Comprehensive Health Care Center	Category A	An ambulatory care facility operating a minimum of 40 hours per week, staffed with a basic health team offering services for acute and chronic ambulatory problems and which may act as a referral center to other levels (higher acuity and specialty) of care. A Comprehensive Health Care Center could include an alternative rural hospital for purposes of the IHS construction priority system.
	Comprehensive Inpatient Facility	Category B	A facility providing inpatient services, ambulatory care, and a range of inpatient and ambulatory specialty care. The facility must meet IHS ADPL ≥ 15 policy and usually provides general surgery and full service OB/GYN. Patients for these facilities are routinely referred from Health Centers.
	Small Health Care Clinic	Category C	An ambulatory care facility designed to serve populations less than 1320.
	Other	Other	Facilities other than those described above, e.g. Youth Regional Treatment Centers, Dental Units, etc.

7. Uses of Scoring

The Phase I scoring will be used by all funded healthcare facilities construction programs to identify facilities for review in Phase II. These programs include the line-item program authorized under Section 301 of the Indian Health Care Improvement Act (IHCIA), Public Law (P.L) 93-437, the Small Ambulatory Program, authorized under Section 316, the Joint Venture Program authorized under Section 818, etc. These will also be used within each Area to identify the projects for the "Area Distribution Program" described on page 16.

C) Phase II

1. Time Line

The IHS anticipates running Phase II of the HFCPS every year to assure a dynamic list of high priority projects for each facilities construction program. However, given the fluctuation in funding for programs, there may not be a need to add projects to the list every year. In a years when appropriated funding is less than anticipated for a program, the IHS may cancel application of Phase II so that a large backlog of unfunded projects do not "clog" the process.

Application of Phase II, which includes development and finalization of a Program Justification Document (PJD) for each project, should take approximately 1 year.

2. Facilities Evaluated in Phase II

Each of the congressionally authorize facilities construction programs has different requirements. To ensure that the requirements of each are addressed, Phase II will be implemented and applied slightly differently for each. Although the basic formula will remain the same, other factors, identified in law

and regulations, will be used to select projects for Phase II review.

The number and type of facilities evaluated in Phase II will depend on the program for which Phase II is being applied. For the line-item program authorized in Section 301 of the IHCIA, the facilities selected will depend primarily on the scoring in the Phase I "Comprehensive National Listing of Facility Need." However, because some types of facilities are funded more quickly than others, selection may be limited to certain categories of facilities (see Table 10 "Facilities Categories"). The actual number of facilities selected depends on the number of facilities already on the Priority List, on the cost to complete these projects, and on what is expected to be appropriated over the subsequent years.

Below is a summary of some of the Phase II selection criteria for other authorized programs:

- Before a facility may be considered in Phase II for the Small Ambulatory Program funding, it must meet specific ownership, size, and population criteria and must not be connected to a hospital. It should be noted that in the past, when funds are appropriated, the Congress has specified the amount that can be expended on each project;
- Before a facility may be considered in Phase II for the Joint Venture Program, a Tribe must show a capability and willingness to enter into an agreement with the IHS. Under the Joint Venture agreement the Tribe will acquire the facility and lease it, at no cost for 20 years, to the IHS; in return, the IHS will equip the facility and provide resources for its staffing and operation.
- Other authorized programs have never been funded by the Congress, but these, too, have requirements that may restrict selection for Phase II..

3. Data Used

During Phase II, data from the approved PJD will be used. This data should be solidly based on the Phase I data but may be applied differently to reflect more accurately the situation and the expected service population. For example, to estimate the required space in Phase II, the IHS will use Health System Planning Process (HSP) instead of the formula used in Phase I. The HSP provides a more detailed and accurate analysis of a population than the space formula used in Phase I.

In addition, Phase II will incorporate two additional factors that are not part of Phase I:

- o Innovation and
- o Barriers to Service

Tribes or service units with facilities evaluated in Phase II that wish to increase the score based on these two factors, will be asked to submit supporting documentation.

The Joint Venture, Small Ambulatory and some other programs may require Tribes and service units to provide other, additional information during Phase II. These requirements are usually specified in authorizing and/or appropriations Law. In addition, policy, regulation, etc. may require additional information that needs to be considered during Phase II.

4. Validation:

Each PJD must be approved by the Director, Office of Environmental Health and Engineering, to ensure consistency with Master Plans and IHS planning guidelines. The HFCPS Validation Committee will review the documentation supporting Innovation and Barriers to Service proposals. The Validation Committee will also review any Tribal facilities information that is not included in the FDS (i.e., existing space, facility condition, and facility age).

Facilities that do not have approved PJDs when the Validation Committee meets to review projects for Phase II will be removed from Phase II consideration. They remain on the Comprehensive National Listing of Facility Need, and may be selected for subsequent Phase II review. These facilities could be bypassed for subsequent review, if there has not been sufficient progress on developing an approvable PJD. If this occurs, the next facility that has not been reviewed or that has made adequate progress in developing a PJD, will be selected for Phase II review.

Facilities with Phase II scores lower than their Phase I score following validation of the data may be removed from Phase II consideration. These facilities will be re-ranked on the "Comprehensive National Listing of Facility Need" using the validated data. They may be considered for subsequent Phase II applications, based on their Phase I scores.

5. Application of Data

The IHS Headquarters Staff applies approved and validated data to the HFCPS formula shown on page 5 in Table 1, "HFCPS Evaluation Criteria and Weighting."

6. Ranking in Phase II

During Phase II, facilities under consideration, are prioritized according to their scores and placed on the Priority List in rank order immediately following any facility already on the list.

D) Area Distribution Program

The Area Distribution Program provides a methodology for allocating funds to Area Offices to address the highest priority projects within the Area. It is initiated only when the Congress appropriates construction funds for this purpose. These funds must be distributed to the highest priority Area Office facilities where the Area and Tribes agree that only limited new staffing is required. The reason for this is that, upon completion of Area Distribution Program projects, the facility will be allocated only about 40% of the additional staffing and operation funds usually allocated to new facilities. The Area Distribution Program funds are allocated as follows:

In a given year, the Area Offices where the line-item amount in the Facilities Appropriation exceeds 20% of the total appropriations for facilities construction may not participate in the Area Distribution Program. Those Areas that receive 20% or less of the annual line-item facilities appropriation are allocated a portion of the Area Distribution Program funds based on the following Formula:

Table 11, Area Distribution Formula

Area Allocation	=	Total Area Distribution Funds Appropriated	X	Area User population X Avg. Area locality factor Sum all the Participating Area's (Area User population X Avg. Area locality factor)

Actual Allocation to the Areas will be based on the capability for completing the highest priority projects with the funding available. This means that there may be some adjustment of actual allocation from year-to-year in order to ensure that projects are fully funded.

After a project is funded under the Area Distribution Program, it is re-scored and re-ranked in the Phase I HFCPS based on planned size and condition of the facility after completion of the project.

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Area Distribution Program – The Area Distribution Program is a subset of the HFCPS that is implemented when Congress appropriates funding to be allocated to Area Offices based on a pro-rata formula. Because appropriations in a given year may not be enough to fully fund a project in each Area, results of this formula may be adjusted to complete fewer projects, with the idea that Areas that do not receive their full allocation one year would be eligible for more funding in a subsequent year. The Areas distributes these funds to address the needs of high priority projects within the Area. The IHS will support requests for partial increase staffing levels at these facilities. Tribes may elect not to participate in this program. Facilities identified for this program are rescored and re-ranked in Phase I of the HFCPS based on changes in the size and condition of the facility following construction.

Categories – Each Tribal and IHS facility will be assigned one of the categories listed on page II–21 in Figure 2, "Facilities Categories," based on a number of factors, including facility workload and the level and type of services to be provided from the facility. Categorization permits IHS to rank each facility's need relative to other similar facilities.

Comprehensive National Listing of Facility Need – A listing of all IHS and Tribal health care facilities in which each facility is scored according to need. Each facility's score is developed during Phase I and is based on estimated space requirements and Master Planning data.

FDI – Federal Health Benefits Plan Disparities Index – An index used to allocate Indian Health Care Improvement funds that includes a health status indicator. The index is based on the relative difference between the federal employee's benefits package and the resources available for treatment of American Indians and Alaska Natives.

FEDS – Facilities Engineering Deficiency System – One segment of the Healthcare Facilities Data System (See HFDS) that defines facilities deficiency categories requiring repair or renovation and provides cost estimates.

HFCPS (Healthcare Facilities Construction Priority System) – The IHS process for evaluating and scoring the need for healthcare facilities to provide access to health services for American Indians and Alaska Natives. It consists of two phases: phase I assesses facilities need to produce the "Comprehensive National Listing of Facility Need," and Phase II re-assesses and determines the placement of high ranking facilities on the IHS Healthcare Facilities Construction Priority List.

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HFDS (Healthcare Facilities Data System) - A database that contains real property and repair backlog information on all IHS and some Tribal facilities.

HSP (Health Systems Planning Process) - A software package designed to provide the documents necessary for the government or its representative to plan and acquire approval for a medical program and collate and communicate the necessary information to an Architect/ Engineer for the design of a facility.

IHS Area - One of the 12 regional administration units within the United States organized by the Indian Health Service to administer the various healthcare programs in partnership with the Tribes.

PJD (Program Justification Document) - A detailed planning document that describes the program and the general facility plan. It is developed by IHS and Tribal using the HSP as a tool.

NPIRS (National Patient Information Reporting System) - The medical information system used by IHS to collect, store and disseminate all related medical data.

Priority List - the list used to request funding from Congress or to allocate funds appropriated by Congress. It is a list of projects that have been fully evaluated and planned. Ideally, IHS should have only one priority list from which it funds the projects with the greatest need. However, there are several Congressionally authorized funding programs, and each of these has different requirements. Some of these requirements limit the kinds of facility project that can be funded, and sometimes these limitations mean that facilities with high Phase I scores are bypassed and not placed on a priority list. For example, the Small Ambulatory Program is authorized by Congress to provide outpatient facilities that are not part of a hospital. In addition, these facilities must provide access to a user population of at least 500. Facilities that do not meet these basic congressional requirements will not be considered in Phase II for the Small Ambulatory Program and will not be placed a Priority List for this program, regardless of their Phase I scores.

PSA (Primary Service Area) - A geographical area where residents of Indian communities receive medical care at a healthcare facility staffed by primary care providers. Outpatient facilities are located within reasonable travel distance from the communities.

Scoring - Each Tribal and IHS PSA/facility will be assigned a score generated by applying data from the IHS databases to the Phase I HFCPS formula in Appendix II, "The Healthcare Facilities

Construction Priority System Methodology." The Phase I scores will be used to establish the Comprehensive National Listing of Facility Need.

Required Space – The space necessary to provide access to healthcare services for a given population. In Phase I of the HFCPS, required space is estimated by using a simple formula (see Table 2, "Phase I Required Space Formula"). In Phase II the required space is obtained from the approved Program Justification Document (PJD) for the facility.

Validation Committee (Healthcare Facilities Validation Committee) – The Healthcare Facilities Validation Committee or Validation Committee is a standing committee consisting of seven individuals appointed by the Director of IHS. Membership may include but not be limited to IHS Headquarters and Area Offices, Tribal, and other health oriented professionals. When formed, members will be asked to serve on the Validation Committee for at least 5 years initially, with no other limit on terms of service.

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Appendix II. The Healthcare Facilities Construction Priority System Methodology

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Overview

This document describes the formula used in the HFCPS methodology. It provides a step by step review of the formula and includes look-up tables as shortcuts some of the calculations. The lookup tables will not always provide the most accurate score. They are developed using calculations from the HFCPS formula, but are not intended to reflect every situation exactly. There are likely to be slight differences between scores generated using the lookup tables and those that use the calculations on which the tables are based. The HFCPS formula will be implemented using an internet database, which will use the formula. Following each application of the HFCPS, the formula (including the data, calculations and results for each facility) will be posted on www.dfpc.ihs.gov.

HFCPS Methodology Formula

Each facility identified in a Services and Facilities Master Plan is evaluated in Phase I using Figure 1, "Calculating the Phase I Score."

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Figure 1, Calculating the Phase I Score

Instructions	Line	Evaluation Criteria	Evaluation Criteria Value		Criteria Weighting		Score
Enter the Facility Deficiency, Health Status, Isolation, and Facility Size criterion values on the appropriate line under the column headed "Evaluation Criteria Value."	A	Facility Deficiency		x	400	=	
Complete the calculation for lines A, B, C, and D, as indicated. Enter each result on the appropriate line in the column headed Score.	B	Health Status		x	200	=	
	C	Isolation		x	100	=	
	D	Facility Size		x	150	=	
Add the scores for lines A, B, C, D and enter the result in line E under Score.	E	Phase I Total Score The Total Score is the sum of the scores on lines A, B, C, and D.					(850Maximum)

The Evaluation Criteria values used on this table can be determined as follows:
For Line A see Figure 4, "Calculating the Facility Deficiency Criterion Value" Calculating this value is fairly complex and will also require the use of Figure 5, "Estimating Required Space for Phase;" Figure 6, "Calculating Adjusted Existing Space;" Figure 7, "Look-Up: Age Factor;" Figure 8, "Calculate Weighted Age for Multi Building Facilities;" and Figure 9, "Calculate Condition Adjustment Factor for Existing Facilities."
For Line B see Figure 10, "Calculating the Health Status Criterion Value."
For Line C see Figure 11, "Calculating the Isolation Criterion Value."
For Line D see Figure 13, "Facility Size Criterion Value Look up Table."

After scoring each facility in Phase I, they are placed in categories shown in Figure 2, "Facilities Categories."

Figure 2, Facilities Categories

Following Phase I scoring, all facilities are placed in an initial category. This initial placement is used as a part of the selection process for Phase II.	Category	Category Abbreviation	Description
	Comprehensive Health Care Center	Category A	An ambulatory care facility operating a minimum of 40 hours per week, staffed with a basic health team offering services for acute and chronic ambulatory problems and which may act as a referral center to other levels (higher acuity and specialty) of care. A Comprehensive Health Care Center could include an alternative rural hospital for purposes of the IHS construction priority system.
	Comprehensive Inpatient Facility	Category B	A facility providing inpatient services, ambulatory care, and a range of inpatient and ambulatory specialty care. The facility must meet IHS ADPL ≥ 15 policy and usually provides general surgery and full service OB/GYN. Patients for these facilities are routinely referred from Health Centers.
	Small Health Care Clinic	Category C	An ambulatory care facility designed to serve populations generating 4400 primary care provider visits or less.
	Other	Other	Facilities other than those described above, e.g. Youth Regional Treatment Centers, Dental Units, etc.

The highest scoring facilities identified in Phase I are selected for review for Phase II. Figure 3, "Calculating the Phase II Score," is used during Phase II to prioritize these facilities.

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Figure 3, Calculating the Phase II Score

Instructions	Line	Evaluation Criteria	Evaluation Criteria Value	Criteria Weighting		Score
Enter the Facility Deficiency, Health Status, Isolation, Barriers to Service Facility Size and Innovation criterion values in column headed "Evaluation Criteria Value" for lines A, B, C, D, E, and F respectively.	A	Facility Deficiency		x 400	=	
	B	Health Status		x 200	=	
Complete the calculation for lines A, B, C, D, E, and F as indicated. Enter each result on the appropriate line in the column headed Score.	C	Isolation		x 100	=	
	D	Barriers to Service		x 50	=	
	E	Facility Size		x 150	=	
Add the scores for lines A, B, C, D, E, and F and enter the result in line G under Score.	F	Innovation		x 100	=	
	G	Phase II Total Score				(1000 Maximum)

The Evaluation Criteria values used on this table can be determined as follows:
For Line A see Figure 4, "Calculating the Facility Deficiency Criterion Value" Calculating this value is fairly complex and will also require the use of Figure 6, "Calculating Adjusted Existing Space;" Figure 7, "Look-Up: Age Factor;" Figure 8, "Calculate Weighted Age for Multi Building Facilities;" and Figure 9, "Calculate Condition Adjustment Factor for Existing Facilities." In addition, the required space in the approved Program Justification Document will be needed.
For Line B see Figure 10, "Calculating the Health Status Criterion Value."
For Line C see Figure 11, "Calculating the Isolation Criterion Value."
For Line D see Figure 12, "Calculating the Barriers to Service Criterion Value."
For Line E see Figure 13, "Facility Size Criterion Value Look up Table."
For line F see Figure 15, "Innovation Criterion Value"

Facility Deficiency Criterion Calculations

Figure 4, Calculating the Facility Deficiency Criterion Value

	Facility Deficiency	Facilities Deficiency Formula
During Phase I, Required Space is estimated using Figure 5, "Estimating Required Space for Phase I." During Phase II Required Space is estimated using the Health System Planning Process (HSP) with no deviations. During both phases, Figure 6, "Calculating Adjusted Existing Space" is used to obtain values for Adjusted Existing Space.		$= 1 - \left(\frac{\text{Adjusted Existing Space}}{\text{Required Space}} \right)$

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Figure 5, Estimating Required Space for Phase I

<table>
<tr><td rowspan="6">Outpatient: During Phase I the estimated size for any outpatient facility will be at least 200m², with and additional .8m² per user population. The IHS user population for a facility is the IHS User Population obtained from the IHS National Patient Information Reporting System.
• Enter the IHS user population for the facility on line B.
• Multiply Line A (0.8 m2) times Line B and enter the result on line C.
• Add line D (200 m2) to line C and enter the result on line E.</td><td>Line</td><td></td><td></td><td></td></tr>
<tr><td>A</td><td></td><td>IHS Average Space per User Population</td><td>0.8 m²</td></tr>
<tr><td>B</td><td>x</td><td>User Population</td><td></td></tr>
<tr><td>C</td><td></td><td>User Population Space</td><td></td></tr>
<tr><td>D</td><td>+</td><td>Base Facility Size</td><td>200 m²</td></tr>
<tr><td>E</td><td></td><td>Estimated Required Space for an outpatient facility</td><td></td></tr>
<tr><td rowspan="6">Inpatient: During Phase I the estimated size for any inpatient facility will be at least 5 500m², with and additional 3.5m² per annual inpatient bed days (ID). The estimated space for the outpatient component of an inpatient facility has been included as part of the calculations F-J. The IHS ABD for a facility is the ID obtained from the IHS National Patient Information Reporting System.
• Enter the IHS ID for the facility on line G.
• Multiply Line F (3.5 m2) times Line G and enter the result on line H.
• Add line I (5 500 m2) to line G and enter the result on line J.</td><td>Line</td><td></td><td></td><td></td></tr>
<tr><td>F</td><td></td><td>IHS Average Space per ID</td><td>3.5 m²</td></tr>
<tr><td>G</td><td>x</td><td>ID</td><td></td></tr>
<tr><td>H</td><td></td><td>IDL Space</td><td></td></tr>
<tr><td>I</td><td>+</td><td>Base Facility Size</td><td>5 500 m²</td></tr>
<tr><td>J</td><td></td><td>Estimated Required Space for an inpatient facility</td><td></td></tr>
</table>

Figure 6, Calculating Adjusted Existing Space

<table>
<tr><td rowspan="8">If there is no existing facility, enter 0as the Adjusted Existing Space on Line E.
If there is an existing facility:
• Refer to Figure 7, "Look-Up: Age Factor" and Figure 8, "Calculate Weighted Age for Multi Building Facilities," to obtain the Age Adjustment Factor for Line A.
• Refer to Figure 9, "Calculate Condition Adjustment Factor for Existing Facilities" to obtain the Condition Adjustment Factor for line B.
• Add lines A and B. If the result is 1 or less, enter the result in line C. If the result is greater than 1, enter 1 on line C.
• Enter 1 on line D.
• Subtract Line D from Line C and enter the result on line E
• Enter the Existing Space on Line F. Existing space is obtained from the IHS FDS data base or, for Tribal facilities, is the documented gross size in square meters.
• Multiply line E times Line F and enter the result on line G.</td><td>Line</td><td></td><td></td><td></td></tr>
<tr><td>A</td><td></td><td>Age Adjustment Factor</td><td></td></tr>
<tr><td>B</td><td>+</td><td>Condition Adjustment Factor</td><td></td></tr>
<tr><td>C</td><td>=</td><td>Space Adjustment Factor</td><td></td></tr>
<tr><td>D</td><td>-</td><td>1</td><td></td></tr>
<tr><td>E</td><td>=</td><td>Space adjustment</td><td></td></tr>
<tr><td>F</td><td>*</td><td>Existing Space</td><td></td></tr>
<tr><td>G</td><td>=</td><td>Adjusted Existing Space</td><td></td></tr>
</table>

Figure 7, Look-Up: Age Factor

<table>
<tr><td rowspan="4">If the facility consists of only one building use the age of that building to obtain the Age Factor using the lookup table to the right.

If the facility consists of multiple buildings, obtain the Weighted Facility Age from Figure 8, "Calculate Weighted Age for Multi Building Facilities," and use that value in the look up table to determine the Age Factor.</td><td>Weighted Facility Age</td><td>Age Factor</td></tr>
<tr><td>0-10 years</td><td>0</td></tr>
<tr><td>11-50 years</td><td>0.0125</td></tr>
<tr><td>51 or more years</td><td>.5</td></tr>
</table>

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Figure 8, Calculate Weighted Age for Multi Building Facilities

The weighted age of a facility consisting of only one building is the age of that building. The weighted age of a facility with multiple buildings is calculated using this table as follows:
Calculate the weighted age of each building by dividing its size by the total size of the facility then multiplying that value times the building age. Use a separate sheet for additional buildings.
Sum the Weighted Building Age of all the buildings to obtain the Weighted Facility Age.
Information for this table may be obtained from the FEDS data base or, for facilities not participating in FEDS, from documentation.

Building Size		Facility Size		Building Age		Weighted Building Age
	÷		x		=	
	÷		x		=	
	÷		x		=	
	÷		x		=	
	÷		x		=	
	÷		x		=	
	÷		x		=	
Weighted Facility Age = Sum of Weighted Building Age						

Figure 9, Calculate Condition Adjustment Factor for Existing Facilities

To determine the Facility Condition Adjustment Factor:

- Enter the cost to correct each FEDS deficiency listed in columns A through K. For facilities not participating in the FEDS, use the documented cost to repair any deficiencies that meet the definitions of the FEDS Categories listed.
- Add lines A through K and enter the result in line L.
- Enter the Existing Facility size (unadjusted) on Line M.
- Divide line L by line M and enter the result on line N.
- Enter the Cost to replace on Line O. Obtain from the IHS Budget Cost Estimating System.
- Divide Line N by Line O and enter the result on line P.

If the Condition Adjustment Factor (line P) is greater than .75, then change it to 1, otherwise use the value calculated.

Line	Table A, Applicable FEDS Codes and Categories			
	FEDS Code	FEDS Category		Cost
A	2	Life Safety Compliance		
B	3	General Safety		
C	4	Environmental Compliance		
D	7	Handicapped Compliance		
E	8	Energy Conservation		
F	10	Architectural Maintenance and Repair		
G	11	Structural Maintenance and Repair		
H	12	Mechanical Maintenance and Repair		
I	13	Electrical Maintenance and Repair		
J	14	Utilities Maintenance and Repair		
K	17	Roof Maintenance and Repair		
L	**Total FEDS Deficiency**			
M	**Existing Facility Size**		÷	
N	**Cost per m² to Repair**			
O	**Cost per m² to Replace**		÷	
P	**Condition Adjustment Factor**			

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Health Status Criterion Calculations

Figure 10, Calculating the Health Status Criterion Value

The Health Status Criterion is the ¼ the sum of the following four indices from the Federal Employees Health Benefits Disparities Index (FDI): Birth Disparities, Percent of Population 55 or older, Composite Poverty Index, and Disease Disparities Index. Calculate the Health Status Criterion by Entering the FDI value for each indicator in lines A, B, C, and D. • Complete the calculations on lines A, B, C, and D. • Sum health status Column rows A, B, C, and D. Enter the result in line E	Line	Health Status Indicators from the FDI	Index Value				Health Status Value
	A	Birth Disparities Index		x	.25	=	
	B	Percent of Population over 55		x	.25	=	
	C	Composite Poverty Index		x	.25	=	
	D	Disease Disparities Index		x	.25	=	
	E	Health Status Criterion					Maximum value = 1

Isolation Criterion Calculations

Figure 11, Calculating the Isolation Criterion Value

The isolation of a population is indicated by the average distance most people need to travel for healthcare services.	If the facility is:					Isolation Value
	Less than 40 Km from an ER	Isolation	=	0	=	0
	40-89 Km from an ER	Isolation	=	Km to Alternatives ÷ 90 Kilometers	=	
	90 or more Km from an ER	Isolation	=	1	=	1
	Not on a road connecting to Federal or state highway	Isolation	=	1	=	1

Figure 12, Calculating the Barriers to Service Criterion Value

If the barriers to service are documented and the documentation is validated by the Validation Committee, the value is 1, otherwise it is 0.	If the Validation Committee:			Barriers To Service Value
	Does not Verify Barriers to Service	Barriers to Service	=	0
	Does Verify Barriers to Service	Barriers to Service	=	1

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Figure 16, Facility Condition Factor Lookup Table

Budget Cost Estimating System Cost per M to replace> FEDS Cost / M	$25-$49	$50-$74	$75-99	$100-$124	$125-$149	$150-$174	$175-$199	$200-$224	$225-$249	$250-$274	$275-$299	$300-$324	$325-$349	$350-$374	$375-$399	$400-$424	$425-$450	$450-$474	$475-$499	$500-$524	$525
$0-$24	1.00	0.50	0.33	0.25	0.20	0.17	0.14	0.13	0.11	0.10	0.09	0.08	0.08	0.07	0.07	0.06	0.06	0.06	0.05	0.05	0.05
$25-$49	1.00	1.00	0.67	0.50	0.40	0.33	0.29	0.25	0.22	0.20	0.18	0.17	0.15	0.14	0.13	0.13	0.12	0.11	0.11	0.10	0.10
$75-$99	1.00	1.00	1.00	0.75	0.60	0.50	0.43	0.38	0.33	0.30	0.27	0.25	0.23	0.21	0.20	0.19	0.18	0.17	0.16	0.15	0.14
$100-$124	1.00	1.00	1.00	1.00	1.00	0.67	0.57	0.50	0.44	0.40	0.36	0.33	0.31	0.29	0.27	0.25	0.24	0.22	0.21	0.20	0.19
$125-$149	1.00	1.00	1.00	1.00	1.00	1.00	0.71	0.63	0.56	0.50	0.45	0.42	0.38	0.36	0.33	0.31	0.29	0.28	0.26	0.25	0.24
$150-$174	1.00	1.00	1.00	1.00	1.00	1.00	1.00	0.75	0.67	0.60	0.55	0.50	0.46	0.43	0.40	0.38	0.35	0.33	0.32	0.30	0.29
$175-$199	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	0.70	0.64	0.58	0.54	0.50	0.47	0.44	0.41	0.39	0.37	0.35	0.33
$200-$224	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	0.73	0.67	0.62	0.57	0.53	0.50	0.47	0.44	0.42	0.40	0.38
$250-$274	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	0.75	0.69	0.64	0.60	0.56	0.53	0.50	0.47	0.45	0.43
$275-$299	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	0.71	0.67	0.63	0.59	0.56	0.53	0.50	0.48
$300-$324	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	0.73	0.69	0.65	0.61	0.58	0.55	0.52
$325-$349	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	0.75	0.71	0.67	0.63	0.60	0.57
$350-$374	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	0.72	0.68	0.65	0.62
$350-$374	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	0.74	0.70	0.67
$375-$399	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	0.75	0.71
$400-$424	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
$425-$450	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
$450-$474	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
$475-$499	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
$500-$524	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
$524-$549	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
$550-$574	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
$575-$599	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
$600-$624	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
$625-$649	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00

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Budget Cost Estimating System Cost per M to replace>	$25-$49	$50-$74	$75-99	$100-$124	$125-$149	$150-$174	$175-$199	$200-$224	$225-$249	$250-$274	$275-$299	$300-$324	$325-$349	$350-$374	$375-$399	$400-$424	$425-$450	$450-$474	$475-$499	$500-$524	$525
$650-$674	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
$675-$699	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
$700-$724	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
725	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00

Figure 16, Facility Condition Factor Lookup Table

Budget Cost Estimating System Cost per M to replace> / FEDS Cost / M	$25-$49	$50-$74	$75-99	$100-$124	$125-$149	$150-$174	$175-$199	$200-$224	$225-$249	$250-$274	$275-$299	$300-$324	$325-$349	$350-$374	$375-$399	$400-$424	$425-$450	$450-$474	$475-$499	$500-$524	$525
$0-$24	1.00	0.50	0.33	0.25	0.20	0.17	0.14	0.13	0.11	0.10	0.09	0.08	0.08	0.07	0.07	0.06	0.06	0.06	0.05	0.05	0.05
$25-$49	1.00	1.00	0.67	0.50	0.40	0.33	0.29	0.25	0.22	0.20	0.18	0.17	0.15	0.14	0.13	0.13	0.12	0.11	0.11	0.10	0.10
$75-$99	1.00	1.00	1.00	0.75	0.60	0.50	0.43	0.38	0.33	0.30	0.27	0.25	0.23	0.21	0.20	0.19	0.18	0.17	0.16	0.15	0.14
$100-$124	1.00	1.00	1.00	1.00	1.00	0.67	0.57	0.50	0.44	0.40	0.36	0.33	0.31	0.29	0.27	0.25	0.24	0.22	0.21	0.20	0.19
$125-$149	1.00	1.00	1.00	1.00	1.00	1.00	0.71	0.63	0.56	0.50	0.45	0.42	0.38	0.36	0.33	0.31	0.29	0.28	0.26	0.25	0.24
$150-$174	1.00	1.00	1.00	1.00	1.00	1.00	1.00	0.75	0.67	0.60	0.55	0.50	0.46	0.43	0.40	0.38	0.35	0.33	0.32	0.30	0.29
$175-$199	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	0.70	0.64	0.58	0.54	0.50	0.47	0.44	0.41	0.39	0.37	0.35	0.33
$200-$224	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	0.73	0.67	0.62	0.57	0.53	0.50	0.47	0.44	0.42	0.40	0.38
$250-$274	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	0.75	0.69	0.64	0.60	0.56	0.53	0.50	0.47	0.45	0.43
$275-$299	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	0.71	0.67	0.63	0.59	0.56	0.53	0.50	0.48
$300-$324	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	0.73	0.69	0.65	0.64	0.58	0.55	0.52
$325-$349	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	0.75	0.71	0.67	0.63	0.60	0.57
$350-$374	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	0.72	0.68	0.65	0.62
$350-$374	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	0.74	0.70	0.67
$375-$399	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	0.75	0.71
$400-$424	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
$425-$450	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
$450-$474	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
$475-$499	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
$500-$524	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
$524-$549	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
$550-$574	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
$575-$599	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
$600-$624	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
$625-$649	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00

The Indian Health Service
Health Care Facilities Construction Priority System

Budget Cost Estimating System Cost per M to replace>	$25-$49	$50-$74	$75-99	$100-$124	$125-$149	$150-$174	$175-$199	$200-$224	$225-$249	$250-$274
$650-$674	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
$675-$699	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
$700-$724	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
725	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00

Budget Cost Estimating System Cost per M to replace>	$275-$299	$300-$324	$325-$349	$350-$374	$375-$399	$400-$424	$425-$450	$450-$474	$475-$499	$500-$524	$525
$650-$674	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
$675-$699	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
$700-$724	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
725	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00

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The CHAIRMAN. Ms. Davidson, thank you very much.

Senator Murkowski?

Senator MURKOWSKI. Thank you, Mr. Chairman.

I want to thank all those of you on the panel for your testimony, your perspective, Chairman Nosie speaking to the detention issues and Mr. Roessel to appreciate a specific situation within the school that you have addressed today, and to also offer the Committee some specific recommendations. I appreciate that.

Valerie, I always appreciate your testimony. As usual, you have summed it up in a very well thought out and comprehensive way. I wanted to just ask you very quickly, you mentioned the reality

that we face when we don't have the facilities, when we don't have the providers, the Alaska Natives and the American Indians have to go somewhere for care. And so what happens is we see increased expenses to contract health services.

Has there been an effort to assess what is actually spent, or the increase that we see in contract health care services because we are not spending money adequately on the facilities? Do we know what that number is?

Ms. DAVIDSON. I can provide that number for you nationally later, but I can provide you a more specific example that just happened in the last couple of months in Alaska. For example, we had a RSV epidemic in Alaska, in Barrow. We have had it before in Bethel. My daughter had it when she was eight months old. As facilities become overwhelmed with their inability to be able to house patients, those patients get sent into the Alaska Native Medical Center in Anchorage, and then when we are full, they get sent over into Providence, in which contract health dollars kick in.

As we indicated earlier, there are entire areas where there are no inpatient beds available at all. California, Portland area, there are entire States on the east coast, entire States on the west coast that have no inpatient facilities, and those are all contract health.

The other thing I wanted to point out is, as Chairman Dorgan indicated earlier, that it is common knowledge in Indian Country that contract health dollars run out in June. So if you are fortunate enough to get sick, which is a terrible thing to say, in those months, you are in a much better position. Unfortunately, when contract health cannot pay anymore, there is no way to be able to capture that data from what the patient incurs when they are forced to go to a private facility. They get sent bills. They get sent to collections. It is staggering if you consider the cost.

Senator MURKOWSKI. But the reality, then, is again, these folks are going to have to go somewhere. So do they go to the private clinic where they have to pay out of their own pocket? Do they go to the emergency room? How are you going to pay there? The reality is that this cost doesn't go away. It is just allocated differently.

I also wanted to ask you just very briefly on the long-term care facilities. We know that in the State of Alaska, we just don't have the facilities for long-term care, and that is something that we want to change. How did these types of facilities, how will they be included in this newly revised construction priority system?

Ms. DAVIDSON. I am going to let my technical expert, Mr. Boyce, answer how those are incorporated into the master plan.

Mr. BOYCE. Actually, right now they are not included in the master plan. The way the process is set up is they are characterized under other facilities when they are identified through the process, so they have been identified. Right now, the IHS has not developed the staffing and service delivery plans which would support that type of health care delivery. So therefore, they don't have the planning models in place to actually plan that type of facility.

So they are being identified. The costs are being captured, but since that is not a service that they currently provide, then they are not prepared to design and construct those facilities.

Senator MURKOWSKI. It is something that under the Indian Health Care Improvement Act we said is an important aspect of the health care we provide. So we want to make sure that this doesn't get lost in the shuffle just because it hasn't been part of that priority list in the past.

Valerie?

Ms. DAVIDSON. Let me give you a snapshot of how that is actually handled in our current system. Since we don't have long-term care facilities throughout Indian Country, what happens is when a patient needs long-term care, what happens is they actually stay in the hospital for months and months and months at a time. So when another patient presents who needs inpatient care, they get put on divert, so they have to be sent somewhere else. It is unacceptable.

Senator MURKOWSKI. Think about the costs that are involved with that.

Ms. DAVIDSON. Exactly.

Senator MURKOWSKI. Again, I want to thank the panel for coming such a long distance to be with us today and for your very important testimony.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Murkowski, thank you very much.

I regret that I have some up against the clock here. We had a vote in the middle of this hearing, and I guess we have now gone 2 hours and 15 minutes. I have to be somewhere that I cannot change. So I am going to submit some questions to the panel that I would like you to respond to. I appreciate very much your filling in a gap of information this morning.

Chairman Nosie, I indicated it was two weeks from Monday. I am told it is one week from Monday that I will be chairing a hearing in Phoenix on law enforcement issues, and Senator Kyl will also a part of that hearing. I would invite you to join us there.

Mr. Roessel, thank you for your testimony. I have a couple of specific questions I want to ask you.

And we appreciate your traveling, Ms. Davidson, all the way from Alaska. I appreciate the two of you coming down and being a part of the hearing this morning.

With that, this hearing is adjourned.

[Whereupon, at 12:15 p.m., the Committee was adjourned.]

A P P E N D I X

PREPARED STATEMENT OF LINDA HOLT, CHAIRPERSON, NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD; SUQUAMISH TRIBAL COUNCIL MEMBER

Chairman Dorgan, Vice-Chair Murkowski, and members of the Committee, thank you for this opportunity to include our statement into the record concerning the state of Indian health facilities. Before I begin, I want to take this opportunity to thank and congratulate the Committee for its hard work in getting the Indian Health Care Improvement Act (IHCIA) passed out of the Senate.

I am Linda Holt and service as the Chairperson of the Northwest Portland Area Indian Health Board (NPAIHB) and am a Tribal Council Member of the Suquamish Tribe located in Washington State. Established in 1972, NPAIHB is a P.L. 93–638 tribal organization that represents 43 federally recognized Tribes in the states of Idaho, Oregon, and Washington on health related matters.[1] The Board facilitates consultation between Northwest Tribes with federal and state agencies, conducts policy and budget analysis, and operates a number of health promotion and disease prevention programs. NPAIHB is dedicated to improving the health status and quality of life of Indian people and is recognized as a national leader on Indian health issues.

This hearing has been a long time coming and is timely given the movement of the IHCIA. The status of Indian health facilities is deplorable when compared to mainstream facilities in which most Americans receive health care. The Medicare and Medicaid programs provide tens of billions of dollars for facilities construction annually, but there is no discussion of facilities construction before the Congress and no separate appropriation for facilities construction in connection with the Medicare or Medicaid program. Yet most Americans receive care in the most modern clinics and hospitals in the world. Indeed it is remarkable, but true, that poor Americans who are eligible for Medicaid in Washington, Oregon, and Idaho now receive their care in the same facilities as other non-poor Americans, that's right, in the very same clinics and hospitals that are the envy of the world. But what about Indian people? Our clinics in the Northwest are notable exceptions; most on average are more than 40–50 years old. A clinic on the Colville Indian reservation is over 70 years old; and in other Northwest Tribal communities, clinics are housed in mobile homes. The clinics are not just old; they are also inadequate. They are often too small, the equipment is often outdated, and the staff is forced to make do as best they can. That is, the staff that is willing to stay under these less than desirable conditions. Many tribes continually battle recruitment and retention of medical doctors and nurses because of the less than desirable working conditions. Who can blame someone for not wanting to work up to his or her potential in a modern state of the art facility?

I. Indian Health Service

The Federal Government has a duty—acknowledged in treaties, statutes, court decisions, and Executive Orders—to provide for the health and welfare of Indian Tribes and their members. In order to fulfill this legal obligation to Tribes, it has long been the policy of the United States to provide health care to American Indians and Alaska Natives (AI/AN) through a network made up of the Indian Health Service programs, tribal health programs and urban clinics. The Indian Health Service (IHS), directly and through tribal health programs carrying out IHS programs under the Indian Self-Determination and Education Assistance Act, P.L. 93–638, as amended (ISDEAA), provides health services to more than 1.9 million AI/AN people. These services are provided to members of 562 federally-recognized tribes in the United States, located in 35 different states.

[1] As defined in the Indian Self-Determination and Education Assistance Act, P.L. 93–638, 25 U.S.C., Section 450(b) a Tribal organization is a legally established governing body of any Indian tribe(s) that is controlled, sanctioned, or chartered by such Indian Tribe(s) and designated to act on their behalf.

Currently, IHS provides access to healthcare services for AI/ANs through 31 Hospitals, 50 health centers, 31 health stations and 2 school health centers. Tribes also provide healthcare access through an additional 15 hospitals, 254 health centers, 166 Alaska Village Clinics, 112 health stations and 18 school health centers. There are also 34 urban Indian health clinics that provide outreach and referral services, or that provide direct medical care.

II. Why the Poor Condition of Indian Facilities?

Unfortunately, it is the budget process itself that annually under funds the IHS budget that is the cause of the poor condition of our facilities. There is no doubt that again this year little progress will be made to address our backlog of facilities need. The average age of IHS facilities is 33 years as compared to 9 years for healthcare facilities in the United States; many are overcrowded and were not designed in a manner that permits them to be utilized in the most efficient manner in the context of modern healthcare delivery. It is estimated by some Indian health experts that the unmet need for health facilities for the IHS and tribal health system is at least $6.5 billion. This includes only the highest priority need for inpatient hospitals, health centers, staff quarters, and youth regional treatment centers. It does not include adult treatment centers, residential long-term care facilities, or sanitation facilities, which are sorely needed.

As a discretionary program, the Congress will ask tribes the annual question: Do you want this year's proposed $100–150 million increase to go to health services programs or facilities? This choice is unfair. No one asks Medicare recipients if they want facilities or programs—they get both. The health plans that deliver care to Medicaid and Medicare patients take out a portion of each dollar paid by these programs to provide adequate facilities. It is bad health care and bad business to have poor facilities. The idea of slicing off a portion of our inadequate health services dollars for facilities is not realistic. There is nothing to slice. Because the Indian Health Service is a discretionary program our funding is limited and proposals for facilities construction are the low hanging fruit that is chopped off every year. In fact, it is wrong that we don't ask for more than we do each year. More facilities funding is needed within the Indian health system.

Recommendation: While the need to provide more funding to address facilities construction is great, there must also be a methodology to access the resources that is fair and equitable to all Tribes nationally.

III. Authorities for Indian Health Facilities

Tribes have seen the benefit of pursuing and leveraging additional resources in the construction of health and sanitation facilities. Between 1986 and 1990 project contributions from other sources to IHS sanitation facilities construction projects averaged $55.7 million annually. Between 1991 and 1995, the Sanitation Deficiency System (SDS) program—established to fund water and waste facilities—averaged approximately $106 million in funding. During this same period, the program resulted in a $50 million annual increase in contributions from other sources. Thus, funding almost doubled because of Tribal contributions from other sources. This type of collaboration can benefit the facilities construction program if established by the Congress and implemented by the IHS. The IHCIA provides the authority for construction and maintenance of Indian health facilities.

Section 301 authorizes the establishment of a *Health Facility Construction Priority System* (HFCPS) that serves to evaluate and rank the facility construction projects for the Indian health system. The significance of Section 301 projects is that they are provided a comprehensive funding package that provides for facility construction, a staffing package, and for medical equipment; and that they are continually provided funding.

Section 302 provides authority for the sanitation, waste, and facilities programs which provide for development and operation of safe water, wastewater, and solid waste systems, and related support to facilities.

Section 306 provides authority for the *Small Ambulatory Program* (SAP), which serves to assist Tribes with their unmet facilities needs. This competitive program provides the construction funds, facility maintenance costs, and medical equipment costs, while the tribe provides the staffing package. The SAP program has not been consistently funded by the Congress nor has the IHS requested adequate funding.

Section 818 provides authority for the *Joint Venture Program* (JV), which was developed to help assist tribes with their unmet facilities needs. This competitive program provides the medical equipment funds and the complete staffing package for a selected facility that is constructed with tribal resources so long

as it meets IHS planning requirements. Again, the JV program has been inconsistently funded by Congress and the IHS has not requested adequate funding for the program.

Recommendation: The IHS could extend the benefits of appropriated funds under the proposed HFCPS to a significantly larger number of tribes and communities by consistently providing adequate funding for the SAP and JV programs. Tribes have built approximately three times more health care space than the IHS has under the HFCPS and have done this with limited funds through the Joint Venture and the Small Ambulatory Programs.

Recommendation: A recommendation developed by Tribes is the creation of an Area Distribution Program (ADP). The ADP is intended to provide funds to each IHS Area to fund projects on the national priority list that are high priorities for the Area but don't rank high enough to receive direct Congressional funding in the near future. Thus, it provides a methodology for allocating funds to Area Offices to address the highest priority projects within the Area. These funds can be used to match other local, state, and federal funds to complete a project that would take many more years to complete if they were limited to using IHS funds. Congress should pilot this recommendation as a demonstration in FY 2010.

IV. Health Facility Construction Priority System (HFCPS)

In FY 2000, Congress recognized the significant and growing unmet facility needs, and directed the IHS to consult with Tribes and the Administration to revise the Healthcare Facilities Construction Priority System (HFCPS). The Interior Appropriations Conference Report (106–406) directed the IHS "to reexamine the current system for construction of health facilities" and to develop "a more flexible and responsive program. . .that will more readily accommodate the wide variances in tribal needs and capabilities." Over the last eight years the IHS Facilities Advisory Appropriation Board (FAAB) and Tribes have been working collaboratively to make a major overhaul of the construction priority system. Although the resulting proposal is a vast improvement over the current process, it has not yet been implemented by the IHS.

One recommendation from the FAAB is the creation of an *Area Distribution Program* (ADP) that is described above. The ADP provides an alternate funding method for facilities construction that is a hybrid of the JV and SAP program. There is precedent for an area funding distribution in the Sanitation Deficiency System (SDS). The program strategically aligns project funds with healthcare mission by eliminating or reducing deficiencies in water supply and waste disposal facilities. It uses a methodology "developed by the Secretary. . .and applied uniformly to all Indian tribes and communities" to address an identified inventory of needed facilities. The system has worked to minimize complaints and concerns from Tribes over access to funds and has met the needs of most Tribal communities. An ADP could achieve the same outcomes.

The ADP would be initiated when Congress appropriates funds for this purpose, the fund would be another line item in the facilities appropriation just as Joint Venture, Small Ambulatory Clinic, Dental, and Priority List Construction are separate line items now.

The ADP proposal would require these funds to be distributed to the highest priority Area Office facilities where the Area and Tribes agree that only limited new staffing is required. Upon completion of ADP projects, the facility will be allocated only about 40 percent of the additional staffing and operational funds usually allocated to new facilities. As proposed by the FAAB, the ADP funds would be allocated as follows:

- In a given year, the Area Offices may not participate in the ADP if the line-item amount in the Facilities Appropriation exceeds 20% of the total appropriations for facilities construction.
- Those Areas that receive 20% or less of the annual line-item facilities appropriation are allocated a portion of the Area Distribution Program funds using a formula based on Area user population and location cost adjustments.

The benefit of this process is every IHS Area is able to participate. Other matching funds can be used to build, renovate, and expand a facility; and some staffing is provided. Each Area can complete a high area priority project, and M&I funds can now be used for code and infrastructure type projects like boilers, chillers, pumps, air handlers and life-safety code issues. More projects addressing the overall unmet needs are completed more quickly and at a lower costs since non-IHS partners like private foundations and other granting agencies contribute funding for some of the staffing and/or construction costs.

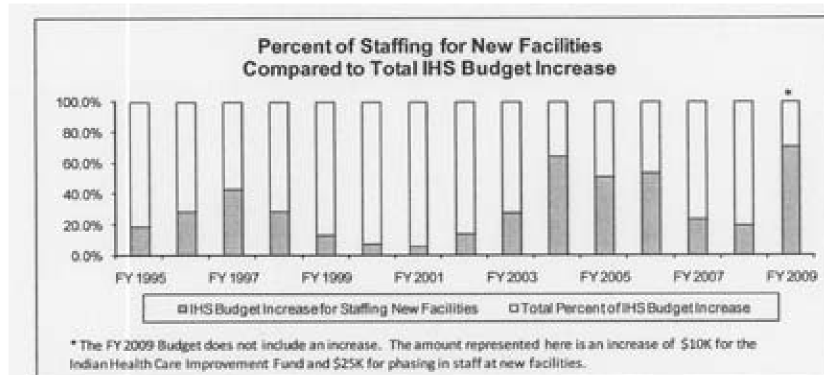
Some Areas have expressed concern about projects identified back in 1991 that are now on the national priority list. They question whether the Area Distribution Funds may dilute the facilities appropriation and further delay funding for their projects. However, the Joint Venture and SAP funding lines are already in place on the facilities appropriation and Congress has continued to provide funding to these programs along with funding individual projects on the priority list.

Recommendation: Tribes have recommended that $20 million be provided for an ADF during the FY 2010 IHS budget formulation process. Congress should pilot this recommendation as a demonstration in FY 2010. The recommendation provides equity for facilities construction that is supported by most Tribes nationally.

V. Facilities Funding Inequities

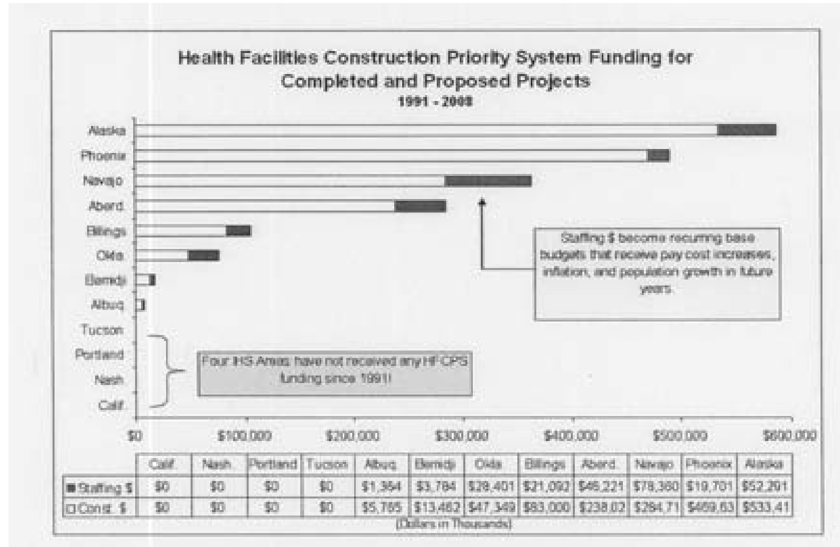
Generally, tribes nationally support funding for facilities construction as long as resources fund all authorities for facilities construction on an equal basis. Those Areas such as Portland, California, Nashville, and Bemidji have never had the opportunity to compete for facilities construction funding on the same basis as other Areas of the IHS system. The California and Portland Areas do not have no inpatient facilities at all and rely on the Contract Health Service (CHS) program to provide specialty and inpatient services. These Areas are often referred to as CHS dependent Areas.

Because the CHS program is chronically under funded and the fact that CHS dependent Areas have never had an equal opportunity to compete for facilities construction funding that provides for staffing and equipment packages, they are not supported facilities construction funding. The significance of staffing new facilities is that it removes funds necessary to maintain current services (pay costs, inflation, and population growth) from the IHS budget increase, which then become recurring appropriations. This results in a disproportionate share of resources to only a few of the IHS Areas and results in developing gaps in the level of health services throughout Indian Country. Tribes nationwide ask, “Why did our health program only receive less than a 1 percent increase in funding, when the overall IHS budget received a 5 percent increase? The answer to this is due to phasing in staffing at new facilities.



The graph above illustrates the significance of staffing new facilities on the IHS budget increase. Staffing packages for new facilities are like pay act costs in two respects: (1) They come “off the top,” (i.e. they are distributed before other increases), and; (2) They are recurring appropriations. In FY 2004, the new staffing was over 60 percent of the IHS budget increase. In FY 2005 and FY 2006, new staffing costs consumed over 50 percent of the increase. This year, the proposed FY 2009 IHS budget was decreased by $21.3 million, yet a new facility within the IHS system will receive $25 million for new staffing. Clearly, the Agency proposes to cut the health budgets of 560 Tribes in order to fund staffing packages.

In addition to the staffing concerns, CHS dependent Areas are not afforded the same opportunity to access facilities construction funding that comes with staffing and equipment packages (Section 301 projects) as other Areas. The graph below illustrates those Areas that have received Section 301 funding between 1991 and 2008.



	Calif.	Nash.	Portland	Tucson	Albuq.	Bemidji	Okla.	Billings	Aberd.	Navajo	Phoenix	Alaska
■ Staffing $	$0	$0	$0	$0	$1,364	$3,784	$28,401	$21,092	$46,221	$78,360	$19,701	$52,291
□ Const. $	$0	$0	$0	$0	$5,765	$13,462	$47,349	$83,000	$238,02	$284,71	$469,63	$533,41

Recommendation: Tribes have demonstrated by building approximately three times more health care space than the IHS, that alternative and innovative forms of facilities construction financing should be supported. If Tribes nationally are to support facilities construction funding, a methodology that ensures equal access must be developed and supported. If this does not happen, Tribes will continue to be divided over facilities construction funding. Establishing the FAAB's recommendation for and ADP would address this concern.

VI. Conclusion

The challenges in providing care to AI/AN people are unlike any other. It serves the poorest, sickest, and most remote populations in the United States. Despite the effective use of a public health delivery model and the advances the Indian health system has made toward addressing health disparities, the funding constraints often result in rationing health services. It has been because of the access to Medicare and Medicaid programs that have often kept many Tribal health programs from going bankrupt. In order to provide quality health care you must have access to services and facilities to provide them. There is no doubt that the condition of Indian health facilities is woeful and that funding is the root cause. There is also no doubt that more new facilities are needed throughout Indian Country.

If the Congress is to provide more funding to address the state of Indian health facilities, than it must also ensure that there is a method that allows all federally recognized Tribes an equal opportunity to access there sources. If an equitable system is not created it will only result in inequities in the level of health services delivered across Indian Country. Those Areas and Tribes that are fortunate to receive new facilities will be able to expand their health services base, while those that do not will continue to ration care.

Any new funding should also go beyond just addressing facility construction and maintenance needs. It should also support medical equipment replacement, facility and environmental support, and support Alaska Native village programs. Adequate funding for these programs will ensure that the facilities we build today will be available for continued use into the future.

Thank you!

PREPARED STATEMENT OF RON HIS HORSE IS THUNDER, CHAIRMAN, STANDING ROCK SIOUX TRIBE

My name is Ron His Horse Is Thunder and I am the Chairman of the Standing Rock Sioux Tribe. Our Reservation is 2.3 million acres and is located in North and South Dakota. We have 14,000 tribal members, 7,000 of whom live on the Reservation. I appreciate the Committee's attention to the longstanding issue of facilities in Indian country and I thank you for holding this hearing. I would like to tell you

the story of our efforts to build a juvenile detention facility at Standing Rock and the obstacles we have encountered.

The question of how to deal with young offenders on our Reservation is a significant problem. Nearly half of our population is below the age of 25, and our young population is disproportionately affected by risk factors known to increase the likelihood of delinquent behavior. We have very high unemployment rates: 91 percent of our population in South Dakota and 56 percent of our population in North Dakota is unemployed.[1] Educational attainment among our members is low: almost one quarter of our members over the age of 25 did not finish high school and only 9.5 percent of our members have completed four or more years of college.[2] Our members also deal with chronic health problems[3] and substandard housing.[4] Drug and alcohol abuse and dependency is the number one health problem among our members, including youth.[5] Standing Rock was the site of a much-discussed suicide cluster in 2004–2005 and we continue to struggle with one of the highest youth suicide rates in the Nation. Given the risk factors faced by our youth, juvenile crime is an urgent problem here, and only effective interventions can begin to stem this tide.

Law enforcement services on our Reservation are provided by the Bureau of Indian Affairs. For many years, the Tribe has considered contracting with the BIA to provide these services for our own people, but the financial resources available to the BIA which Indian tribes may assume under a P.L. 93–638 contract are so severely inadequate that we believe it would be impossible to provide an acceptable level of law enforcement services to our members. We are unwilling to assume responsibility for these services without the assurance of at least minimally adequate base funding. So we continue to work with the Bureau to ensure that services are provided.

The BIA operates an adult detention facility on the Reservation. That facility is outdated by today's standards. For example, according to a 2004 report by the Bureau of Justice Statistics, only routine counseling and psychotropic medication are provided, but mental health screenings, psychiatric evaluations, 24-hour mental health care, and even on-site medical care are not available.[6] Staff is not trained in suicide prevention, and only basic intake screening and suicide watch are provided when needed.[7] Domestic violence and sex offender counseling is not provided.[8] An older adult facility such as ours is also not physically equipped to house juveniles. BIA standards, which mirror federal policies set forth in the Juvenile Justice and Delinquency Prevention Act, require that juveniles be separated by "sight and sound" from adult offenders, and our building cannot accommodate this.[9] BIA standards also require that staff who work with juvenile offenders be specially trained. Our facility has neither the architecture nor the staffing and services necessary to handle young offenders.

When a young person is arrested on Standing Rock, he or she can be temporarily held in the adult facility for a maximum of six hours. After adjudication, if a young person is given a disposition of detention, the first challenge is to find bed space at an off-Reservation detention facility. If we can find a bed, BIA law enforcement officers must then transport the juvenile off-Reservation to a facility at Cheyenne River Sioux or to a county facility. This takes staff time from the limited number of BIA law enforcement officers on the Reservation, making those officers unavailable to respond to calls or to investigate crimes. Our youth must serve out their de-

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[1] U.S. Dep't of the Interior, Bureau of Indian Affairs, American Indian Population and Labor Force Report (2003).

[2] Census 2000 American Indian and Alaska Native Summary File, Table DP–2, Profile of Selected Social Characteristics, Educational Attainment for Standing Rock Sioux Tribe (2000).

[3] Fifty-percent of our members aged 60 and older have been diagnosed with diabetes; 43.6 percent have heart disease and 80 percent suffer from hypertension. Fort Yates Indian Health Service Unit, GPRA/DM Audits (2007). Only 3.6 percent of our members are over the age of 65, indicating a very low life expectancy. Census 2000 American Indian and Alaska Native Summary File, Table DP–1, Profile of General Demographic Characteristics, Sex and Age for Standing Rock Sioux Tribe (2000).

[4] Nearly 40 percent of houses on the Reservation we built before 1970 and 22 percent were built before 1960. Census 2000 American Indian and Alaska Native Summary File, Table DP–4, Profile of Selected Housing Characteristics, Year Structure Built for Standing Rock Sioux Tribe (2000).

[5] Standing Rock Sioux Tribe Comprehensive Chemical Prevention Program, CY 2006 Annual Report (March 2007), at 2.

[6] U.S. Dep't of Justice, Bureau of Justice Statistics, Jails in Indian Country, 2004 (Nov. 2006, revised Feb. 7, 2007), at 18, 24.

[7] *Id.* at 25.

[8] *Id.* at 26.

[9] *See* 42 U.S.C. § 5633(13) and 42 U.S.C. § 5633(14) for Juvenile Justice and Delinquency Prevention Act requirements.

tention miles from their home community. As you can imagine, this situation makes it very difficult for family members to visit youth while they are detained. Distance also makes it difficult for family counseling to be effective. Even worse, many youth are not arrested or treated at all because of the lack of facility space. BIA law enforcement employ a "catch and release" strategy which leaves young offenders unmonitored and untreated, leaving those youth to create disruptions in our schools and our community. It sends a poor message.

In 2004, to address the need for a safe and effective juvenile facility, the Tribe began working with architects, planners and agency officials to design a juvenile detention and rehabilitation facility. The facility is planned as an 18-bed facility—just large enough to meet our need to house young offenders. More importantly, it will permit young offenders to be treated on the Reservation in a culturally-appropriate setting. It will be staffed by professionals who can address the behavioral, family, mental health and alcohol and drug issues that our youth face.

In FY 2004, we received a $3 million grant from the Department of Justice (DOJ) to build this facility and in FY 2006 we received a supplemental grant from DOJ of $695,000. The Tribe contributed $900,000 towards the project. In December 2006, we secured a Finding of No Significant Impact (FONSI) from the BIA, but our efforts have been slowed due to lack of funding. We are grateful for the assistance provided so far, but the amount we received is far short of the actual cost of planning, designing and constructing a facility. Through our planning and budgeting process, we have identified an estimated project cost of $5.7 million. Our total budget so far is $4.5 million (including $3.7 million in DOJ funding and nearly $1 million in Tribal funds). This leaves the Tribe scrambling to cover a shortfall of $1.2 million.

Our Tribe battles extremely high poverty rates. Over 40 percent of tribal households have incomes below the poverty line.[10] Our rural location means that economic development opportunities are limited. The Tribe primarily raises revenue through various taxes, leasing of tribal lands for grazing, and through operation of the Prairie Knights Casino in North Dakota and the Grand River Casino in South Dakota. While the casinos are an important source of jobs for Tribal members, they contribute only modest revenues to tribal operations, due mostly to our remote location. Simply put, we cannot afford to make up for these federal shortfalls for construction of essential detention space.

Because of funding shortages, we also had to cut a portion of the original design. The facility was originally planned as a 36-bed unit and included a Transitional Living Unit along with a secure detention facility. This unit would contain eight beds and classroom space designed to help youth transition from detention back into the community. Transition and aftercare are extremely important pieces of effective intervention and rehabilitation in order to ensure that young people do not return to the destructive habits that brought them into the system in the first place. Yet the Transitional Living Unit portion alone would have cost an additional $1.5 million, so we were forced to eliminate it from the project. We also reduced the planned number of beds from 36 to 18. Yet even with this cutback, the facility has not yet been completed.

Despite the Bureau's responsibility to provide law enforcement and detention services at Standing Rock and the clear need for a facility devoted to juveniles, the Tribe has had to work hard to make this facility happen. The Tribe applied for the initial DOJ grant, contributed a substantial amount of money, and has worked closely with architects and planners to make sure construction continues to progress. Quite simply, we have stepped in where the Bureau is failing to provide adequate facilities to meet our population's needs. And yet we still lack the resources to complete the facility. We have also not been assured by the Bureau that program funds will be added to the BIA budget for recurring staffing and operation and maintenance (O&M) costs.

I know that you have heard from many tribes concerning the need for juvenile detention facilities. While some funding has been made available through DOJ to build facilities, the amount provided is not enough to build a detention facility, nor does there seem to be any coordination between DOJ, the Tribal grantees and BIA. BIA participation is necessary because BIA is required to fund staffing and operations and maintenance costs of such facilities. Many facilities similar to ours have been fully constructed, but they stand empty because of lack of staffing and O&M money. Idle facilities benefit no one. We are not interested in building another substandard facility, but a quality detention facility can easily cost $5–10 million to construct. We were lucky–some tribes need detention facilities but did not receive

[10] Census 2000 American Indian and Alaska Native Summary File, Table DP–3, Profile of Selected Economic Characteristics, Employment Status for Standing Rock Sioux Tribe (2000). The rates were similar in 2007.

a DOJ grant at all. The outlook for more funding is not good; DOJ has recently stated that only small grants (less than $1 million) are available for rehabilitation of existing facilities because the entire DOJ facilities budget is only about $6 million annually.

I understand the Bureau plans to release a report on the need for detention facilities in Indian country, along with a plan to address this need. I hope this plan prioritizes completion of the facilities all over Indian country that are incomplete or lack adequate staffing. I also hope that BIA and DOJ will coordinate in order to make enough money available to construct, staff, operate and maintain new facilities, rather than leaving Tribes stuck with the piecemeal approach of requesting annual earmarks to complete construction, staff and operate their projects. Detention facility construction and operations seems to have fallen through the cracks between these two agencies, with Indian youth and Native families as the main victims. I hope that Congress will continue to encourage the agencies to work together to correct this flawed system.

Thank you for giving me the opportunity to present this testimony.

PREPARED STATEMENT OF KYLE PRIOR, CHAIRMAN, SHOSHONE-PAIUTE TRIBES OF THE DUCK VALLEY RESERVATION

Chairman Dorgan, Vice Chair Murkowski, and members of the Committee, thank you for accepting this testimony. My name is Kyle Prior. I am the Chairman of the Shoshone-Paiute Tribes of the Duck Valley Reservation. I am experienced in the area of juvenile justice and I am a member of the Idaho Juvenile Justice State Advisory Group. The story I want to tell you involves what I believe is an ongoing problem for the BIA–the absolute failure to proved safe and effective juvenile justice services to Indian children and the refusal to assist tribes when they step in to create these services themselves. I know all too well that facilities of all types in Indian country are in dismal condition. At Duck Valley, we have seen our share of dilapidated schools, outdated hospitals, makeshift office buildings, and substandard housing. I want to focus on juvenile facilities because this is our most pressing need at Duck Valley right now. I also believe the problems we at Duck Valley have faced in trying to open a juvenile detention facility are similar to the problems faced by many other tribes in the same situation. Somewhere in the process of designing, building, opening, staffing and maintaining a facility, the BIA always seems to fall through. This is an area in which the BIA's inept management of facilities is having serious consequence for Indian youth and for tribal governments seeking to create effective community-based interventions for those youth.

I. The Duck Valley Reservation

We live on a remote, rural reservation located in Idaho and Nevada. The nearest population centers, Mountain Home, Idaho and Elko, Nevada, are 100 miles away. A two-lane road runs through the Reservation between these towns, and the road is sometimes closed during storms. Approximately 2,300 tribal members live on the Reservation. Like many isolated, rural tribes, our community is relatively poor. The unemployment rate is 60 percent, and 95 percent percent of students are poor enough to qualify for free or reduced lunch.[1] In the area of law enforcement, we are a direct service tribe. The Bureau of Indian Affairs provides our police and detention services. Attracting and retaining adequate law enforcement staff has always been an issue at Duck Valley. We are now down to only 3 police officers, including the Chief of Police.

II. The Need for a Juvenile Detention Facility

Several years ago, juvenile crime rates on the Duck Valley Reservation were very high. At that time, we had no place to send youth on the Reservation when they got into trouble. Although we have a BIA-run adult jail in Owyhee, we do not have a facility in which to house juvenile offenders. Our 27-bed adult facility is the only BIA facility in Nevada, and it serves as a regional facility, housing offenders from several other reservations. Our area has a similar lack of juvenile facilities. Delinquent youth are sent by the BIA to a county facility 100 miles away in Elko, where the BIA rents detention beds. However, we have encountered at least two problems with this system. First, the local community is often overwhelmed by its own juvenile justice needs. Often, no beds are available for youth from Duck Valley. Sometimes, we send a young person there, only to receive a call several days later saying

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[1] University of Nevada, Nevada Cooperative Extension, "MAGIC" (Making a Group and Individual Commitment): A Program for Entry-Level Juvenile Offenders in Owyhee, Nevada (2000), available at *http://www.unce.unr.edu/publications/files/cd/2000/fs0031.pdf, at 2.*

the bed is needed and the juvenile has to be sent home. Second, youth in Elko are usually detained for only a few days, whereas Duck Valley youth are frequently given detention terms of weeks or months. Because Elko is run as short-term facility, it is not well equipped to handle offenders with longer terms.

The other option available to the BIA at that time was to send youth several states away to Peach Springs, Arizona. At that time, the Peach Springs facility was the only BIA-run juvenile facility in the area. When your children are sent so far away, it is very difficult to monitor their well-being or be sure they are safe. Parents were not familiar with the Peach Springs facility. They didn't know what type of programs and recreation were available, how closely the youth were monitored, or whether adequate health care was provided. In one instance, a young boy from Duck Valley was beaten up by other juveniles while at Peach Springs. His tooth was knocked out, and his mother was left to find him medical care. Incidents like these caused concern in the community about what was happening to our children in this distant facility. As it turned out, our concerns were well-founded. The Peach Springs facility was closed by the BIA for several years after questions were raised about the adequacy of supervision and whether some youth were bringing contraband into the facility. Today, offenders requiring longer detention terms are sent to a juvenile facility is in Towaoc, Colorado, which is run by the Ute Mountain Tribe. In my opinion, it is much better than Peach Springs; unlike BIA-run juvenile facilities, it offers recreation facilities and an on-site nurse. Nevertheless, our Tribes' overall experience with sending children away from the community led us to begin searching for ways to bring a juvenile facility to Duck Valley.

III. Planning and Building Our Facility

As you might expect, the BIA was unresponsive to our requests for a juvenile facility. The Tribes then approached the state with a proposal for a state-run juvenile detention facility in Owyhee. In our view, having a state-run facility in our community was a better option than letting our youth go to an Indian facility located hundreds of miles away. This plan fell through, however, because the State saw the remote Reservation as an ideal location to build a juvenile super-prison containing several hundred beds. This was not the type of local facility we had in mind.

In 1998, we were awarded a grant through the Department of Justice's "Correctional Facilities on Tribal Lands" program. Planning began in 2000, but we did not have enough money for the size of the facility we sought to construct because of a significant increase in fuel prices and construction costs. We received a supplemental grant from DOJ, and construction began in 2002. The total cost of the project was over $4 million, with the Tribes contributing the required 10 percent match (about $500,000). In addition to the basic building costs, the Tribes also built the access road and the infrastructure (e.g., water, power, sewer). Construction on the 28- bed facility was finally completed in 2004, with building furnishings provided by the BIA.

We worked closely with the BIA during the planning and building process. As this was to be a BIA-run facility, we were careful to follow all of the BIA requirements. We were in close contact with the Owyhee office and the Regional office; the District Commander for District 3 approved our plans. In 2004, the completed facility was inspected by BIA's Office of Facilities Management and received all the necessary certifications. After years of planning and building, the Tribes expected that our new juvenile facility would open the following year.

IV. Staffing and Operational Failures

It is now 2008 and our brand new juvenile facility has never opened. Soon after we received our facility certification, officials from the BIA Office of Law Enforcement Services visited the facility. The staff of OLES at that time was almost all different people from those involved in the planning process. These new staff had new ideas about how a juvenile detention facility should look, and ours did not fit that idea. For example, we were told our security glass was not positioned correctly and that our doors were not made of the correct type of reinforced steel. The type the BIA wants to see is the type used in places where the most serious offenders are housed, places where high-security reinforcements are needed to keep unruly offenders from breaking down doors.

This is not the kind of issue we face at Duck Valley, and the Tribes did not intend to build a high-security facility for the most serious offenders. The Shoshone-Paiute Tribes are committed to a community-based, treatment-focused approach to juvenile justice, rather than an overly punitive model. While building the new facility, the Tribes also worked to improve juvenile diversion and intervention services through our MAGIC (Making A Group and Individual Commitment) program, which teaches first time and non-violent offenders and their parents the skills needed to avoid de-

linquent behavior. Working with BIA and DOJ staff, we designed a built a facility suited to the type of offender we most often encountered at Duck Valley, generally less serious and nonviolent offenders. Yet at the very end of the process, the BIA informed the Tribes that several changes that would need to be made to bring the facility up to its new standards, standards that were not communicated to us before. Of course, they never explained how these changes were to made, who would pay for them, or whether the BIA would assist with them or expected the Tribes to make these changes on our own. In fact, during my tenure as Chairman, we have not even received a comprehensive list of the changes that must be made.

Knowing that some changes would need to be made, the Tribes sought to open half the facility to house juveniles. Our staffing plan calls for about 30 staff to run the entire facility, meaning we need about 15 staff to open half of it. We have only 6 staff now. We have asked the BIA many times about hiring staff, but the only answer we get is that it's hard to find qualified staff people and hard to pass background inspections. The Duck Valley Council passed a resolution long ago waiving the BIA Indian preference, allowing them to hire non-Indian law enforcement and detention officers. Yet even with this additional leeway, they can find no one. In my view, the BIA's inattention to the facility is to blame. We have hired juvenile detention officers. At one point, we had 12 officers, nearly enough to open half the facility. Currently, we have a highly qualified Juvenile Corrections Supervisor from Chicago working on the Reservation. But the facility remains closed, the space is used for BIA office space, and our juvenile detention officers are detailed into other positions. One by one, they grow frustrated and leave.

We are in a Catch–22. We are told the facility cannot open because of a lack of adequate staff, but qualified staff do not stay long because the BIA's failure to open to facility means they have no work to do. The Bureau makes only minimal effort to recruit and hire staff. And the question of whether the facility needs improvements, and what kinds, looms. Meanwhile, the building itself is aging and will slowly begin to deteriorate. Because it is not open, the BIA is not performing any maintenance. Many tribes complain that they need new jails, hospitals and schools. We have a new building, but it has been sitting empty for over 4 years. We have traveled to Washington several times to ask the BIA why our facility is not open. Each time, new Central Office personnel say they will look into it. Each time, nothing happens at all.

V. The Problem

Beyond the BIA's general failure to build and maintain facilities, there are several factors at work here that should be remedied. First, there is a lack of communication between the Central Office and the field offices, which sometimes results in inconsistent policies. This is how a multi-million dollar project that was approved by Regional supervisors can be later disapproved and ignored by Central Office. This is an expensive lack of communication.

Second, the policy shifts within the Office of Law Enforcement Services (now Office of Justice Services) are frequent and abrupt. The BIA's disapproval of our facility is based on the opinion of certain Bureau personnel that it doesn't fit the current BIA mold, which is a highly secure lockdown facility. My experience with juvenile justice has taught me that such facilities are a poor choice, especially in a community like ours, which does not have very many extremely violent offenders. While I understand that BIA policies will change, these shifts cannot be used as an excuse to completely abandon a tribally-driven project just because it doesn't match the Bureau's preference that young offenders be locked in high-security warehouses.

Finally, when issues arise, the Bureau utterly fails to communicate with tribes. We know our facility is not open, but we have never been given a clear explanation of why no staff have been hired, what aspects of the building need to be changed, and whether the BIA intends to assist us with making these changes and to begin maintaining the building. This is especially inexcusable on a Reservation like ours where the BIA is responsible for the delivery of law enforcement services. Not only has the agency completely failed to meet the needs of the Tribes in the area of juvenile justice, it continues to stand in the way of solutions pursued by the Tribes.

Thank you for providing me the opportunity to present this testimony, and thank you for your attention to the important issue of facilities in Indian country. Chairman Dorgan, I hope you will consider ways to address construction, operation and maintenance, and staffing of detention facilities in your law enforcement bill. I would be pleased to provide further information and recommendations as needed.

PREPARED STATEMENT OF THE NATIONAL INDIAN EDUCATION ASSOCIATION (NIEA)

Founded in 1969, the National Indian Education Association is the largest organization in the nation dedicated to Native education advocacy issues and embraces a membership of nearly 4,000 American Indian, Alaska Native and Native Hawaiian educators, tribal leaders, school administrators, teachers, elders, parents, and students.

NIEA makes every effort to advocate for the unique educational and culturally related academic needs of Native students. NIEA works to ensure that the federal government upholds its responsibility for the education of Native students through the provision of direct educational services. This is incumbent upon the trust relationship of the United States government and includes the responsibility of ensuring educational quality and access. Recognizing and validating the cultural, social and linguistic needs of these groups is critical to guaranteeing the continuity of Native communities. The way in which instruction and educational services are provided is critical to the achievement of our students to attain the same academic standards as students nation-wide.

A pattern has developed in recent years where Native education programs get smaller increases in years where overall funding is up and larger cuts in years when overall funding is down. This is unconscionable and must be corrected! Over the years, the President's budget requests have proposed many significant cuts in Native education, which have deepened the negative effects of previous cuts. If these budget cuts to Native education are not reversed, then Native children and Native communities will be further harmed as well as future generations, especially given the tragic reality that the standard of living in Native communities continues to be far lower than any other group in the United States. Native communities continue to experience the highest rates of poverty, unemployment, morbidity, and substandard housing, education, and health care.

There are only two educational systems for which the federal government has direct responsibility: the Department of Defense Schools and federally and tribally operated schools that serve American Indian students. The federally supported Indian education system includes 48,000 students, 29 tribal colleges, universities and postsecondary schools. Despite all of the funding needs for educational services for American Indian, Alaska Native, and Native Hawaiians, many of the programs critical to successful Native students academic achievement, including stable and healthy learning environments and facilities, are unmet year after year.

Indian School Construction and Facilities Improvement and Repair

The inadequacy of Indian education facilities is well documented and well known. The continued deterioration of facilities on Indian land is not only a federal responsibility; it has become a liability of the federal government. Old and exceeding their life expectancy by decades, Bureau of Indian Affairs/Bureau of Indian Education (BIA/BIE) schools require consistent increases in facilities maintenance without offsetting decreases in other programs, if 48,000 Indian students are to be educated in structurally sound schools.

Of the 4,495 education buildings in the BIA/BIE inventory, half are more than 30 years old and more than twenty percent are older than fifty years. On average, BIA/BIE education buildings are 60 years old; while, 40 years is the average age for public schools serving the general population. Sixty-five percent of BIA/BIE school administrators report the physical condition of one or more school buildings as inadequate. Of the 184 BIA/BIE Indian schools, ⅓ of Indian schools are in poor condition and in need of either replacement or substantial repair.

In May of 2007, the Department of Interior visited 13 schools as a part of a Department wide audit and found "severe deterioration at elementary and secondary schools, including boarding schools, that directly affects the health and safety of Indian children and their ability to receive an education." In this report, the Department of Interior found sever deficiencies such as classroom walls buckling and separating from their foundation, outdated electrical systems, inadequate fire detection and suppression systems, improperly maintained furnaces, and condemned schools buildings.

At the Chinle Boarding School located in Many Farms, Arizona, the children have to be transported by bus to an alternative meal site because the cafeteria is condemned. As a result of the off site "cafeteria", injuries have been sustained to students and staff related to transportation, and buses often return late resulting in cold meals for the students. At the Shonto Preparatory School, located in Shonto, Arizona, an employee and her husband were diagnosed with carbon monoxide poisoning due to an aging wall furnace that had not been properly maintained.

Funding for Indian School Construction and Maintenance for Fiscal Year 2009

For FY 2009, the President's budget will only allow for the replacement of one school and the replacement of structures at another school. There are currently BIA/BIE schools that are in need of major repairs or replacements. At the funding level recommended in the President's budget, the backlog for new BIA/BIE schools will not be reduced at all. The need for additional school construction dollars is so great that there should be no slow down in appropriations. Instead, there should be an increased effort to get Tribes and the BIA/BIE to work more efficiently on completing school construction projects while recognizing that schools take time to plan and build.

NIEA requests a *$120.47 million increase* from the FY 2008 enacted level of $142.935 million for a total of $263.4 million in FY 2009 to the BIA for Indian school construction and repair.

After FY 2005, the funding levels have dramatically decreased for this critical program. The funding level in FY 2005 was instrumental in reducing the construction and repair backlog. BIA's budget has historically been inadequate to meet the needs of Native Americans and, consequently, Indian school needs have multiplied. The Administration has sought to justify the decrease over the past few years by stating that it wants to finish ongoing projects. The amounts over the past few years have failed to fund tribes at the rate of inflation, once again exacerbating the hardships faced by Native American students. Further, the funding that has been allocated over the past few years will not keep pace with the tremendous backlog of Indian schools and facilities in need of replacement or repair.

In 1997, GAO issued a report "Reported Condition and Costs to Repair Schools Funded by the Bureau of Indian Affair" that documented an inventory of repair needs for education facilities totaling $754 million. In 2004 the backlog for construction and repair was reported to have grown to $942 million. We believe that we must keep pace with the FY 2005 level of funding in order to finally make some headway in the construction backlog. The purpose of education construction is to permit BIA funded schools to provide structurally sound buildings in which Native American children can learn without leaking roofs and peeling paint. It is unjust to expect our students to succeed academically, if we fail to provide them with a proper environment to achieve success.

The Mandaree Day School located in Mandaree, North Dakota has taken out a loan in the amount of $3 million to cover the costs of building a new education facility. The Mandaree Day School could not wait any longer for the funding from the Department of Interior to build their school. The loan only covers the facility structure and the 210 children attending this school have no playground and the teachers do not have a paved parking lot.

Although education construction has improved dramatically over the last few years, the deferred maintenance backlog is still estimated to be over $500 million and increases annually by $56.5 million. As noted by the House Interior Appropriations Subcommittee in its Committee Report accompanying the FY 2006 Interior appropriations bill, "much remains to be done." Of the 184 BIA/BIE Indian schools, ⅓ of Indian schools are in poor condition and in need of either replacement or substantial repair.

For the past three school years, only 30 percent of BIA schools made AYP goals established by the state in which the school was located. Department of Education statistics indicate that student performance at BIA/BIE schools is lower than students at public schools. NIEA strongly believes that there is a correlation between academic achievement and the environment in which one is expected to learn.

Conclusion

NIEA thanks the Committee for its tremendous efforts on behalf of Native communities. With your support we are hopeful that we can begin to provide the funding for education that Native communities deserve. The National Indian Education Association thanks Chairman Dorgan and Vice-Chairman Murkowski for championing on behalf of all Native students and their successful educational achievements.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. BYRON L. DORGAN TO DOMINGO S. HERRAIZ

Question 1. Your testimony indicates that 17 Tribes have received funding for construction planning. How many of these 17 planning grants will be for new construc-

tion? Is the Department's Indian Jails Construction program moving away from new construction? If yes, please explain why.

Answer. While these 17 grants are not for new construction, the funding will directly support the Tribes' ability to effectively assess their projected correctional needs to accurately determine whether new construction, renovation, or incarceration alternatives will best serve their communities' correctional needs.

With input from Tribal leaders, the Department has implemented a comprehensive approach to supporting Tribes as they plan for short and long term correctional facility needs. In this way, Tribal partners, the Department, and the Bureau of Indian Affairs (BIA) can better identify new construction and renovation priority projects that not only comply with BIA standards, but are safe, secure, appropriate for the intended population, and reflect cultural and traditional values.

Question 2. What is the Department's long term plan for meeting the jails/detention center needs of Indian Country? And have you consulted with Tribes on that plan?

Answer. The Department's long term plan for meeting jail and detention center needs of Indian Country supports Tribal leaders as they assess their own correctional needs and develop strategies to address those needs through renovation, construction, and correctional alternatives. Funding and technical assistance for planning, construction, and renovation efforts is provided to Indian Country, with activities based on input from Tribal leaders, BIA's Office of Law Enforcement Services, and the Office of the Inspector General's recommendations for Tribal jails. The Department will continue to find ways to collaborate with Tribal and federal partners to maximize current and future correctional resources to Indian Country.

The Department of Justice regularly consults with Tribes regarding correctional needs. In 2005, the Department hosted "Listening Conferences" with Tribal leaders and related partners regarding their priorities for Tribal justice programs. Based on their feedback, the Bureau of Justice Assistance (BJA) hosted a focus group with BIA for Tribal leaders in September 2006. In addition, the Interdepartmental Tribal Consultation, Training and Technical Assistance Sessions held in FY 2007 and FY 2008 included several tribal consultation sessions and training focusing on Tribal corrections.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. MARIA CANTWELL TO DOMINGO S. HERRAIZ

Question. In my home state of Washington, our tribes have seen a drastic increase in gang activity and meth use on their reservations. This criminal activity not only causes reservations to be less safe, but many times the communities around them as well. Tribal police and law enforcement have been chronically underfunded and the tribes are struggling to gain control of the rising crime on their reservations. How, in a time where crime is on the rise and the need for more law enforcement funding crystal clear, do you justify the proposal to eliminate funding for New Jails Construction in the DOJ budget?

Answer. The Department's Office of Justice Programs (OJP) has developed a close working relationship with many American Indian and Alaskan Native (AI/AN) tribes and remains committed to helping these communities meet the unique challenges they face in the areas of law enforcement and criminal justice.

The FY 2009 budget request proposes a reorganization of OJP's state and local law enforcement and criminal justice assistance programs, streamlining its many existing programs into three competitive, multipurpose, discretionary grant programs: (1) Violent Crime Reduction Partnership Initiative; (2) Byrne Public Safety and Protection Program; and (3) Child Safety and Juvenile Justice Program. This reorganization will enhance OJP's ability to direct assistance to those jurisdictions demonstrating the greatest need, providing tribal grant recipients with greater flexibility in using their grant funds.

In September 2007, OJP implemented a new Tribal Grants Policy, which will help Tribal communities seeking OJP resources through our competitive grant solicitation process. OJP will continue its support for the Tribal Criminal Justice Statistics Program and victims assistance initiatives serving AI/AN populations through discretionary funding. OJP's tribal budget plan for FY 2008 estimates spending of nearly $44 million in funding for programs to assist MAN tribes, an increase of more than $6 million over FY 2007 funding levels.

In addition, OJP will continue hosting Tribal Consultations and Training & Technical Assistance (T&TA) sessions. These sessions will focus on tribal priority issues related to public safety for families and communities. They will address drugs, tribal

court systems, multi-jurisdictional coordination and communication, sex offender registry, and other law enforcement areas.

OJP will also continue to support efforts to expand federal outreach to tribal governments, such as the Tribal Justice and Safety website (*http://www.tribaljusticeandsafety.gov)* launched last year to assist tribal governments. The website features information on a variety of justice issues, as well as grant funding and training. These efforts are designed to improve communication and to help build tribes capacity to create and leverage resources.

WRITTEN QUESTIONS SUBMITTED BY HON. BYRON L. DORGAN TO JACK REVER AND W. PATRICK RAGSDALE *

Tribal Jails/Detention Centers

Question 1. How many jails and detentions centers in Indian Country are newly built, but remain empty due to lack of staff? Please explain why they are empty?

Question 2. Your testimony states that "there are currently 84 detention facilities across Indian Country. Of these, 38 are owned and operated by the Federal Government, five are owned by Tribes and operated by the Federal Government, and 41 are owned and operated by Tribes." However, the Bureau's Budget Justifications for Fiscal Year 2009 states that "The OJS Division of Corrections funds 67 tribally-operated detention programs and directly operates 24 detention programs facilities."

(1) Please explain the discrepancy, and

(2) provide the exact number of the following based on your latest information:

(a) total number of tribal jails/detention centers;

(b) number of juvenile detention centers;

(c) number of jails/detention centers owned and operated by the Federal Government;

(d) number of jails/detention centers owned by Tribes and operated by the Federal Government;

(e) number of jails/detention centers owned and operated by Tribes.

Question 3. The Budget also requests a nominal increase in staffing. However, I note that of the 146 new staff that would come on board if Congress granted your Budget request—only 20 staff would go to fund staff at the 67 Tribally-owned and operated jails. The remaining 126 new corrections staff would be placed at 24 directly operated BIA jails. Please provide an explanation justifying this request.

Question 4. The poor state of Indian Jails is a long standing problem. Attorney General Reno testified in 1998 about this issue. The Inspector General recommended in 2004 that Justice and Interior develop a strategic plan for jails replacement and renovation. What the status, if any, of the strategic plan between the two Departments to replace and renovate Indian jails?

Question 5. Mr. Guillermo Rivera discussed the Shubnum Indian Jails Report last March before the Prison Rape Elimination Commission. He reported that Shubnum found an approximate $6 billion backlog in Indian jails for construction and maintenance. Can you confirm that number?

Question 6. Have you shared any portion of the Shubnum Report with the Department of Justice who is responsible for administering funds for new Indian jails construction?

Question 7. We know that the backlog for Indian jails is in the billions of dollars. However, the Department requested less than $8 million for Indian jails renovation—a $3 million dollar cut from last year's appropriated figure. Can you explain the Department's justification for this request?

Question 8. What is the condemnation process at the Bureau and what do you do to help tribes once you've condemned their building?

Question 9. A number of Tribes have to transport their inmates to far away jails. It is my understanding that your office does not include a line item for prisoner transportation. Please explain why transportation costs are not included in your budget, and answer whether the Department will include a line item for corrections transportation in the future?

Tribal Schools

Question 10. The Committee understands that in addition to the 14 schools on the priority construction list, over 70 schools need replacement or repair.

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* Response to written questions was not available at the time this hearing went to press.

Question 11. What it the cost to complete the 14 schools on the 2004 priority list?

Question 12. What is the estimated cost to replace or repair the additional 70 schools?

Question 13. The Committee understands that a new priority list for school construction will be developed this year with the goal of releasing a new list in 2009. What is the current status of forming a team to work on the list? Will it be open to all tribal leaders? What process will you use to develop the list?

Question 14. We received testimony today describing a lengthy process for school facilities construction. It appears that some schools have been in the planning stage for 7 years and will likely take 12–13 years for completion. Why does the process take so long? What is the Bureau doing to address this backlog?

Question 15. How would you suggest the Bureau streamline the process? Do you currently allow schools that are ready to move to the next phase do so, or do you hold them up until schools ahead of them on the list have progressed?

Question 16. The Inspector General released a Flash Report in May 2007 warning of the dangers that existed at Indian schools. It is our understanding that a final report will be released within the next month.

Question 17. What has the Bureau done to address these emergency conditions?

Question 18. What is the Bureau doing to ensure these types of situations don't occur in the future?

Question 19. We understand that in addition to those schools identified in the Inspector General report, other schools face similar emergency situations. For example, the Committee has been informed that the Laguna Elementary School in New Mexico was temporarily shut down in November due to "unsafe" conditions until a review of the structural stability of the building could be completed.

Question 20. What has the BIA done in terms of follow-up since the November engineer's report and re-opening of the school?

Question 21. Will the BIA provide any funding to temporarily cure defects of the facility?

WRITTEN QUESTIONS SUBMITTED BY HON. TIM JOHNSON TO JACK REVER AND W. PATRICK RAGSDALE *

Question 1. It seems that one of the major problems facing detention facilities is actually the staffing issue. I find this ironic because unemployment is one of the most severe problems facing Indian tribes. What is the BIA doing to recruit detention officers in Indian Country?

Question 2. Is there any coordination with tribal employment programs or tribal colleges?

WRITTEN QUESTIONS SUBMITTED BY HON. JOHN BARRASSO TO JACK REVER AND W. PATRICK RAGSDALE *

In 2006, the Drug Enforcement Agency in cooperation with BIA and local law enforcement officials took down the Hermosillo Methamphetamine Trafficking Group operating on the Wind River Reservation. This was one of the largest drug busts in Wyoming's history. Yet, it is my understanding that Wind River Reservation law enforcement officials are operating out of very limited facilities and the detention center has even less space. There is clearly a trend of drug gangs using Indian reservations to operate their criminal enterprises, and the Wind River Reservation has already seen this firsthand.

Question 1. As such, do you believe the Wind River Reservation's law enforcement facilities are adequate to deal with this new trend?

We have fundamental problems meeting the needs of tribal facilities in both funding and construction. Yet, we also need to focus on the maintenance needs of these structures to get return on the investment of federal dollars.

Question 2. How can the system be improved to ensure that money and manpower is available and accountable for maintaining BIA properties?

On the Wind River Reservation, the one tribal school—St. Stephens' school—was approved for a new high school facility. It is my understanding that the much-need-

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ed construction project has been reduced in scope several times since it was first approved by the BIA. As a result, there will be no room for additional students.

Question 3. What BIA actions can be expected if the school enrollment exceeds the new facility's capacity?

Question 4. Would the school be placed on a separate priority list for expansion or would it be required to compete for funding with all other replacement facilities?

Question 5. Considering the disparities in BIA facilities funding allocated to certain tribes and regions in recent years, do you believe the current priority system of facilities funding equitably distributes federal dollars?

Question 6. How can it be revised to meet our obligation to *all* tribal members?

WRITTEN QUESTIONS SUBMITTED BY HON. MARIA CANTWELL TO RANDY GRINNELL *

Question 1. Mr. Grinnell, I understand that the revised Health Facilities Construction Priority System was submitted to the Indian Health Service by the Facilities Advisory Appropriation Board in March 2007. It has now been a year, and we have seen no action by the Indian Health Service on the Board's recommended changes.

When can we expect to see a decision on the revised system?

Given the backlog under the current priority list, how long do you expect it will take to implement the new priority system?

Question 2. Mr. Grinnell, as you know, the current state of Indian health facilities in Washington state is appalling. Our tribes do not have access to their own Indian Health Service inpatient facility, and some are making do with clinics operated out of mobile homes. Despite the pressing need for health facilities, the Portland Area has not faired very well under the current priority system, which includes no project for Washington state under the locked priority list.

Your written testimony mentions that a revised Health Facilities Construction Priority System would "provide an assessment of health services and facilities needs today and would rank those facilities' needs based upon contemporary criteria."

Can you elaborate on what you mean by "contemporary criteria?" How would the revised system address the facility needs of the Portland Area?

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